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The experiences of nurses on Local Health Group boards in Wales: A gendered analysis.

Hughes, Alison Irene

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Alison Irene Hughes

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Summary

This thesis sets out to explore the role of gender in nurses' organizational experiences. In particular, it charts the way in which gender shapes and impacts upon the organizational lives of nurses on Local Health Group (LHG) boards in Wales.

This study is underpinned by a feminist framework. Data were generated using an ethnographic approach. Two separate phases of fieldwork were undertaken. The first phase of fieldwork began soon after LHGs were established in 1999; the second phase took place some 18 - 24 months later. Research methods included in-depth interviews with nurses (21), GPs (5), and managers (3) and participant and non-participant observation.

This thesis argues that gender is key to understanding the organizational experiences of LHG board nurses. In particular it is argued that nurses' experiences as board members and their ability to contribute to and influence the work of the LHG have been circumscribed by their devalued and subordinate identity as nurses and women. It is also argued that nurses' experiences need to be contextualised with reference to the gendering of organizational culture and the masculinity of organizational life. Such an understanding is vital if some of the obstacles nurses face in their attempts to influence and contribute to health care policy and decision making are to be addressed.

Declaration and Statements

Declaration

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed...(candidate)

Date.......... 29th November 2005 ....

Statement 1

This thesis is the result of my own investigation, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed..(candidate)

Date.......... 29th November 2005 ......

Statement 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan and for the title and summary to be made available to outside organizations.

Signed.. (candidate)

Date.......... 29th November 2005 ....

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Abbreviations

PHCT	Primary Health care Team
LHG	Local Health Group
LHB	Local Health Board
PCG	Primary Care Group
PCT	Primary Care Trust
CGL	Clinical Governance Lead
HIP	Health Improvement Programme (LHGs)
HIMP	Health Improvement Programme (PCGs)
PMS	Personal Medical Services
GMS	General Medical Services
NSF	National Service Framework
TPP	Total Purchasing Pilot
LHCC	Local Health Care Cooperatives (Scotland)
PCCG	Primary Care Commissioning Groups (N. Ireland)

Transcription Conventions

Interviews were transcribed verbatim.

Pseudonyms have been used for all participants.

Data have been edited in order to preserve anonymity.

…. words or phrase omitted from interview extracts.

( ) Descriptive material added by the researcher to make the meaning clear or to

indicate body language.

Chapter One   Introduction

This thesis sets out to explore the role of gender in nurses' organizational experiences. In particular, drawing on feminist theory, it charts the way in which gender shapes and impacts upon the organizational lives of nurses on Local Health Group (LHG) boards in Wales.

The research began shortly after LHGs were established in 1999. This was a critical time for the health service when major changes in the organization of primary care were taking place throughout the United Kingdom (UK). LHGs heralded new organizational roles for nurses and paved the way for nurses' increased involvement in policy debate and decision making. Given the historical marginalisation of nursing from the health policy arena (Strong and Robinson 1990, Davies 1995, Antrobus and Brown 1997) this marked a significant point in nursing history. However, the opportunities afforded nurses need to be viewed in a critical light. Taking as a starting point work which highlights the importance of gender in understanding the issues and dilemmas facing nurses and nursing (for example Muff 1982a, Reverby 1987, Smith 1992, Witz 1992, 1994, Davies 1995, Porter 1995, Wicks 1998) this thesis provides an insight into the experiences of nurses and the opportunities and obstacles they faced in these new roles.

Following clarification of the key concepts as used within this thesis, this chapter provides an overview of LHGs and their development, outlining existing research on LHGs and their English counterparts, Primary Care Groups (PCGs). I then discuss my rationale for undertaking this study and highlight my research questions. I also situate the research in terms of my own experiences as a woman and nurse. The chapter concludes with an overview of the remaining chapters contained within the thesis.

The concepts of 'gender' and 'organizational experience' are central to this thesis and are clarified below as a prelude to discussing the background to the study in more detail.

Gender

Gender is often associated with the differences between men and women that are socially constructed as opposed to biologically determined (Crowley and Himmelweit 1992). A number of authors (see for example, Acker 1991, 1992, Gherardi 1994, 1995, and Davies 1995) have also suggested that gender can be seen as more than just a set of attributes expressed by individual men and women. Masculinity and femininity can be seen as a set of 'cultural codes' (Davies 1995 p. 21) that help shape and inform social life, including organizational life. This concept points to gender's relational quality and highlights the way in which gender operates at a number of different levels. Thus in exploring the role of gender in nurses' organizational experiences, attention is given to the way in which organizations reflect and actively construct and maintain gendered subjectivities and power relations through a complex interplay of various processes and interactions. This understanding of gender is explored in detail in the literature review.

Organizational experiences

The phrase 'organizational experiences' refers to those experiences which are directly connected to the organization in which nurses work or of which they are a part. It relates to nurses' work experiences, but with specific emphasis on the various practices and social processes which help determine the structural and cultural content of organizational life. Power and power relations form an integral part of these practices and processes. These issues are discussed fully in the literature review.

1.1 Local Health Groups: background and context

Changes to health care services across the UK and Europe indicate that primary care is at the centre of current health policy reform (Exworthy 2001, Williams and Heyerdahl 2004). The past seven years (1998-2005) have seen significant changes in primary health and social care in the UK.

The establishment of LHGs in Wales and PCGs in England[1] was a central part of these changes and marked an important shift in government policy. The changes, outlined in the White Papers *Putting Patients First* (Welsh Office 1998a) and *The New NHS: Modern, Dependable* (Department of Health 1997), signalled the eventual demise of GP fundholding and the rejection of aspects of the internal market.

One of the principal aims of LHGs, as with PCGs, was to give a more local focus to the development and delivery of health services. Increased decision making powers would be devolved to those working within health and social care and to local communities who would take greater responsibility for developing primary and community care and shaping services to meet local need (see Diagram 1, p. 4)

The key tasks and responsibilities of LHGs were:

- To develop primary and community healthcare services.
- To improve the health of their local population and to address inequalities in health.
- To commission hospital and other services to meet local need.
  (Welsh Office 1998b)

Initially LHGs were to operate as sub-committees of the Health Authority covering a population of approximately 100,000 people (see Diagram 2, p. 5). In time, it was anticipated that the responsibilities and budgets of LHGs would increase. Each LHG had a board which was made up of representatives from a range of health and social care providers and users. These boards were expected to identify local health needs in consultation with local people and to develop and commission services to meet those needs.

The production of a health improvement programme (HIP) was a key part of this process. The programme would address national health priorities, as well as the needs and perspectives of the local community, and detail how these would be met.

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[1] Similar changes to the organization of primary care in Scotland saw the development of Local Health Care Cooperatives (LHCCs), and in Northern Ireland, Primary Care Commissioning Groups (PCCGs), though the pace of reform was slower and the responsibilities and remit of these new organizations were more limited.
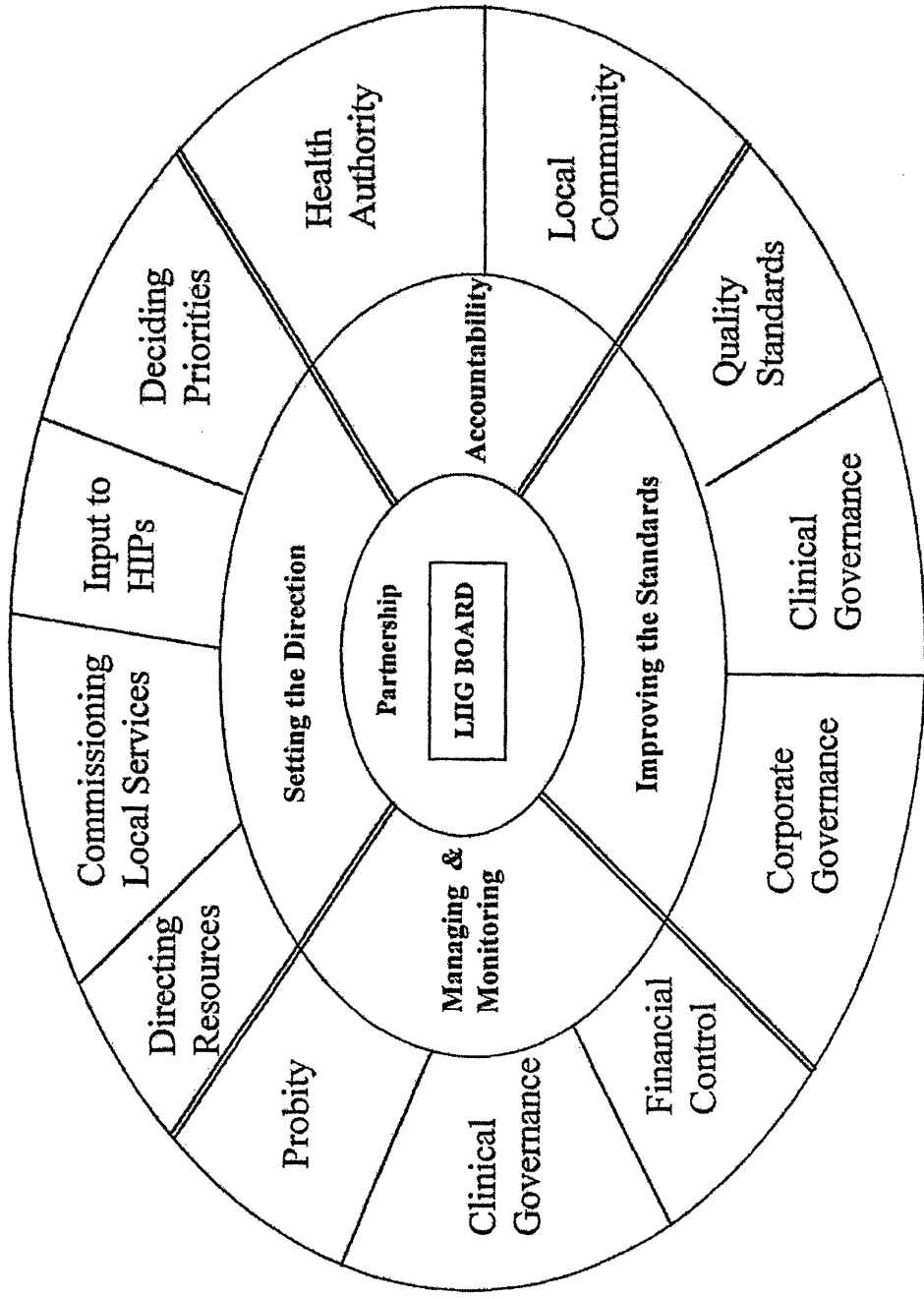
Diagram 1: Overview of LHG board role (January 1999) (Anonymous 1999)

The diagram consists of concentric ellipses divided into segments. The central box reads "LHG BOARD". The inner ring contains: Partnership, Accountability, Improving the Standards, Managing & Monitoring, Setting the Direction.

The outer ring segments read: Health Authority, Local Community, Quality Standards, Clinical Governance, Corporate Governance, Financial Control, Clinical Governance, Probity, Directing Resources, Commissioning Local Services, Input to HIPs, Deciding Priorities.

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Welsh Assembly Government

Health Authority (x 5 in Wales)

Each HA is responsible and accountable for between 3 – 6 LHGs in their area.

LHG (x 22 in Wales)

LHGs are sub-committees of the HA

LHG boards comprise members of the local community and health and social care professionals including:

nurses, lay and voluntary reps, GPs, pharmacist, optometrist, dentist, social services and health authority representation.

LHG Secretariat

Provides administrative and management support to the LHG board. Typical roles within the secretariat include strategic and service planning, health development, finance and performance.

Diagram 2: Structural relationship between Welsh Assembly Government, Health Authorities and LHGs in Wales (January 1999)

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Underpinning the work of the LHG was a commitment to improve partnership, collaborative working and integration between the various service providers in health and social care.

Whilst LHGs built on existing models of health care commissioning (for example GP fundholding), they also signalled a shift in emphasis from organizations that were largely the preserve of GPs, for example, Total Purchasing Pilots (TPPs), to organizations that were ostensibly more multi-disciplinary. As such, they offered the potential for a more holistic model of commissioning (Smith 2000). Until 2003, the boards of LHGs included six GPs, a dentist, a pharmacist, an optometrist, two nurses, two Health Authority and two Local Authority representatives, one representative from a local voluntary organization, one lay member and a general manager – a total of 18 members. Guidelines stipulated that nurse board members (and other health care professionals on the board) were to be based in clinical practice. Amongst the 22 LHGs in Wales, nurse board members included practice nurses, district nurses, midwives, health visitors and community psychiatric nurses. The boards were supported by a number of administrative and managerial staff – commonly referred to as the secretariat.

The term 'LHG' was often used by participants to refer to the *board* of the LHG. Strictly speaking, the LHG refers to the board *and* the wider constituency of general practices and other health and social care providers which are served by and represented on the board. So for example, one of the LHGs in my sample (LHG3) covered 13 general practices with GP representation at board level from six of these practices. Within the thesis I distinguish between LHGs and LHG boards.

The research reported in this thesis began in early 1999 as LHGs were just being established. In March 2003 – and some four years into the research and after my fieldwork was completed – LHGs were superseded by Local Health Boards (LHBs). In England, PCGs gave way to Primary Care Trusts, (PCTs) which were phased in a year or two earlier. Following the abolition of Health Authorities in Wales, LHBs were expected to build on and extend the work of LHGs and would have more scope and influence as commissioners and providers of health care (*Improving Health in Wales*, National Assembly for Wales 2001). LHB board membership was also set to

change. Increased lay representation was amongst these changes. In the final chapter of the thesis, I highlight the implications of my findings for LHBs. The following section outlines my rationale for undertaking this study.

1.2 Rationale for this study

In order to explore the role of gender in nurses' organizational lives I chose to study the experiences of nurses on the boards of the newly established LHGs. The appointment of nurses to the boards of LHGs and PCGs was seen as offering nurses a unique opportunity to influence health care policy (Antrobus 1998, RCN 1999, Mayor 1998, Rowe 1998, Smith *et al*. 1999, Rowden 1999) and was viewed as a long overdue response to nursing's invisibility and exclusion from the policy making arena. At the time, expectations with regard to nurse involvement appeared high, as the then Minister of Health, Baroness Jay, commented:

> By giving community nurses a formal place on primary care group boards, the White Paper signals recognition of the contribution nurses can make to improving healthcare... in the new NHS nurses views will be heard and valued (cited in Mayor 1998 p. 578).

Yet given the devalued status of nursing work and nursing's historical subordination within health care (Gamarnikow 1978, Reverby 1987, Robinson 1992, Davies 1995) I wondered to what extent nurses' views would be 'heard and valued'. In the context of a health service marked by divisions and hierarchies, to what extent would nurses be able to take their place at the policy making table as equal partners and collaborators? My key research questions, which developed during my review of the literature (see chapter two), are listed below:

- What are the experiences of nurses on the boards of LHGs?
- To what extent does gender shape and inform these experiences?
- How have nurses been able to contribute to the work of the LHG board and how has gender influenced nurses' contribution?
- To what extent do nurses themselves understand and make sense of their organizational experiences in terms of gender?

Whilst there is a growing interest in the relationship between gender and nursing, there is still relatively little work which sets out to explore in detail the role of gender and the way in which it constructs and informs nurses' daily organizational lives. In addition, at the time I embarked on this study and during the first year of fieldwork, there was very little published research available which explored the work of LHGs (or PCGs). Of the research that was published, nurses' experiences as board members comprised a small component (see section 1.3 below). To the best of my knowledge, there is still very little work which looks at the experiences of these nurses or of those on the boards of LHBs or PCTs. This is significant given the importance of these new roles for nurses.

The next section of this chapter provides a brief overview of existing research on LHGs (and PCGs).

1.3 Overview of research on LHGs and PCGs.

To date, there have been a number of national, government funded evaluative studies on the progress and work of LHGs and PCGs. The majority of these have centred on PCGs. Whilst there are some important differences between LHGs and PCGs, there are many similarities, principally those in relation to their structure, overall aim and function. Given these similarities and the paucity of work on LHGs, I have drawn on studies of PCGs to help provide background information and to help make sense of the data where appropriate.

One of the most extensive reviews of PCGs comes from the Health Services Management Centre (HSMC) at the University of Birmingham (Regen *et al.* 1999, and 2001, Smith *et al.* 2000). Similar research has been carried out by the National Primary Care Research and Development Centre (NPCRDC) at the University of Manchester – known as the Tracker Survey of PCG/Ts (Wilkin *et al.* 2001). The Audit Commission (2000) has also reported on the early progress of PCGs. To my knowledge there is only one similar evaluation of LHGs, that undertaken by the Audit Commission (2000). However, a national study of LHGs by the University of

Wales, Bangor has provided some insight into collaborative working between LHGs and other agencies (Linck *et al*. 2001).

For the most part, the above studies focus on the evolution of the new primary care organizations, and examine the structure, functions, and achievements of PCGs and LHGs. Of particular relevance to this thesis is the review undertaken by the HSMC in Birmingham. For example, their series of reports address the organizational development of PCGs, and include within this an analysis of the relationships amongst board members and the contribution of specific members. However, whilst their reports highlight some important issues in relation to the nursing contribution and allude to gender - reference is made to medical dominance and power relations between doctors and nurses - detail and discussion on these issues was limited by the overall remit of the evaluation.

More emphasis is given to the nursing experience in a number of other studies. Dowswell *et al*. (2002a) draw on data from the Tracker Survey to explore the experiences and perceived influence of PCG board nurses on policy development. This study concluded that whilst nurses felt they made a valuable contribution to local health policy, nurses perceived their influence on decision making as limited.

Another study undertaken as part of the National Nursing Leadership Project (Dawes and Dobson, 2001) explored the development of nursing leadership in first and second wave PCTs – the successor organizations to PCGs. This work identifies the different models of nursing leadership within PCTs and highlights some of the opportunities for and barriers to the development of nursing leadership. For instance, the authors draw attention to the personal and professional development needs of clinical nurses operating at a strategic level.

One year on from the inception of PCGs, the *Nursing Times* and *Community Nurse* commissioned a postal survey to ascertain nurses' views regarding the progress made by PCGs. Six hundred community nurses responded - a 100 of whom were PCG board members. A brief overview of the findings is presented by O'Dowd (2000). The findings suggest that progress was patchy, with some board nurses doubtful of the actual or potential benefits to patient care – though as several made clear it was

still early days for PCGs. Commenting in the article on the progress of LHGs and the nursing contribution, Liz Hewitt, then RCN Welsh Board secretary, conceded that it was difficult to see concrete changes, but pointed to the number of nurses taking the role of clinical governance lead (CGL).

Whilst providing some useful background material, these studies are not placed within a framework that privileges issues of power and gender and, as such, offer what I believe to be a partial view of the nursing experience.

The following section further explores my rationale for undertaking this study by highlighting the influence of my own experiences as a woman and nurse.

1.4 Situating the research in terms of my own experiences as a woman and nurse.

My interest in gender and nursing stems from own experiences as a woman and a nurse. The majority of my time as a nurse has been spent working in the community, first as a district nurse then more recently as a primary care facilitator working with community and practice nurses. Notwithstanding recognition from individual patients and their families, as a nurse I have often felt undervalued. At the same time, I have been acutely aware of the centrality of nurses and nursing for the welfare of patients and for the NHS as an organization. As Wicks (1998) comments of her nursing experiences, 'it was as though the importance of nursing work was a secret held by nurses and patients and of which others did not know' (p xiii).

In many ways this thesis needs to be seen in the context of my own experiences as a nurse and the difficulties I have encountered in articulating and believing in the value of my work in the face of what has felt like overwhelming indifference and denial. As Marshall (1984) contends, all writing is autobiographical and this study is no exception.

Undertaking a degree in women's studies was to prove a turning point for me in terms of how I made sense of and contextualised my experiences and feelings. I

came to see my identity as a nurse and my identity as a woman as inextricably linked and to view this relationship as profoundly problematic. By virtue of their occupational identity, nurses embrace cultural conceptions of womanhood. Gendered stereotypes of women as caring, nurturing and compassionate are central to nursing identity. However, the caring labour of women is also characterised by a lack of perceived value and worth within patriarchal society (Graham 1983). I was struck by what seemed to me a double burden of identity for nurses, most of whom are women.

My thoughts on this subject developed further when I was introduced to gendered organizational theory as part of an MSc course. For example, the view that organizations reflect and actively reproduce a 'masculine vision' reinforced the importance of considering gender identity as a potentially significant factor in nurses' organizational lives. For Davies (1995 p. 38), 'Nurses are expected to uphold values of female identity in face of a masculinity that is profoundly ambivalent about it and in face of institutions imbued with that same masculinity.'

The appointment of nurses to the boards of LHGs provided an important opportunity to explore this dilemma. Nurses in these new organizational positions would have a formal, strategic role in influencing local health care policy and provision. As previously indicated, this marked a significant step for nurses and nursing, for as a number of writers argue, both had long been neglected from policy making and debate (Strong and Robinson 1990, Davies 1995, Antrobus and Brown 1997).

This thesis focuses on the role of gender in nurses' organizational experiences, but as Isaacs and Poole (1996 p. 41) comment, 'responses to gender issues are always mediated through other identities such as age, material status, class, ethnicity'. Where appropriate I have drawn attention to the interaction of identities and inequalities. However, my concern has been to privilege gender given its centrality to nursing (Game and Pringle 1984, Witz 1994) and given my own interests and experiences.

1.5 Overview of chapters

Chapter two provides a review of the literature relevant to the thesis. This review begins with an examination of feminist accounts of woman as Other, and then explores literature that highlights the relationship between gender and nursing. The chapter concludes with an exploration of gendered organizational theory and outlines the way in which this can be usefully applied to the experiences of LHG board nurses.

Chapter three offers an overview of the research design and research process as they relate to this thesis.

Chapters four - seven detail the findings of the study. Chapter four explores the way in which board nurses have been able to influence and contribute to the work of the LHG and highlights some of the opportunities and challenges they faced. Chapter five develops this analysis to explore the role and impact of gender on the nursing contribution.

Chapter six builds on the previous chapter to explore in more detail issues of identity. The way in which nurses theorise their identity as women (and men) and as nurses is discussed. The impact of their gender and occupational identity on their organizational lives as board nurses is further analysed.

Chapter seven addresses the issue of medical power - one of the key themes from the data. The way in which nurses and GPs experience and make sense of medical power is discussed. Particular attention is given to the doctor/nurse relationship and the gendered nature of medical professionalism.

Chapter eight concludes with an overview of the findings, and consideration of the wider implications of this research for nursing and health policy.

It is important to note at the outset that Davies' *Gender and the Professional Predicament in Nursing* (Davies 1995) has been a key influence on this thesis. Her work brings together many strands of inquiry and analysis that resonate with my own

experiences and have been central to my thinking. In *Gender and the Professional Predicament in Nursing,* Davies (1995) draws on a feminist perspective to explore the connections between nursing and gender and the implications this holds for nursing. Her use of psychoanalytic theory and her understanding of women and nurses as 'Other' is particularly appealing, for it seems to go some way to accounting for the persistence of damaging and oppressive gender power relations which continue to marginalise and silence women. Davies also draws on gendered organizational theory to highlight some of the difficulties and dilemma's facing the profession. I too wanted to use this theory to help make sense of nurses' experiences. In her review of *Gender and the Professional Predicament in Nursing,* Latimer (1996) is critical of what she sees as an over reliance on a macro analysis of the issues, and argues for 'more ethnography, more texture and detail, a closer view' (p 318). This research goes some way to providing such a perspective.

Chapter Two   Literature Review

2.1 Introduction

The range of literature reviewed in this chapter covers theoretical works which have helped to shape my thinking about the role of gender in nurses' organizational lives. There are some important examples of literature that explore the relationship between gender and nursing and these have helped inform my thinking (see for example Smith 1992, Davies 1995, Porter 1995, Wicks 1998). However, the paucity of empirical research directly related to nurses' experiences as LHG/PCG board members and the relative lack of research dealing with the gendered nature of nurses' everyday working lives has prompted me to draw on empirical work from other areas of inquiry. For example, studies by feminists researching the lives of women in male dominated industries have provided a useful framework for exploring nurses' experiences as board members (see for example Marshall 1984, Sheppard 1989).

The literature review is organized as follows: after a brief discussion on the methods used for accessing the literature, section 2.2 provides an overview of the literature on the position of woman as Other. In many ways this forms the starting point of my research and significantly informs my interpretation of nurses' experiences. Section 2.3 identifies literature that highlights the relationship between nursing and gender. I begin by identifying the implications of defining woman as Other for nursing identity. I also highlight the close cultural links between femininity and nursing, drawing attention to the dilemma this represents for nurses. The section then continues with a discussion of work (Roberts 1983, Attridge and Callahan 1989, Smith 1992) that influenced my early thinking on gender and nursing.

The relationship between gender and nursing is further developed in section 2.4 and 2.5. In section 2.4, I examine literature which highlights nurses' exclusion and marginalisation from the policy making arena – an issue of particular relevance to the study of nurses newly appointed to LHG boards. Section 2.5 then focuses on the doctor/nurse relationship. This relationship has clear implications for an exploration of gender and the organizational experiences of board nurses. Section 2.6 introduces

the topic of gendered organizational theory and provides the reader with an overview of some of the ideas and theories I use to help me make sense of nurses' experiences.

2.1.1. Methods used for accessing the literature

I have taken a broadly exploratory approach to the literature search. As a baseline I revisited the literature reviewed as part of my MSc. course and built on and extended the review. I made use of electronic databases (CINAHL, BIDS, MEDLINE 1980-2005) and serendipitous references in texts. The journal *Gender, Work and Organization* was particularly useful in this respect. In addition, I found Davies' (1995) guide to literature on gender and nursing in the appendices of her book very helpful.

As previously indicated, when I began the research little was written about nurses' experiences on LHG/PCG boards. What debate and discussion there was took place mainly in the pages of the popular nursing press. As the research progressed, in addition to the national studies cited in the Introduction to this thesis, a range of other relevant work appeared in peer reviewed journals (see for example, Kaufman 2000, Dowswell *et al.* 2002a). The literature review draws on a wide range of work from the UK, as well as work from the United States (US), Australia and Europe, and includes recent, as well as classical texts.

2.2 Gender identity and woman as Other.

Fundamental to my understanding of nurses' organizational experiences is the social definition of woman as Other. This concept provides a useful way of interpreting the lives and experiences of nurses, the majority of whom are women, and for whom work and work identity are intimately linked to cultural conceptions of womanhood and femininity (Muff 1982a, Hudson Jones 1988, Reverby 1987, Davies 1995).

De Beauvoir (1949) was the first to examine in detail the position of woman as Other in her book *The Second Sex*. De Beauvoir argues that within much social and political thought women have been defined in relation to men - men and masculinity stand as the reference points.

> Humanity is male and man defines woman not in herself but as relative to him; she is not regarded as an autonomous being... she is defined and differentiated with reference to man and not he with reference to her; she is the incidental, the inessential as opposed to the essential. He is the Subject, he is the absolute – she is the Other (p.16).

As McDowell and Pringle (1994 p.3) suggest, 'men's specific gender is thus ignored: they represent the universal and the human to which women are 'Other''. A whole series of dualisms or binary oppositions reflect this thinking, whereby the first category is associated with men and privileged, whilst the second is associated with women and devalued - for example: public/private, reason/emotion, mind/body, autonomy/dependence, active/passive, subject/object. Women come to represent what men are not. Feminists have long argued that the use of binary oppositions within language and culture in which the 'feminine' is consistently relegated, reflect a masculine vision of the world (see for example, Spender 1980). The semantic and linguistic rules that stipulate that male is positive and female is negative are 'both enshrined in and expressive of, patriarchy itself' (Marshall 1984 p. 50).

Feminists have explored women's position as Other from a number of different perspectives. For example, Ortner (1974) and Strathern (1987) discuss the issue from an anthropological perspective, Stanley and Wise (1993) draw on sociology and Chodorow (1978), Irigaray (1985) and Benjamin (1988) use psychoanalytic theory. I have found psychoanalytic thinking particularly useful. Highlighting the role of the unconscious in the formation of gender identity appears to go some way to accounting for the persistence of the cultural definition of woman as Other.

For the purposes of this section, I shall focus primarily on the work of Chodorow (1978) and the insights her theory offers for understanding the development and expression of gender identity and the Othering of women. Drawing on psychoanalytic theory, specifically object relations theory, Chodorow (1978) argues that female mothering is instrumental in gender differentiation in girls and boys and a key factor in the continuance of oppressive gender power relations. According to Chodorow (1978) both boys and girls identify with their primary love object (the mother). However, in order for boys to achieve a sense of self and identity, they are required to 'dissolve this identification and define themselves as the different sex'

(Benjamin 1990 p.75). Girls however are spared this task because for them, their mother represents sameness, not difference.

Masculinity is experienced as less certain, less secure. The male child experiences a constant tension – he is attracted to the 'oneness' and 'completion' he once experienced with his mother, yet in order to become masculine, he must repress and deny these feelings and impulses. The development of masculinity within Chodorow's account lays the foundations for the denial of the feminine and for the relation of women as Other:

> For children of both genders, mothers represent that regression and lack of autonomy. A boy associates these issues with his gender identification as well. Dependence on his mother, attachment to her and identification with her represent that which is not masculine; a boy must reject dependence and deny attachment and identification. A boy represses those qualities he takes to be feminine inside himself and rejects and devalues women and whatever he considers to be feminine in the social world (Chodorow 1978 p.181).

Significantly, the development of masculinity can be seen as an ongoing task - an active process in constant need of reaffirmation. As Hall (1989) comments in her discussion on the experiences of lesbians within organizations:

> If one considers the role of women in institutions, e.g. the organization, it would seem that this process of male individuation reputedly a stage-specific event is, instead, a never ending psycho-social process. (p. 126)

The requirement that the boy severs the connection with his mother and denies all that she is, makes it difficult for him to recognise his mother as subject. As Benjamin (1988) comments, 'she is not seen as an independent person (another subject), but as something other – as nature, as an instrument or object, as less than human' (p.76).

There are a number of important criticisms of Chodorow's work. For example, the formation of gender identity as outlined by Chodorow (1978) presupposes a certain conception of femininity and masculinity. As Segal (1990) observes:

> For mothering to create ... 'the psychology and ideology of male dominance' we need to presuppose a society where femininity is already devalued and masculinity already more highly valued (p. 82).

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Others have rejected her argument as over simplified in so far as she appears to hold women's responsibility for child care as the key factor in the development of gender identity. Too little attention is given to the social, cultural and historical variations within different families and of conceptions of masculinity and femininity, which are not fixed and homogenous (Grimshaw 1986).

Whilst Chodorow's work does not provide an adequate explanation for gender inequality, her work, and that of object relations theorists more generally, offers some important insights. For example, her work highlights the role of the unconscious in the construction of gender identity, in particular the way in which masculinity and femininity may follow different, opposing, developmental pathways - one to independence, separation and autonomy; the other, to connectedness, intimacy and a relational self (Davies 1995). In her study of *Nurses and Doctors at Work*, Wicks (1998) highlights the implications of this for nursing and medicine. Object relations theory 'points to the crucial fact that the sexual division labour is permeated from within by the deepest psychic desires, fears and insecurities' (p.131).

Chodorow's analysis provides one possible account of the way in which masculinity is implicated in the repudiation of women as Other. Highlighting the role of the unconscious also has relevance for understanding the pervasiveness and power of masculinity within social and cultural life, including organizational life.

Chodorow's work has been used by a number of writers (Hall 1989, Davies 1995 and Wicks 1998) to explore the way in which gender identity is implicated in and central to women's (and nurses') organizational experiences. I discuss the work of these authors in more detail in sections 2.5 and 2.6.

I conclude this section by briefly considering a point made by Martin (1992) in relation to the concept of woman as Other. Drawing on the work of post-structuralists, most notably Foucault [2], Martin argues that:

> To totalise or universalize Otherness as an answer to the question of woman is to leave ourselves with no possibility for understanding or intervening in the processes

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2. Foucault (1980) *Power/Knowledge: selected interviews and other writings.*

through which meaning is produced, distributed and transformed in relation to the shifting articulation of power in our world (1992 p.285).

This argument has been important for me to consider. I am aware of the pull I feel towards the idea of woman as Other. I return to this issue in the concluding chapter of the thesis.

I next explore the relationship between nursing and gender, highlighting why gender is an important factor to consider in nurses' organizational experiences. As a number of authors reflecting a range of perspectives and interests have argued, the relationship between gender and nursing is key to understanding the issues and dilemmas facing the profession (see for example, Muff 1982a, Hudson Jones 1988, Reverby 1987, Salvage 1992, Mulligan 1992, Witz, 1994, Davies 1995 and Wicks 1998).

2.3 Nursing, Nurses and Gender: making the connections

Defining woman as Other has implications for nursing and nurses. Within Western culture, the ideals and images of nursing and nurses correspond closely to those of womanhood (Gamarnikow 1978, Muff 1982a, Reverby 1987, Hudson Jones 1988). Dedication, co-operation, compassion and, above all, self-sacrifice are stereotypical ideals of nursing and womanhood. These ideals were firmly enshrined in 19th Century Britain as nursing leaders drew on ideologies of femininity in the struggle to legitimise nursing reform (Gamarnikow 1991). Whilst much has changed within nursing and in the position and role of women in society, the association between femininity and nursing remains a powerful one (Reverby 1990, Smith 1992, Davies 2003, Bolton 2005).

Nursing work is intimately connected to what it is seen as women's work. The caring, nurturing, labour of nurses is commonly viewed as an extension of women's 'natural' qualities and attributes as expressed within the domestic sphere (Muff 1982a, Game and Pringle 1983, Salvage 1985, Colliere 1986, Reverby 1987, Robinson 1989, Hughes 1990, Smith 1992). As Graham (1983 p. 16) comments, in

nursing, as with other so called 'caring' professions, '"the women's touch" has been formally incorporated into the job specification'.

Nursing is also gendered because the majority of nurses are women and work within systems which reflect marked gender divisions and hierarchies (Game and Pringle 1983, Saks 1990, Porter 1992). These divisions extend to nursing itself, where men, who comprise a minority of the workforce, are over-represented in senior posts (Davies and Rosser 1986, Finalyson and Nazroo 1998, Brown and Jones 2004). Hence, as Muff argues, 'the issues that concern nurses are women's issues (and vice versa)' (1988 p.197).

Nursing's association with women's work has meant that it has traditionally been accorded little status or value (Muff 1982a, Chinn and Wheeler 1985, Attridge and Callahan 1989, Reverby 1987). This is significant for if, as Graham (1983 p. 30) contends, 'caring is the medium through which women are accepted into and feel they belong in the social world', then nurses, whose job it is to care, embrace an identity that is essentially devalued. Gender identity and work identity combine to confront female nurses with a 'double burden' - in undertaking nursing work they reconfirm their status and position as less than, as Other. (For a similar argument in relation to nurses in academia, see Meerabeau 2005). It is therefore critical to understand the implications for nursing and in particular, for those who nurse.

The dilemma facing nurses is, as Reverby (1987) observes in her historical analysis of American nursing, 'the order to care in a society that refuses to value caring' (p.1). This dilemma is central to my enquiry into the organizational experiences of nurses. Drawing on feminist organizational analysis, this thesis is concerned in part with understanding the way in which individual nurses experience, make sense of and negotiate this dilemma.

Despite a growing body of work which addresses the question of gender and its relationship to nursing, it would seem this issue remains under-theorised and under researched. There are however, some important examples of work within the nursing and sociological literature which acknowledge the issue of gender in relation to nursing and which provide useful insights into the role of gender in nurses'

organizational experiences. I shall begin by discussing the work of several authors whose writing on gender and nursing has been instrumental in shaping my own research interests.

2.3.1 Early influences in defining the research problem

Reading the work of Roberts (1983) late on in my clinical nursing career was an important starting point in helping me to define some of the issues and problems which this thesis attempts to address. Her article, *Oppressed group behaviour: implications for nursing* helped me to understand what it was that interested and troubled me about my own nursing experiences and to contextualise these in relation to gender.

Drawing on the work of Friere (1971), Roberts (1983) argues that nurses, the majority of whom are women, can be seen as an oppressed group. She highlights a process of oppression whereby the values and norms of a dominant group (for example, men and doctors) come to be viewed as the 'right' ones in society and are internalised by both oppressors and the oppressed. The characteristics of the subordinate group are negatively valued. This sets in place a number of behaviours and characteristics typical of oppressed groups, which Roberts (1983) suggests are evident in nursing. For example, negation and denial of nurses' own skills and knowledge leading to self-hatred and low self-esteem, covert behaviour and internal divisiveness and conflict and fear of change and dissent. Compliance with the dominant cultural values and norms brings its rewards insofar as nurses are accepted and this in turn bestows a sense of power. Rather than viewing these characteristics as inherent in nurses, Roberts argues that they can be seen as the result of oppressive practices that marginalise and exclude nurses, as women. This has been an important argument in helping me to reframe some of the attitudes and behaviour I personally witnessed in nursing.

Roberts (1983) concludes by calling for nurses to better understand their oppression and urges them to reject negative images of nursing and instead take pride in their work and contribution to health care. Whilst I saw this as imperative, the task confronting nurses seemed overwhelming. Roberts (1983) perhaps underplays the

potential struggle nurses face in trying to assert a different reality or vision – one that openly values nurses and nursing. The experiences of those I interviewed suggests it requires great effort on nurses' part to un-think negative and damaging images of themselves. This struggle needs to be seen in the context of an organizational culture which seemingly contests this vision, reflecting and reproducing as it does oppressive and hierarchical gender power relations (Davies 1995).

The other criticism of Roberts' (1983) analysis is that she conceptualises nurses as a homogenous group, subject to the same influences, experiences and responses. In doing so, she risks denying diversity and differences amongst women. As Wicks (1998 p.6) argues more generally:

> The effect of this emphasis on the determining power of patriarchal ideology has been the representation of nurses as an undifferentiated bloc of subordinated women … the emphasis on an all-pervasive ideological structure has also had the effect of denying nurses' subjectivity.

This issue was something I grappled with as I interpreted nurses' accounts of their experiences and is discussed in more detail in chapter three and in the concluding chapter of the thesis.

The model of oppressed group behaviour outlined by Roberts (1983) has been usefully applied by Attridge and Callahan (1989) in their work on *Women in women's work: nurses, stress and power*. This writing was another key influence on my thinking and several issues emerge from their study, which are relevant to this thesis.

To begin with, the authors were keen to access nurses' views on their experiences of power and powerlessness. This reflected my own concern to privilege the voices of women and nurses in understanding some of these issues. Attridge and Callahan (1989) locate nurses' experiences within a system that devalues nursing work and worth, and highlight the impact of this for nurses and nursing. This, too, was central to my research. I wanted to understand what it felt like to 'care in a society that refuses to value caring' (Reverby 1987 p.1) and the implications this held for nurses and for their work in LHGs.

In contextualising their research, Attridge and Callahan (1989) argue that those outside the profession have little understanding of the skills and knowledge fundamental to nursing care and this contributes to the 'invisibility' of nursing and nurses. They cite Diers (1978) to illustrate this dilemma:

> Nursing done right is physically, emotionally and intellectually fulfilling... take for example, "tender loving care". Most people, lay people, physicians and members of other professions think that is all that nursing is about and they think it's *simple*. Just take *nice people and turn them loose*. But to give tender loving care is exquisitely difficult... It requires a kind of delicious delicacy and discipline which are among nursing's province and special skill (Diers 1978, cited in Attridge and Callahan 1989 p.50).

This extract captures one of the key issues nurses face in their everyday organizational lives. Nursing takes skill, knowledge and tremendous effort, yet this goes largely unacknowledged. Attridge and Callahan (1989) argue that doctors, nursing management, and administrators typically fail to recognise the importance of nursing knowledge and expertise when making decisions regarding patient care. In addition, they argue that nurses contribute to their invisibility. In line with 'oppressed group behaviour', they comment that nurses themselves struggle to place value on their work and find it hard to describe the complexities of nursing care. Nurses appear to lack the language with which to articulate how nursing and nurses make a difference. I would add to this analysis by suggesting that at some level nurses do deeply value the work they do, yet given the cultural devaluing of caring work, nursing identity may be experienced as profoundly contradictory and problematic. I shall explore this issue in more detail in chapter six.

The invisibility of nursing is an important theme in the nursing literature (see for example, Colliere 1986, Benner and Wrubel 1989, Robinson 1989, James 1991, Smith 1992). As Colliere (1986 p.105) suggests:

> Care has not been and still is not considered valuable or of great necessity to society... Care remains invisible, priceless in health institutions as well as at home, and those who provide it remain socially unconsidered, and unknown.

I discuss the invisibility of nursing in more detail below in relation to the work of Smith (1992) whose research is also particularly relevant to this thesis.

Drawing on interview data, Attridge and Callahan (1989) point to nurses' feelings of anger, humiliation, self-doubt, frustration and helplessness when confronted with their organizational powerlessness. These feelings were in contrast to the positive emotions which nurses experienced when they felt they had been listened to and their contribution to patient care recognised. The opinions of those in more powerful positions, namely doctors, were particularly important in gaining recognition.

The issues Attridge and Callahan (1989) raise resonate with my own experiences as a nurse. I found no discursive space either within the organization or as part of my own vocabulary with which to articulate the value of my work and my occupational identity as a woman and nurse. The language and meanings available to me served only to reconfirm my status as Other. I was also acutely aware of the key role doctors played in determining my self-image.

Reflecting on these issues, I wondered how nurse board members, charged with raising the profile of nursing and articulating the value of their work would experience and make sense of some of these issues. To what extent would nurses be able to contribute effectively and influence the decision making processes? From a gender perspective, I imagined these issues would be brought into sharp focus for nurses as members of LHG boards, which were medically dominated and (for the most part) male dominated.

Smith's (1992) account of the emotional labour of nursing is another important contribution to the debate on gender and nursing. Through the stories and accounts of nurses, Smith (1992) explores the nature of caring; in particular, she renders visible the emotional complexities of caring undertaken by nurses, which have remained largely invisible and under valued.

Smith (1992) argues that conceptualising care requires an understanding of the role of gender. She contends that we need to acknowledge the way in which care has traditionally been associated with women's 'natural' work and the way in which, as she states:

> ...the gender division of labour and the power relations between doctors
> (predominately men) and nurses (predominately women) within the health service
> ... marginalise care to the 'little things' (1992 p. 135).

She concludes that emotional labour, a key element of caring, needs to be seen as complex work that requires training, skill and support. Smith's (1992) focus on how nurses care and the arguments she proposes have much in common with the work of James (1991, 1992). Drawing on research with nurses working mainly in a hospice setting, James similarly locates her discussion on caring in the context of gender and highlights the demands and complexities of emotional labour and the way in which principles of care are enacted and modified within the workplace.

Smith's study is relevant to this thesis in a number of ways. For example, she highlights the association of caring work with the devalued domestic labour of women to pose the following question at the outset of her book:

> What then are the implications of [this] for nurses given that nursing reproduces
> many of the traditional female roles and domestic tasks in the workplace? (1992
> p.18)

Smith's (1992) desire to draw on the direct experiences of nurses to explore the way in which gender and occupational identity combine and influence nurses' work lives, shares much in common with my own research interests. Her central arguments also have implications for understanding the experiences of nurses on LHG boards.

Because caring remains a central requirement of nursing and is implicitly linked to nursing identity, questions of what it means to care and how caring is perceived and understood by others are important for LHG board nurses. Nurse board members were expected to talk about the value of nursing and use their understanding to inform the strategic direction of the LHG. However if, as Smith (1992) argues, the caring work of nurses is devalued, poorly understood and poorly conceptualised the potential of nurses to contribute to the work of the LHG must be in question. In addition, the structure and composition of LHG boards reflect and reinforce hierarchical gender divisions of labour and power within the NHS, which, as Smith (1992) argues, marginalise and subordinate the caring work of women.

Whilst I found Smith's (1992) work immensely valuable, a more explicit exposition of how nurses themselves made sense of gender in terms of their experiences would have been worthwhile. Such an undertaking would perhaps afford a better understanding of the reproduction of gender and occupational ideologies within health care - an interest implicit in her work.

Taken together, the work of Roberts (1983), Attridge and Callahan (1989) and Smith (1992) have been important early influences in the development of my interest in gender and the organizational experiences of nurses. In the next section I build on some of the themes outlined above to explore the invisibility of nursing and nurses within the policy making arena.

2.4 Nurses and nursing's exclusion from policy making and debate

The absence of nursing issues from the formal policy agenda, and nurses' absence from concrete policy decision making processes have clear implications for the thesis. As already indicated, the appointment of nurses to the boards of the new primary care organizations was seen by some as reflecting wider recognition of the nursing contribution to health care. However, given the historical exclusion of nursing from the policy debate, the basis on which nurses have been included in these organizations, together with the outcomes of nurse involvement need careful consideration.

A number of writers have highlighted nursing's absence from the policy making arena, (see for example Robinson 1989, 1992, 1997, Strong and Robinson 1990, Antrobus 1997, 1998, 1999, Antrobus and Brown 1997, Goodwin 1992, Rafferty 1992, Davies 1995 and Gough 1997). Drawing on historical data, Rafferty (1992) highlights the way in which nurses and nursing issues were poorly represented in the policy decisions and debate of the early NHS. The success of nursing policy initiatives depended on them fitting with wider political and organizational exigencies. Nursing's relative lack of influence is contrasted with that of medicine, which was able to exert significant influence over NHS reforms.

A similar point is made by Smith *et al.* (1999) with reference to the numerical dominance of doctors on the boards of PCGs. Communication between the then Health Minister, Alan Milburn and doctors' leaders made it clear that conceding to the demands of the medical profession was paramount in securing policy reform.

Gough (1997) highlights the devastating effect of the managerial reforms in the 1980s on the fledgling nursing management structure. These changes resulted in nurses losing their seats on executive decision making bodies within the NHS and fundamentally undermined nurses' influence in the policy making arena. The impact of these reforms on nursing is the subject of critical analysis by Robinson (1992, 1997) and Strong and Robinson (1990).

The work of Robinson has been especially important in the area of nursing policy. Reflecting on her earlier research on the management of nursing after the Griffiths Inquiry Report (Strong and Robinson 1990), Robinson (1992) highlights some of the key findings of this work. In particular, she draws attention to the obscurity of nurses and nursing in policy terms. She comments:

> We suddenly realised that despite the impressive statistics (half a million workforce in the UK) nursing is relatively unimportant to government and to managers in comparison with medicine (1992 p. 5).

Robinson (1992 p.7) contends that the nursing voice within health care reforms continues to be denied, 'despite nurses' very real knowledge and concern about their likely impact on some of the most disadvantaged NHS clients'. This has implications for LHG nurses, whose place on the boards has been justified, at least in part, precisely because of the unique knowledge and perspective they are seen to hold with regard to patients and with regard to the suitability and implications of policy decisions for patient care (Antrobus 1998, Rowe 1998, RCN 1999, Kaufman 2002).

Significantly, Robinson (1989) highlights the role of gender in her discussions, locating nursing's marginalisation from policy debate in relation to a gender division of labour within the NHS and the cultural devaluing of caring as women's work. With this in mind, a number of points are worth further discussion. For example, following the analysis of the Griffiths reforms, she comments that:

.... we surmised that education is a crucial factor in producing more self-confident nurses who are not afraid to take their seat at the various policy making top tables and to make a creative contribution to the planning, delivery and evaluation of healthcare (1992 p.5).

But given the gendered context of nurses' organizational lives a greater number of educated, self-confident nurses would only offer a limited solution. It is one thing to have the confidence to put oneself forward as a potential board member and to contribute, but this does not ensure influence. A recognition of the complex processes whereby gender power relations operate at the micro level, and the daily interactions and practices which serve to diminish and silence women (Acker 1992) is needed to help make sense of nursing's position as outsider in the policy making arena.

In addition, the idea that nurses are 'afraid' and lack the requisite education focuses attention on nurses' individual shortcomings and risks blaming them for their own demise (for a similar argument in relation to Robinson's work, see Davies 1992). An understanding of the way in which relations of power operate at both the institutional and individual level is required. For example, whilst having the confidence to 'take their seat' on the board, and believing absolutely in the value of their contribution, some of those I interviewed nonetheless felt overwhelmed by contradictory and inhibiting feelings of worthlessness and incapacity. They attributed these feelings to a negative and devalued self-image of themselves as nurses.

Nursing's lack of influence within policy making is also highlighted in relation to the operational confinement of nurses (more especially female nurses) and their marginalisation from senior management and leadership positions within the NHS, as Carpenter (1977), Davies and Rosser (1986) and Hardy (1986) suggest. These authors point to negative and discriminatory attitudes and beliefs which have helped confine female nurses to the bedside and limited their opportunity to take on senior positions. For example, Carpenter's (1977) analysis of managerialism and the division of labour in nursing, highlights the way in which the influential Salmon Report (1966) into nursing management implicitly questioned the leadership and managerial capacity of female nurses. According to Carpenter (1977), 'the whole report can be read as an attack upon the effects of female authority' (p.98). The new

managerial posts favoured a 'masculine' management style, emphasising rationality and decisiveness, qualities seen as inherently lacking from female nurses who, it was suggested, appeared more concerned with the minutiae of administration. The traditional 'feminine' attributes of nurturance and care were more appropriate to bedside nursing, to which female nurses were seen to be naturally suited.

These findings have implications for nurses on LHG boards. Given nurses' historical exclusion from senior decision making roles, Antrobus (1998 p.50) asks whether PCG nurse board members will be 'recognised as credible strategic players contributing to the nation's health.' Indeed, this was a question I explored with participants during the interviews. Nurses' perceived lack of credibility emerged as an important factor, and is discussed at some length within the context of gendered organizational theory in chapter six.

The next section explores nursing's exclusion from policy making and debate in the context of commissioning, a core function of LHGs.

2.4.1 Commissioning

The question of nursing's absence from the policy arena is discussed more specifically in relation to nurses' purchasing and commissioning roles by Goodwin (1992), the King's Fund College (1993), the Department of Health (1994), Antrobus and Brown (1997), Antrobus (1998, 1999) and Kaufman (2002). This body of work explores the value of nurses and nursing to the purchasing and commissioning process and identifies some of the obstacles which have so far precluded greater nursing involvement. However, as I hope to demonstrate, within some of this work the obstacles nurses face are not sufficiently contextualised; in particular, there is a tendency to blame nurses for their exclusion from the policy making arena.

To begin with I shall briefly discuss two reports which clearly spell out the various skills and qualities nurses can bring to purchasing (King's Fund College 1993, Department of Health 1994). Within these reports, the term 'purchasing' and 'commissioning' are used interchangeably. The reports are based on separate studies, both of which explored the views of nurses in purchasing roles and the views of

senior managers and other key personnel within the NHS to highlight the nursing contribution to purchasing. The skills and experiences seen as relevant included: nurses' close relationship with service users and their experiences of working at the sharp end; their ability to speak several health 'languages'; their understanding of the implications of changes for service users; experience in and focus on quality monitoring and standard setting; understanding and experience of different client groups and different service providers and how these providers could work together for the benefit of patient care. The nursing contribution was also seen as important in, 'injecting a nursing perspective into the currently medically-dominated model of health needs assessment' (King's Fund College 1993 p.15).

A number of obstacles were identified which were seen to limit the nursing contribution. These included a lack of specific skills relevant to the commissioning agenda, the newness of some of the commissioning roles which led to some uncertainty about role, and the absence of nursing roles and careers in purchasing and commissioning. Of particular relevance to this study is the suggestion that prejudicial attitudes were also an inhibiting factor. For example, whilst chief executives were positive about the contribution of nurses within their own organizations, they expressed concerns about the ability of nurses in general to contribute to the commissioning debate. This lead the Department of Health report to conclude that, 'the clear disparity between attitude and actual experience of nurses' capacity to switch cultures may still stand in the way of nurses joining purchasing teams' (Department of Health 1994 p. 24). As outlined above, nurses' credibility is open to question and this appears to be the case even when the 'evidence' would suggest otherwise. As Christine Hancock, then Royal College of Nursing (RCN) General Secretary commented of nurses' contribution to commissioning:

> The major challenge for nurses could well be overcoming the …ambivalence that
> exists in the health service towards nurses carrying out the purchasing function and
> taking part in policy decisions (King's Fund College 1993 p.39).

The other important obstacle relates to the assumption amongst many that within commissioning debates, the opinion of the Director of Public Health (DPH) encompasses *all* clinical opinion (Department of Health 1994). Despite recognition that purchasers purchase more than medical services, the medically-led model of

commissioning dominates: 'As a result nurses feel that their clinical opinion is only considered valid when it matched *(sic)* that of the DPH' (Department of Health 1994 p. 24). As part of my exploration I was keen to ascertain the extent to which LHG board nurses faced similar issues. Amongst nurse participants the medically-led agenda and medical model of health were consistently cited as key barriers to the nursing contribution. This is discussed in detail in chapters four, five and seven.

Goodwin's (1992) research also explores the nursing contribution to purchasing. Her research methods consisted of a literature review, a number of structured interviews with purchasers (25) and a 'snap shot survey' of purchasers (number not disclosed). Purchasers had a background in general management and a minority were nurses. Goodwin laments nurses' lack of involvement in the purchasing debate and highlights the vital contribution nurses can and should be making to purchasing decisions.

However, her analysis of why nurses are absent from the purchasing arena is problematic. In particular, she risks blaming nurses themselves for their lack of involvement. A key finding of her research is that 'nurses and others working with them are ambivalent about nurses' involvement in purchasing' (p. 11). Given that only a minority of her interview sample were nurses, it is unclear as to whether *nurses* themselves were ambivalent, or whether those they interviewed *perceived* nurses to be ambivalent.

Goodwin (1992) expresses frustration at the way nurses have been overlooked in purchasing, but she reverts to locating the problem with individual nurses, focusing on their lack of interest in, and understanding of purchasing. Similarly she acknowledges the invisibility of nursing: 'what nurses know and do is frequently invisible not only to others, but to nurses themselves' (p.8), but this analysis is not built upon to develop an understanding of nurses' absence from purchasing roles.

A similar tension is found in the work of Antrobus (1999) and Antrobus and Brown (1997). For example, Antrobus and Brown (1997) highlight nursing's historical lack of influence in terms of the commissioning agenda, pointing to the absence of any statutory requirement that nurses are represented on the boards of commissioning

organizations. They present a compelling argument as to why nurses should be involved in commissioning and outline in detail how nurses can contribute to this process.

Antrobus and Brown (1997) acknowledge the difficulty nurses face in translating the value of their work to the language of strategy, a problem they suggest is compounded by the cultural devaluing of caring. They also argue that the operational confinement of nursing stemming from the Griffiths Report (1983), has 'limited the pool of nurses with the expertise and experience to contribute to strategic thinking' (p.313), and consequently limited the number of nurses able to inform the commissioning debate at board level.

However, as with Robinson's (1992) account above, recognition of the wider, structural barriers facing nurses is undermined by the suggestion that nurses themselves are in some way responsible for their exclusion from the policy making agenda. References are made to nurses' ignorance of and unwillingness to engage in the commissioning debate, to their political naivety and their lack of interest in the policy/practice interface. Nurses' preoccupation with clinical work is presupposed and viewed negatively.

Antrobus and Brown (1997) call for the appointment of clinical leaders in practice development to help nurses acquire the requisite skills to develop strategic thinking and political awareness. They conclude:

> Only when nurses place their practice and develop it within the context of health policy, with the political understanding this entails, will nursing's voice be heard and have the potential to influence the political agenda (p. 315).

The solution to nursing's exclusion from the policy agenda is located with nursing and nurses. The hierarchical power relations within the NHS which continue to subordinate the caring work of nurses and which contribute to nursing's invisibility within the policy arena are left unexplored and go unchallenged.

Where I think Antrobus' arguments are more persuasive is in her analysis of the process of commissioning and, echoing the findings from the King's Fund College

(1993) and the Department of Health (1994), why nursing is so central to the commissioning debate. She also highlights the difficulty nurses have in articulating and translating their clinical knowledge and experience to the language of strategy (Antrobus 1997, Antrobus and Brown 1997, Antrobus 1999). Antrobus (1997) locates this difficulty in terms of competing gendered ideologies evident within nursing and the wider health care context. Nursing is characterised as a humanistic, intuitive and caring act and this is seen in contrast to the scientific, rational, outcome driven management culture of the current NHS within which nursing takes place (see also Traynor 1999 and Scott and Thurston 2004).

The question of how nurses articulated their worth and contribution to the work of the LHG within an organizational culture in which nursing is devalued and subordinated was central to my enquiry. As Antrobus (1997) comments, 'Feminine values in a masculine defined market and management style is (*sic*) fraught with difficulties of representation' (p.451). It was precisely this issue of representation that interested me. Certainly, the difficulties of representation to which Antrobus refers resonated with the experiences of some of the nurses I interviewed and emerge as a key interpretative theme within the findings chapters of this thesis.

Kaufman's (2002) study is also relevant to this discussion, particularly as she locates the debate about nurses' contribution to commissioning against the backdrop of nurses' role as board members of PCGs. Drawing on interview data with community nurses (9), GPs (4) and managers (7), Kaufman (2002) set out to explore the skills nurses were perceived to bring to the commissioning process, the constraints to the nursing contribution, and the strategies needed to overcome some of these obstacles. None of the participants appear to have been board members themselves.

The findings support arguments put forward in the literature cited above. Nurses' clinical knowledge and experience, their awareness of local health needs, their skills in health promotion and health education, and their close involvement with the local community and service providers, were all seen as key to enabling sensitive and effective commissioning.

A number of constraints to the nursing contribution were identified. These included a lack of commissioning related knowledge and skills; concerns regarding nurse representation being seen as a token gesture; disunity within the profession, in particular, between the different disciplines within community nursing; workload constraints and lack of support; negative attitudes and resistance on the part of some GPs.

Kaufman (2002) argues that a number of strategies are needed to help overcome these obstacles. For example, sufficient training and development should be provided to enhance nurses' commissioning and leadership skills, adequate time should be provided for nurses to combine their clinical and strategic function, and access to mentorship schemes encouraged. Kaufman suggests that medical resistance and prevailing attitudes which cast doubt on the nursing contribution, 'reflect the domination of health-care by masculinist ideology that devalues women's work and therefore devalues nursing...' (p.92). For Kaufman, nursing education and leadership skills are seen as key to, 'empowering nurses to address the devaluing of nursing' (p. 92). Nurses are also urged to promote their skills and to highlight their value and worth to the commissioning process.

Kaufman raises some important points and based on the findings from my research I would broadly support the strategies she outlines. However, these strategies also raise several issues. It is uncertain as to whether education and enhanced nursing leadership skills would do much to undermine masculinist ideology. Feminist research suggests that women's credibility as competent organizational members is in doubt, even when they have the requisite skills and abilities for the job. The issue of nurses' (and women's) marginalisation and the operation of masculinist ideology is more complex than Kaufman suggests. In addition, from her perspective the solution to the problem once again lies with nurses themselves - it is up to them to overcome barriers and negative attitudes.

In this section I have highlighted the historical marginalisation of nursing and nurses from policy making and debate, arguing that the ambivalence toward greater nursing involvement has important implications for nurses on LHG boards.

I next turn to the literature on the doctor/nurse relationship, a topic which has clear implications for the study of gender and is central to understanding the experiences of board nurses.

2.5 The doctor/nurse relationship

Given doctors' presence in relatively large numbers on the board and their positions in key leadership roles, the inequalities and conflicts that have traditionally defined the relationship between doctors and nurses are important to consider (Willis 1998, Sweet 1999, Rowe 1999, Poole 2000). As Rowe, herself a board member (1999 p.29) suggests:

> ... official urging of collaborative working in primary care groups may fall on stony ground if the underlying tensions and difficulties of power imbalances and ambiguous professional relationships are not addressed.

The subject of the doctor/nurse relationship has received much attention, particularly within the popular nursing press. There are also some important examples of empirical studies and critical analyses to be found within both the nursing and sociological literature.

Gamarnikow's (1978) historical analysis of the sexual division of labour within health care is an early example. Her study of nursing in Britain during the nineteenth century has been influential in highlighting the patriarchal underpinning of this relationship. Gamarnikow argues that within the male and medically dominated health care of the day, nursing was relegated to a subordinate position. The division of labour between medicine and nursing emerged as a sexual division of labour – the vast majority of doctors were men and nurses, women:

> Professional power relations were overdetermined by the patriarchal relations implied in the sexual division of labour: hence the subordination of nursing – whose tasks were defined and practices limited – to medicine (1978 p.103).

The subordination of nursing to medicine and nurses to doctors has been reinforced and justified through appeals to naturalism and that men and women are naturally suited to different spheres and tasks, and exhibit different qualities. Indeed, women's caring nature and their unique 'natural' ability to perform the domestic tasks of wife,

mother and housekeeper were central to nineteenth century nursing reforms which included entry to existing health care institutions (Gamarnikow 1978). For Gamarnikow, the doctor-nurse-patient relationship comes to resemble the power relations between husbands, wives and children within the patriarchal family, 'the doctor being the incumbent of the 'rule of the father'' (1978 p.97).

The burden of this history is important to recognise. Although much has changed in health care and in the relationship between nurses and doctors, my own experiences as a nurse and of working with nurses have led me to believe that the doctor/nurse relationship continues to be based on gendered patterns of domination and subordination, albeit expressed in perhaps more subtle and complex ways. Exploring the doctor/nurse relationship was an important aspect of understanding the gendered organizational experiences of LHG nurses.

More recently a number of other writers have explored the doctor/nurse relationship drawing on interview and observational research data; see for example Game and Pringle (1983), Keddy *et al.* (1986), Hughes (1988), Porter (1991, 1992), Mallik (1992), Whale (1993), Mackay (1993), Walby *et al.* (1994), Svensson (1996), Allen (1997, 2001), Wicks (1998), Manias and Street (2001) Davies (2003).

Reflecting some of the themes raised within Gamarnikow's (1978) account, Keddy *et al's* (1986) historical research draws on interview data with nurses to highlight the way in which patriarchal power relations between doctors and nurses are played out and importantly, the implications of this relationship for nurses' sense of self and identity. The aim of their study was to explore the history of nursing in Canada. The doctor/nurse relationship was one of the main themes to emerge from nurses' accounts. Their study comprised interviews with 34 nurses who had worked in Canada in the 1920s and 1930s.

Nurses spoke of the importance of being a 'good nurse' (p.748) which was equated with deference and obedience to doctors. Keddy *et al.* (1986) highlight the power and control doctors had through their role as educators and employers to determine what constituted a 'good nurse'. Occupational ideals were conflated with gender ideals of

womanhood. Keddy *et al.* argue that, 'to be a doctor's preferred nurse, meant you were a good nurse and occupied a place of special status with other nurses' (1986 p.747). Doctors were generally revered, which was 'reflected in a form of idolisation of the physician' (p.748).

Significantly, Keddy *et al.* (1986) also draw attention to nurses' internalised feelings of inferiority and fear of humiliation which developed through their training. They argue these feelings give rise to submission, which 'is part of the reason why nurses have often not felt free to contribute to decision making with regard to patient care improvements' (p.749). This is an important point. The issue of nursing identity, which Keddy *et al.* (1986) raise, is central to this thesis. I was keen to explore the way in which nurses made sense of their identity as nurses and women and the impact their occupational and gender identity might have in terms of their ability to contribute to the work of the LHG. As indicated above, feelings of low self-esteem and worthlessness were mentioned by some of those I interviewed, and seen as precluding more pro-active involvement on the board.

The importance of addressing issues of identity and self-image when considering the nursing contribution to decision making is illustrated by Whale (1993) in her study of nurse participation on a hospital ward round. Whale also highlights the importance of the doctor/nurse relationship in this context. Whale (1993) tape recorded 13 multidisciplinary group meetings on a hospital ward and interviewed a sample of 12 nurses who participated in the meetings on 23 occasions (23 interviews in total). She also observed three meetings.

Whale (1993) found that nurses contributed to the majority of patient cases (81%) under discussion. They provided rich and detailed information on individual patients and their families which were vital to effective decision making and planning - evidence, according to Whale, of nurses' abilities to 'think nursing' (1993 p.160). However, their comments were invariably in response to direct cues, most commonly from the consultant. Indeed, Whale suggests that at times nursing insight and knowledge, 'had sometimes to be prised out of the nurse!' (1993 p.161) This comment is interesting because it suggests a lack of confidence on the part of nurses and uncertainty as to the value and legitimacy of nursing knowledge.

Whale (1993) concludes that to maximise the nursing contribution to multi-disciplinary decision making, '*personal factors* such as confidence, experience, assertiveness and beliefs about nursing' (p.159, my emphasis) need to be addressed through training and development. However, Whale does not locate these factors within the broader context of the power relations between medicine and nursing - a relationship which she has already highlighted as problematic and as being played out and reproduced through a number of organizational practices and rituals. Doing so would allow for an exploration of the interplay between the personal, and the wider social and political barriers to the nursing contribution (see also Manias and Street 2001 for a similar point).

In Mallik's (1992) study of the nursing role on the consultant's ward round, Mallik also highlights the influence of the doctor/nurse relationship on multi-disciplinary decision making. She interviewed 19 nurses to ascertain their views of the nursing role on ward rounds. She then observed a total of nine ward rounds from three wards to compare what nurses said they would do, with what was observed in practice (due to time constraints, the nurses who were interviewed were not always the ones observed on the round).

Mallik (1992) concludes that whilst nurses identified their involvement on the round as pro-active, her observational data suggested that nurses adopted a predominately 'passive' role (p.51) – responding to questions from medical staff. As Whale (1993) had found, unsolicited comments were virtually absent. Similarly, despite nurses' emphasis at interview on the importance of adopting a patient-centred approach - for example, acting as patient advocate and providing psychological support - Mallik found little evidence of this in practice. Interestingly, Mallik highlights the physical position of the nurses on the round, noting that nurses commonly positioned themselves behind the medical staff, as opposed to near the patient - in effect making themselves invisible.

In accounting for the differences, Mallik (1992) reflects on some of the negative feelings nurses' expressed about the ward round at interview: 'Nurses mentioned that if they did speak or give an opinion it was ignored and the impression created at

interview was that they had given up trying after a while. Perhaps this could explain the passivity observed' (p.51).

Manias and Street (2001) also explored nurse-doctor interaction on the ward round. Their work focused on a critical care unit in Australia. Data collection methods included participant observation, individual interviews and focus group discussion with six nurses working in the unit. As Whale (1993) and Mallik (1992) found, nurses' contribution to decision making was limited and largely reactive. The authors provide a vivid account of the way in which the consultant regulated the involvement of nurses during the ward round. When called for, nurses would 'dart' in and out of the discussion room (where part of the round was held) and once there, sit in relative silence waiting to be asked for their input. The authors describe the way in which nurses moved from invisibility to visibility depending on the information needs of doctors: 'during these medically oriented discussions, nurses struggled to find a time and space to speak' (p. 448).

Manias and Street (2001) also argue that whilst doctors recognised nurses' knowledge with regard to patients and listened attentively to their comments, if nurses were unable to attend when the patient they cared for was being discussed, then no attempt was made to delay the discussion until they were available. They argue that this may have important consequences for patient care.

The other interesting observation they make is that initially nurses believed that doctors provided them with many opportunities to speak, yet on critical reflection they realised that the opportunities were limited, with nurses only speaking at particular points. On several occasions nurses in my study argued that their contribution was valued because during discussion, doctors asked for their opinion. But as Manias and Street's (2001) work suggests, this does not necessarily equate with an adequate recognition of nursing knowledge and expertise.

Davies (2003) presents a somewhat different view of nurse involvement in the ward round in her research on the relations between doctors and nurses in hospital work. The research was carried out in Sweden during the late 1990s. Doctors and nurses took part in a similar ward round where they would discuss patients in a room prior

to doctors seeing the patients on the ward. Nurses would initiate discussion by presenting their assessment of the patient's progress. Were nurses not available immediately to discuss their patient, doctors would have to wait until they were available. Nurses were overwhelmingly positive about the round and Davies (2003) suggests that the arrangement facilitated nurses' advocacy and decision making role. However, the extent to which nurses were able to influence the final decision with regard to patient care is unclear, especially as doctors then continued the bedside round without nurses.

The issues raised by Whale (1993) Mallik (1992) and Manias and Street (2001) are important to consider. The difficulties nurses face in actively contributing to decision making processes within multi-disciplinary groups have clear implications for this study. In particular, being dependant on the direct action of others - notably doctors - to facilitate the nursing contribution is problematic and reflects and reinforces inequalities in status and power. The work of these authors also illustrates the complex interplay of oppressive practices and processes – something I was keen to explore as part of my research. Nurses' apparent reluctance to contribute during the round is compounded by the behaviour of doctors which marginalises the nursing contribution. For example whilst Mallik found that during the round nurses positioned themselves behind the doctors – making themselves invisible, Manias and Street (2001) cite one nurse who complained that nurses were 'pushed to the back of the bed area and they have to physically push their way to the front' (p.447).

The perception that some doctors are not interested in what nurses have to say is also highlighted by Mackay (1992, 1993). Mackay studied the working relationships between doctors and nurses in five hospitals in England and Scotland between 1989-1990. She interviewed 127 doctors and 135 nurses from a variety of specialities and of varying levels of seniority. The account she provides offers a rich description of some of the frustrations and difficulties, as well as some of the pleasures, which characterise the working relationships between nurses and doctors. She argues that a major source of conflict for nurses is around communication: 'It's the perennial problem of 'I-can't-hear-what-you-are-saying-because-of-who-you-are' – most frequently and bitterly voiced by nurses about doctors' (1992 p.129).

For their part, medical staff bemoaned what they saw as nurses' lack of initiative and unwillingness to take responsibility. Mackay draws attention to the impact of poor communication and inter-professional relations on patient care and argues that fundamental changes are needed in perspective and attitude on the part of nurses and doctors if the relationship is to improve. For example, she comments that: 'An unwillingness to assert themselves, carefully engendered in nurse training is compounded by nurses' refusal to see themselves as partners in the delivery of healthcare' (1993 p. 180).

This point is significant because it suggests that aspects of self-image and personal identity are important in shaping the doctor/nurse relationship and have implications for nurses wanting to be more actively involved in health care decision making. However, having identified the negative effect of nurse training on nurses' sense of self, Mackay risks blaming nurses for their own predicament. She underplays the impact of structural processes and power relations in shaping and determining nurses' attitudes and beliefs and in perpetuating oppressive power relations. Nurses may well fail to see themselves as partners in the delivery of healthcare, precisely because the message they receive from those around them - patients, the medical profession and management - is that they are not partners.

The next section mainly focuses on the work of Porter (1991, 1992, 1995) and Wicks (1998), both of whom make gender an explicit concern in their studies of the doctor/nurse relationship.

2.5.1 A closer look at gender and the doctor/nurse relationship

I shall begin by discussing the work of Porter (1991, 1992, 1995). As a precursor I shall give a brief overview of the work of Stein (1967) whose analysis of the 'doctor-nurse game' has proved hugely influential and is central to Porter's (1991, 1995) reappraisal of the doctor/nurse relationship.

Drawing largely from his own experiences and observations as a doctor, Stein (1967) refers to the 'doctor-nurse game'. According to Stein the doctor-nurse game involves nurses adopting certain strategies with which to manage and negotiate their lack of

status and power *vis-à-vis* doctors. The doctor-nurse game results in the nurse exercising a degree of decision making, but in such a way that recommendations for patient care are highly covert and avoid threatening (male) medical dominance. For their part, doctors must seek advice from nurses without appearing to do so; their sense of omnipotence remains intact.

Porter's (1991, 1995) exploration of the power relations between doctors and nurses sets out to investigate the extent to which the doctor/nurse relationship continues to be characterised by traditional patterns of dominance and subservience as outlined by Stein (1967). Using participant observation, Porter studied interaction between doctors and nurses over a period of three months. The research took place in an Intensive Care Unit (ICU) of a general hospital in Ireland where he worked as a staff nurse. Porter (1991, 1995) analysed interactions between doctors and nurses against a set of four types, which ranged from 'unproblematic subordination' to 'formal overt decision making' on the part of the nurse (1991 p.731).

Porter (1991, 1995) concludes that whilst unproblematic subordination and the doctor-nurse game appeared widespread, further analysis suggested a less straightforward interpretation. Doctors often gave a reason for their requests and Porter suggests this indicates a less deferential relationship: 'If dominance was unproblematic, one would assume that justification of requests ... would be redundant' (1991 p.732). I am less convinced than Porter appears to be that this marks a levelling in relations between doctors and nurses. Offering an explanation might reflect awareness on the part of doctors that to ensure their orders are carried out, they simply need to be polite. In making sense of what he observed, it would have been useful had Porter been able to share his understanding with participants to ascertain their views.

Porter does cite numerous examples which suggest that nurses are overtly involved in decision making, the exception being in the interactions between consultants and nurses. Porter's work supports that of Hughes (1988) whose observation of doctor/nurse interaction in a casualty department suggests that whilst the doctor-nurse game was still being played, in a variety of situations and circumstances nurses contributed openly to decision making. Indeed, in a later revision of Stein's work,

Stein *et al.* (1990) argue that the doctor/nurse relationship has changed greatly. Significantly, nurses have been the main instigators of change. They write:

> What is happening is that one of the players (the nurse) has unilaterally decided to stop playing the game and instead is consciously attempting to change how nurses relate to other health professionals (p. 266).

As part of his research, Porter (1992, 1995) also explored the structural impact of gender on nurses' working lives. In particular, he examined the role of gender in the doctor/nurse relationship and in relations between male and female nurses. Porter also explored the way nurses interpret the role of gender in their organizational lives – something I was also keen to do in my own research. Porter (1992, 1995) argues that the gender of the nurses had little impact on the interaction with doctors. This was based on the number of times he observed male and female nurses making 'evaluative comments to doctors in reply to medical requests' (Porter 1992 p.516). He concludes that 'the inability of male nurses to utilise the advantages of their gender is the result of the ascription to nursing of a position of female subordination' (p.517).

In contrast, Porter (1992, 1995) suggests that the sex of the doctor did make a difference - female doctors were seen to be more egalitarian than male doctors. In her study of women doctors and nurses, Pringle (1996) provides an interesting account of this relationship and highlights the contradictions and difficulties female doctors have in managing and negotiating their occupational and gender identity.

Porter (1995) concludes that the relative unimportance of nurses' gender compared to doctors', 'indicated the power differential that still existed between the two groups overall' (p. 183). Reflecting on the power relations between doctors and nurses, Porter (1991) makes the point that:

> … because of their position of authority, doctors have considerable latitude in deciding how they are going to interact with members of other occupations. They have the opportunity to avail themselves of the power that they implicitly possess if they wish to, or to act in a more egalitarian fashion if they do not (p.517).

This is important because seen from the nurses' point of view, it suggests a degree of unpredictability with regard to the exercise of medical power. Nurses are never sure when their subordinate position *vis-à-vis* doctors will be evoked. A similar point with regard to women's organizational experience is made by Sheppard (1992) in her study of women managers. Sheppard argues that women never quite know when their status as managers will be undermined by their subordination as women.

In examining nurses' attitudes to gender issues, Porter (1992, 1995) suggests that nurses did view gender as influencing the status of their occupation and that nurses were critical of negative medical attitudes regarding their position as women and nurses. Nurses however did not apply the same understanding to medicine: 'sexism was seen as an individual phenomenon of specific doctors rather than an institutional ethos' (p.518). Porter suggests that the status and power of doctors was attributed by nurses to credentialism.

The extensive interview extracts within Porter's (1991, 1992, 1995) work allow the reader to explore the various ways in which nurses theorise gender. Whilst I would have appreciated more discussion around nurses' own sense making, that Porter raises this issue at all is significant given that relatively little work has explicitly addressed this subject directly with nurses. Chapter six of this thesis details my own findings in relation to this issue and explores what I interpreted as the ambiguous and contradictory place of gender within nurses' accounts.

Porter's (1991, 1992, 1995) claim that power relations between doctors and nurses are shifting is supported by Svensson (1996) who also argues for a reappraisal of the doctor/nurse relationship. Findings were based on interview data with 45 nurses (staff nurses and ward sisters) from general medical and general surgical wards in five Swedish hospitals. Svensson rejects the doctor/nurse relationship as necessarily oppressive and hierarchical. He suggests that the relationship between nurses and doctors is now more collegiate and characterised by negotiation. Nurses are increasingly able to determine the nature of the relationship with their medical colleagues and exert greater influence in terms of decision making with regards to patient care.

The principal catalyst for this change is an increasing emphasis on chronic disease management and care – a shift, 'from preventing death to handling life' (1996 p.384). This shift requires new medical knowledge which must take into account patients' social situation and their experiences, views and understanding of their illness. Svensson argues that this knowledge is a key component of nursing work, and as such, paves the way for greater nurse involvement in decision making. Doctors have become more dependent on the knowledge and insights of nurses in the treatment and management of patients: 'On the wards covered in this study, the voice of nursing clearly makes itself heard in more areas and with greater strength that it did before' (1996 p.396).

Whether Svensson's analysis could be applied to primary care and by extension to the experiences of LHG nurses and GPs is an interesting question. By virtue of their role and function, GPs in general may have more knowledge of and may be more conversant with the social elements of patient care than their hospital colleagues. This is especially the case when dealing with patients for whom no nursing is required. In addition, GPs currently act as gatekeepers to other services, including social services and consequently have greater involvement than their hospital colleagues in negotiating and liaising with other agencies.

However, a number of studies examining teamwork in primary care suggest that conflict between nurses and GPs remains an issue. Such conflict relates in part to opposing philosophies of care, with GPs accused of an over reliance on the traditional medical model of health and of undervaluing the nursing contribution to patient care (Cant and Killoran 1993, Wiles and Robison 1994). In addition, the traditional power and status of the medical profession is seen as hindering teamwork and with that a shift to more democratic ways of working (Field and West 1995).

The other point to make about Svensson's (1996) work is that he did not interview doctors and as a result - as he himself concedes - the picture is an incomplete one.

My main concern is that Svensson fails to consider the impact of gender in terms of the negotiated order between doctors and nurses. For example, Svensson highlights the large amount of service work nurses perform for doctors - work which nurses

may feel reluctant to do, but which they feel is forced on them by doctors. Svensson argues that whilst this work is enforced, nurses also use it as a way of negotiating a more collaborative relationship in general.

> If the nurse is good at her service work the doctor appreciates her and they cooperate well in other situations too. If she tries to negotiate away part of this work and lay it on the doctor, controversies and irritation easily arise, and the cooperation may also collapse in other cases (1996 p.393).

Svensson (1996) suggests that nurses back down when their attempts to negotiate fail, because it is usually patients who suffer when conflict arises and as nurses are closer to and identify more with patients, it is they, rather than doctors who tend to retreat. It seems likely that in addition, the greater social status and power of doctors within health care is an important contributory factor informing nurses' behaviour.

Svensson (1996) underplays the way in which this division of labour both reflects and perpetuates prevailing gender power relations. The servicing work undertaken by nurses reflects the servicing work of women more generally which continues to define and determine women's unpaid and paid labour. The work of Allen (1997) is relevant here. Drawing on interview and observational data from her study of hospital nursing, Allen highlights the way in which the nursing-medical boundary in a hospital ward is blurred, as nurses take on medical tasks in an attempt to manage the turbulent work of the environment and co-ordinate patient care. As she comments, 'observing the nurse on the ward, the juggling analogy, so often applied to women's domestic work, seemed equally fitting' (p.506).

In Svensson's account, nurses are expected to be good at service work - anticipating and responding to the needs of others and doing so with good grace. If they aren't or they reject this role, patient care is compromised – nurses then appear to take responsibility for addressing this. The issue of responsibility is interesting given that doctors frequently cite clinical responsibility and autonomy as justifications for their greater power and control within health care (Stacey 1992). Yet in managing the doctor/nurse relationship in such a way that does not compromise patient care, it is nurses who take responsibility, or are held responsible. This 'work' helps to sustain individuals and the smooth running of the organization as a whole. As Allen (2001)

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comments of her own research, 'nurses' flexible working practices constituted a vital organizational glue ... and acted as an antidote to the centrifugal effects of the modern hospital setting'(p. 142).

Svensson rejects the doctor/nurse relationship as necessarily oppressive, yet in his account the conditions are set for the maintenance of oppressive power relations. Nurses' ability to renegotiate existing social relations is diminished, whilst compliance with their traditional gender and occupational role in servicing the needs of others remains paramount.

The role of gender in determining power relations between doctors and nurses is discussed at some length by Wicks (1998). Her book *Nurses and Doctors at work: rethinking professional boundaries*, which is based on her doctoral thesis, sets out to explore the way in which gender, 'enters into, constructs, negates and shapes' nursing work and the everyday working relationships between nurses and doctors (p.xiv). A central concern is to illustrate the agency of nurses (and doctors). Drawing on post-structuralist theory, Wicks (1998) urges the reader to reject accounts of nurses as hapless victims of immutable patriarchal structures and oppressive medical power, but to see them as active social agents involved in constructing and challenging dominant hierarchical relations. Wicks' (1998) emphasis on gender as a social practice or process constructed and negotiated through the daily activities and work place relations is of relevance to this thesis. I shared this perspective and was similarly concerned with investigating the 'smaller picture' – the everydayness of gender formation and interaction (see section 2.6).

The empirical research on which Wicks' book is partially based consisted of an ethnographic study in a teaching hospital in Australia. Wicks (1998) undertook participant and non-participant observation over a six month period on a general medical ward during the early 1990s. She also carried out a number of in-depth semi-structured interviews with those connected to the ward. Her sample consisted of 20 nurses, seven doctors, a physiotherapist, occupational therapist, social worker and a number of patients.

Wicks (1998) argues that a struggle between competing discourses lies at the heart of power relations between doctors and nurses. These discourses reflect the scientific, mechanistic, bio-medical discourses of medicine, and discourses around healing and holism evidenced within nursing and amongst nurses. Wicks acknowledges that the division along strictly occupational lines is not absolute, but is historically and culturally specific. For example, she argues that there are doctors - particularly in areas such as palliative care - who work with and embrace holistic working practices.

Wicks (1998) draws attention to the hierarchy of knowledge within health care and the invisibility of nursing skills. Reflecting some of the concerns already highlighted in this chapter, Wicks argues that nursing skills and knowledge: '...aren't so much rejected as never seen in the first place. When they are seen it is usually in an instrumental way, in terms of how they can be useful for medical practice' (p 142).

Central to Wicks' argument is that within the prevailing hegemonic discourses of scientific medicine, marginalised discourses of healing continue to exist and find expression in the work and practices of nurses. Wicks provides a number of examples where nurses directly or indirectly challenge medical authority and practice by recourse to alternative, holistic, patient-centred approaches to care. Resistance to bio-medical knowledge and practice provides the potential for a renegotiated division of labour between medicine and nursing and between doctors and nurses.

Wicks' (1998) findings have implications for this study. I was interested to see how nursing knowledge and priorities would translate to the LHG board and the extent to which prevailing bio-medical discourses might be disrupted. This was especially relevant in light of the rhetoric of NHS policy in relation to LHGs which emphasised a broad understanding of health care – one which acknowledged the social, environmental and economic determinants of health and well being, as well as the physical (see *Putting Patients First*, Welsh Office 1998a).

Another important point that Wicks (1998) makes is in relation to the psychodynamics of gender identity and the part this plays in shaping and determining the sexual division of labour within nursing and medicine. Wicks asks the question, 'how is it that men and medicine fit together so well?' (p.127). Drawing on

Chodorow's theory of mothering (see section 2.2 of this chapter), Wicks argues that features of masculinity (e.g. the drive for separation, objectivity and the fear and denial of emotionality) can be seen as expressed and reproduced within medicine and medical discourse. Similarly, she highlights the fit between femininity (as expressed by the need for intimacy, connection and emotionality) and nursing. Wicks continues:

> The point is that men have the social power to institutionalise their unconscious defences against repressed, yet strongly experienced developmental conflicts. In other words, they have the social power to avoid or at least minimise their involvement with situations which they find emotionally confronting or uncomfortable. The work of ...object relations theorists points to the crucial fact that the sexual division of labour is permeated from within by the deepest psychic desires, fears and insecurities (1998 p. 131).

Whilst much of Wicks' work is of relevance to my own study, I do have some reservations. My main concern relates to what I interpret as Wicks' (1998) relatively optimistic analysis of the doctor/nurse relationship and the nursing challenge to medical authority. Her insistence that we see nurses not as victims, but as individuals actively involved in constructing and challenging work place relations is important; however, I would suggest that Wicks underplays the power of social structures and oppressive practices which marginalise and devalue nurses and nursing.

My understanding is more in keeping with those writers who acknowledge that gender identity and relations are socially constructed and contested, but who also highlight the relative fixity of gender power relations and subjectivities (see for example Pringle 1989b, Hartsock 1990, Cockburn 1991). As Cockburn (1991) comments:

> ...we should understand women's subordination as *systematic*. That is, not casual but structured, not local but extensive, not transitory but stable, with a tendency to self-reproduction (p.6).

The literature on the doctor/nurse relationship as described above suggests power relations between doctors and nurses and between medicine and nursing may be shifting. Yet it is also clear this relationship remains a troubled one and continues to be defined by damaging patterns of dominance and subordination. As Porter (1995) suggests:

> ... while decision making may now be done in the open, with nurses feeling it is their right to participate, both sides are also well aware that, in the last instance, the balance of power still remains firmly in the hands of doctors (p. 93).

The next section of the literature review sets out to explore in more detail the relationship between gender and organizations. Gendered organizational theory has been influential in informing my approach to the research. Of particular importance is the way in which this approach allows for an understanding of masculinity as central to the construction of organizational culture, practices and rituals. This raises important questions as to how nurses, whose identity is intimately connected to images of womanhood and femininity, experience and negotiate organizational life.

2.6 Gender and organization

Traditionally, organizational studies and organizational theory have focused on ways of improving productivity and efficiency in organizations. Within these accounts little attention or priority has been given to gender (Hearn and Parkin 1992, Acker 1991, Mills and Tancred 1992, Calas and Smircich 1996). Feminists argue that organizational theory has, for the most part, been generated by men and reflects the experiences of male society. Acker suggests that:

> As a relational phenomenon, gender is difficult to see when only the masculine is present. Since men in organizations take their behaviour and perspectives to represent the human, organizational structures and processes are theorized as gender neutral (1991 p.163).

Women's accounts of organizational life - their experiences and voices - have been overlooked, as Hearn and Parkin, writing in 1983, comment:

> Until those most discriminated against can themselves research and theorize, or at least have their concerns brought more centrally into organization theory, then the male domination of organization theory is likely to continue (1992 p. 64).

A large amount of feminist work on gender and organizations has emerged during the last two or three decades. Much of this work has focused on women's occupational inequality in terms of sex segregation, pay differentials and women's shortened careers (Calas and Smircich 1996). This research has proved of great benefit in highlighting women's inequality and the many obstacles they face in

gaining access to, and advancing within, the workplace. As a consequence, important legislative measures to address sex discrimination and equal opportunity have been developed. However, the limitations of these approaches to understanding women's organizational experience are becoming apparent, as Acker (1991 p.166) comments:

> … some of the best feminist attempts to theorize about gender and organizations have been trapped within the constraints of definitions of the theoretical domain that cast organizations as gender neutral and asexual. These theories take us only part of the way to understanding how deeply embedded gender is in organizations.

More radical analyses have thus emerged, influenced by constructivist thinking, which view organizations not as static, gender neutral spaces, but as social constructs, 'that arise from a masculine vision of the world and that call on masculinity for their legitimation and affirmation' (Davies 1995 p. 44). These analyses draw attention to the way in which organizations reflect and actively construct and maintain gendered subjectivities and relations. Gender is understood not so much as who and what men and women 'are' but as a social dynamic, actualised through interaction. So, for example Kerfoot (1999 p. 186) argues that:

> Rather than see masculinity as a 'fixed' outcome of biological or other configurations, this is to understand masculinity as actively produced in given settings and in specific moments… Masculinity exists merely as a way of being, most often, but not exclusively expressed by men…

These ideas have led to a focus on gendering processes and how we 'do gender' (West and Zimmerman 1991), that is, 'how gender is constantly redefined and negotiated in the everyday practices with which individuals interact'(Gherardi and Poggio 2004 p. 227). Gender is seen as, 'a routine, methodical and recurring accomplishment' (West and Zimmerman 1991 p.14).

The concept of 'organizational culture' is useful in helping to understand how the process of gendering takes place (see for example, Mills 1992 and Gherardi 1994, 1996). Using Strati's (1992) definition, Gherardi suggests that organizational culture:

> …consists of the symbols, beliefs and patterns of behaviour learned, produced and created by the people who devote their energies and labour to the life of an organization. It is expressed in the design of the organization and of work … in its ceremonials of encounter and meeting, … in the quality and conditions of working

life, in the ideologies of work, in the corporate philosophy, in the jargon, lifestyle and physical appearance of the organization's members (Strati 1992, cited in Gherardi 1994 p.593).

Highlighting organizational culture allows for an exploration of 'societal-organizational inter-relationships' (Mills 1992 p. 98). So for example, Mills argues that social and cultural understandings of gender, 'are not left outside the gates of organizational reality' (p. 99) - rather they are central in defining and shaping any given organizational culture and are manifest in the 'rules' which govern behaviour. These rules, which are implicit or explicit, help us to understand how the organization functions, how we should behave, what is expected of us, and how we can achieve things (Mills 1992). Given that it is predominately men who lead and govern organizations, the question is, as Mills suggests: 'to what extent do values of masculinity permeate understandings of organizational reality, its purposes and structure?' (1992 p. 99).

The literature on gendered organizational theory is now wide-ranging and has been applied in varying ways to help explain women's and men's organizational experiences (see for example the edited collection of work by Hearn *et al.*1989, Mills and Tancred 1992, and Calas and Smircich 1996 for an extensive review of different feminist approaches to the subject).

In order to explore in more detail what a gendered organizational analysis might look like and how I have applied this theoretical approach to my research, I shall be focusing mainly on the work of Acker (1991, 1992) Davies (1995), Marshall (1984), Pringle (1989b), Sheppard (1989, 1992), and Gherardi (1994, 1995).

2.6.1 The Gendering of Organizations.

Acker (1991, 1992, 1998) has made a significant contribution to the study of gender and organization. Acker (1991, 1992) argues that the gendering of organizations takes place through a number of *interrelated* processes.

The first set of processes relates to the creation and maintenance of gender divisions and hierarchies. Men almost invariably occupy the most powerful organizational

positions, whilst women predominate in the low paid, low status support work. The NHS stands as a striking example of this (Davies and Rosser 1986, Finlayson and Nazroo 1998, Lane 2000). Walking into a typical general practice, the gendered division of labour and hierarchy is immediately apparent. In most practices patients are greeted by female receptionists whose job it is to respond to and negotiate the (often conflicting) demands and needs of patients and GPs. Receptionists are predominately part time and poorly paid, and whilst this work is very demanding, it is seldom recognised or rewarded as such. In contrast, men working in general practice tend to be either GPs or practice managers and enjoy better pay, status and freedoms.

The second set of processes whereby organizations are gendered involves the use of representation: 'symbols and images that explain, express, reinforce, or sometimes oppose [gender] divisions' (Acker 1991 p.167). For example, researchers have highlighted the use of sexist jokes, pornographic imagery and male narratives as powerful expressions of masculinity within the workplace which work to subordinate and control women (Collinson and Collinson 1989, Cockburn 1991).

In addition, the image of successful organizational leaders and of the organization itself reflects a masculine bias (Kerfoot and Knights 1996). For example, rationality, competition, mastery, ruthlessness and objectivity are associated with individual and organizational success. Carpenter's (1977) critique of the Salmon Report on nursing management (see section 2.4 of this chapter) illustrates this point.

The rational, scientific, masculine discourse of medicine to which Wicks (1998) refers is another example of how organizations are gendered through representational practices. Likewise, the stereotypical image of the nurse as 'Madonna, Battle-axe and Whore' (Muff 1982c, Salvage 1985, Hudson Jones 1988) is also relevant in this context. Such imagery continues to find expression within contemporary, popular culture (for example, in Channel 4's recent TV series 'No Angels').

The third set of processes involve the daily interactions that take place between people at work and which serve to reproduce relations of dominance and subordination. For example, drawing on their own experiences of working in a male

dominated academic community, Katila and Merilainen (1999) highlight one of the ways in which gendered relations of domination and subordination operate. Reflecting on the interactions between members participating in a seminar discussion, they argue that men did most of the talking, and frequently referred to their academic achievements and successes, whilst women were more tentative and said little:

> To take the public space by referring to one's credentials in the field of management and academia reflects that men are expressing values contiguous to their relationship with masculinity – visible, aggressive, successful. Women on the other hand tend to adopt the role of an outsider. They keep silent as if they had nothing to contribute to the discussions, even if the topic concerns their own field of expertise (p. 168).

As LHG board nurses will be taking their place in an organizational setting dominated by men, gender inequality in conversation and everyday talk (Acker 1991) has important implications for this study. The above extract resonates with work cited earlier on the doctor/nurse relationship in which Whale (1993) Mallik (1992) and Manias and Street (2001) reflect on the passivity and silence of nurses on ward rounds.

Feminists have also highlighted the way in which sexual harassment reproduces relations of dominance and subordination within the workplace (Marshall 1984, Sheppard 1989, Collinson and Collinson 1989, Cockburn 1991). Sexuality is seen as a powerful organizational resource. Game and Pringle (1983) highlight this in relation to the doctor/nurse relationship: 'Doctors exercise not only the power of the father, but direct sexual power over nurses. Medical dominance is reaffirmed by sexual domination' (p.108).

Pringle's (1989b) study of secretaries also provides an interesting account of processes and relations of dominance and subordination. Pringle identifies a number of different discourses that characterise the boss-secretary relationship. These discourses construct different subject positions, for instance the 'master-slave' and 'mother-daughter' discourses. Pringle also emphasises the contradictions and pleasures involved in relations of dominance and submission. This was of particular

interest to me. The ways in which nurses, as women, relate to male doctors was something I hoped to explore.

The fourth set of processes Acker (1991, 1992) identifies is the 'internal mental work' (1992 p. 253) of individuals as they make sense of the gendered structures, opportunities and rules governing organizational behaviour, and act accordingly – 'creating the correct gendered persona' (ibid.). This 'work' was to prove particularly relevant to the experiences of nurses on LHG boards. Research which explores the experiences of women within male dominated occupations and industries is particularly helpful in elucidating this process (see for example, Sheppard 1989, 1992, Marshall 1984, 1995, and Gherardi 1996).

Sheppard (1989) conducted in-depth interviews with managers and professionals from a range of Canadian organizations. Her sample included 34 women and 16 men. The aim of her research was to explore the way in which gender identity defined and maintained power relations at work. One of the key findings of her research was the way in which 'femaleness' was experienced as profoundly problematic. Women managers felt compelled to 'manage' their gender identity in order to fit in and succeed within organizations. Women expressed a tension, a conflict in their dual position as 'woman' and 'manager'.

> Without constant vigilance regarding gender (and sexual) self-presentation, these women perceive that they run the risk of not being taken seriously, not being heard, and not receiving necessary information – in other words of not being able to participate fully in the organizational system (p. 145).

Significantly, gender management occurs with reference to the prevailing set of male –defined norms and expectations (Sheppard 1989). Most commonly women attempt to 'blend in' (p.146) to the organizational culture. This involves a careful balancing act of being 'feminine enough' whilst also being 'businesslike enough' (ibid.). Detailed attention is given to dress, self-presentation and behaviour. This strategy was seen to reduce the threat and disruption caused by women managers' entry into a male world. At the same time, strategies such as this shore up existing gender power relations; as Acker (1992) comments, 'such internal work helps to reproduce divisions and images even as it ensures individual survival' (p. 254).

Marshall's (1984) work on women managers was another important early influence in raising awareness of some of the issues and dilemmas facing women in male dominated occupations. In a later study, Marshall (1995) revisited some of these themes. Her original work was funded by the Equal Opportunities Commission (EOC) who wanted to derive a profile of women who succeed in management jobs. In order to explore women's accounts of their work lives, Marshall (1984) undertook 30 in-depth interviews with women managers from two separate organizations (publishing and retailing).

As Sheppard (1989) found, issues relating to personal identity and the need for women to manage others' perceptions of them were commonplace. Strategies for this included doing the job well, adopting a non-competitive style of management (to appease male sensibilities), not taking things too seriously and being careful not to fulfil negative stereotypes of women:

> The managers list of problems reveals how devalued by others at work they could feel. From their list of strategies we see how often they took on personal responsibility for managing the disturbance they represented in the work environment (Marshall 1984 p. 159).

Marshall (1984) highlights the implications this has for women. She suggests that women experience a distorted, fragmented sense of self as they adapt to and negotiate the conflicting requirements of their gender and organizational identity. Her study provides a compelling account of the demanding nature of this work and the sheer effort, time and energy women invest in managing their devalued identity.

Gherardi (1994, 1995, 1996) offers an interesting explanation as to the meaning of this work. Gherardi suggests that when women enter organizations, most particularly in male dominated occupations, they disrupt the 'symbolic order of gender based on the separation between male and female, public and private, production and reproduction' (1995 p. 141). She argues that we can understand strategies of gender management as 'remedial' or reparative work, which restore the 'gender order'. Remedial work is expressed in many ways. For example, women enter organizations but maintain a discreet presence; they 'take their place in segregated jobs' (1994 p. 602) and take on roles which, 'express their femininity and the continuity with

maternalism' (ibid.) – nursing being a case in point. Remedial work is also evident in other rituals. The unassertive actions and behaviour of nurses on the ward round in Manias and Street's (2001) study, is perhaps an example of remedial work, as Gherardi (1994) comments:

> I suggest that women's lack of assertive style can be interpreted as a ritual that repairs the offence caused by the infringement of the symbolic order of gender when they speak (p. 605).

Gherardi also argues that we 'do' gender through 'ceremonial' (p. 599) work. This work relates to the customs, etiquette and rules which govern gendered behaviour. The doctor-nurse game outlined earlier in this chapter is illustrative of this. Deference is required of nurses (or women), whilst masculine attributes of authority, mastery and control are required by doctors (or men):

> Men and women are engaged in the ceremonial work of giving proper representation to the attributes and behaviour of their own gender, of acknowledging and expecting that others will do the same, and of legitimating this ceremonial in appropriate discourse strategies (Gherardi 1994 p. 599).

Gherardi's ideas are explored in more detail in the context of my research findings in chapter six.

The issue of 'gender management' raised by these authors has implications for the organizational experiences of nurses, particularly those in senior positions. For example, the possibility that nurses might choose to play down their femininity is clearly problematic, when their occupational identity is so intimately linked to ideals and cultural understandings of womanhood. The use of strategies to manage their gender and occupational identity was something I was keen to explore with nurses.

Returning to Acker's analysis of the gendering of organizations, the processes outlined above are intimately connected to what Acker refers to as the 'gendered substructure of organizations' (1991, 1992) – an argument she develops in later work (Acker 1998): 'Gender is implicated in the fundamental ongoing processes of creating and conceptualizing social structures… gender is a constitutive element of organizational logic (1991 p.168).

To illustrate her argument, Acker highlights the way in which the concept of 'a job', though presented as a gender-neutral abstraction, is implicitly gendered male and relies on the separation of public and private spheres and a gendered division of labour. It is men who are best placed to fit the requirements of a job: 'the abstract worker transformed into the concrete worker turns out to be a man whose work is his life and who wife takes care of everything else' (1992 p. 257). Acker also suggests that hierarchies within organizations similarly rely upon gendered criteria that advantage men. Seniority and privilege are related to levels of responsibility and job complexity, which in turn are defined in relation to professional and managerial tasks. This relationship contains gendered assumptions about skill (see also Corcoran-Nantes and Roberts 1995). So for example, the range of caring, nurturing activities typically performed by women are not viewed as skilled in the same way as professional and managerial activities, yet arguably are equally responsible and complex (Davies 1995).

Masculine organizational logic is also evident in the denial and exclusion of 'bodied' (Acker 1991 p.173) processes. Since the abstract worker is male, 'it is the man's body, its sexuality, minimal responsibility in procreation and conventional control of emotions that pervades work and organizational processes' (ibid.). Women's bodies, their sexuality, reproductive capacities, and 'mythic emotionality' (ibid.) are rendered Other, excluded and confined to the private sphere.

Acker (1991, 1992, 1998) is at pains to point out the significance of the gendered substructure of organizations because gendering at this level is hard to see, hidden within supposedly abstract, rational systems and practices. Yet as she suggests, the use of these systems, 'continually reproduces the underlying gender assumptions and the subordinated or excluded place of women' (1991 p. 175).

2.6.2 Applying elements of gendered organizational theory to nursing

Davies (1995) draws on Acker's (1991, 1992) work to explore and highlight the particular predicament facing nursing. Davies argues that 'bureaucracy' and 'professionalism' are gendered in a similar way to 'jobs' and 'hierarchies' - they are based on the inclusion of woman within organizations as Other. Davies (1995)

argues that in Weber's influential writing on bureaucracy, he conceives the bureaucratic ideal as characterised by predictable and ordered rules and hierarchies. The rules governing bureaucratic behaviour prioritise universality, impartiality and rationality. For example, decision making is seen as being devoid of personal and emotional influence. The bureaucrat is presented as disembodied (see also Kerfoot and Knights 1996) and remains distanced from decision making processes in which private thoughts and emotions are suppressed.

Davies (1995) argues that seen through a gendered lens, Weber's bureaucratic ideal can be seen as confirming and reproducing a masculine vision. Davies' conception of masculinity is informed by the work of Chodorow (1978), Gilligan (1982) and Bologh (1990) and draws on psychoanalytic theories of gender identity and construction:

> Intimacy and exercise of emotion are no part of the vision that is bureaucratic organization. The longed for but dangerously all-powerful mother, together with the overwhelming, engulfing threatening character of a climate of nurturance and care, these are both set aside. Formality and distance are not only valued, but are seen as the only route to a rational decision (Davies 1995 p. 53).

In many ways nurses represent a powerful reminder of all that organizational logic seeks to repress. As surrogate mothers, nurses risk evoking those ambivalent emotions surrounding women/mothers as both objects of desire and threats to autonomy (Melosh 1988). It would appear that nurses, as emblematic of all that is feared and desired, occupy a particularly uneasy position within masculine organizational culture.

Using arguments put forward by Pringle (1989a), Davies further contends that the bureaucratic ideal as envisaged by Weber is a myth. The detached objectivity and impartiality of bureaucratic decision making is a fiction, sustained by the unacknowledged labour of women. Davies uses Pringle's (1989a) study of secretaries and her own work on women within NHS administration (Davies and Rosser 1986) to illustrate this point. Through their emotional labour, servicing work and personal support, women in these jobs perform a range of tasks and roles that sustain and nurture the organization. Yet such work is rarely openly acknowledged or

rewarded and remains devalued and largely invisible. The rational character of bureaucracy 'relies upon, yet denies the work of women' (Davies 1995 p. 56).

Davies (1995) also highlights the way in which gendered organizational logic extends to the concept of professionalism. The same features of impartiality, detachedness and impersonality that characterise the ideal bureaucracy are evident within the ideal professional encounter (see also Hughes 1990).

Davies (1995) argues that autonomy is another defining feature of both professionalism and masculinity. The image of the autonomous practitioner, self-reliant, independent, using their own particular knowledge and expertise to affect change is a powerful one. However, Davies argues that as with the bureaucratic ideal, the autonomous professional is a myth. Considerable effort on the part of others (mainly women) in terms of preparatory and servicing work is required if the appearance of autonomy is to be maintained:

> Once again the calm detachedness of the style, the very notion of what it is to act and to be competent derives from the masculinist vision that fails to recognize its partial and dependent character (Davies 1995 p. 60).

Much of nursing work in terms of its support function to medicine can be viewed in this context, as indicated in the literature review of the doctor/nurse relationship outlined earlier. Davies suggests that on account of its co-ordinating, support function, nursing allows medicine to 'present itself as masculine/rational' (p. 61). In this sense, nursing is best understood not as a profession, but as 'an adjunct to a gendered concept of profession' (p. 61). For Davies (1995), nursing's future in part lies in dismantling this concept.

In their discussion of Davies' (1995) work, Crompton *et al.* (1999) question whether the concept of profession is necessarily gendered:

> We would question whether expertise, impartiality, and impersonality are specifically masculine characteristics. Indeed as professionals have argued, they may be required for the successful pursuit of the occupation' (p. 184).

I would agree that, for example, expertise is an important professional requirement if patients are to receive safe and effective care. However, Davies' argument suggests that attention needs to be given to the way in which prevailing ideals of professionalism serve particular interests and privilege certain characteristics, whilst denying and marginalising others – the implications of which are important to consider.

Davies (1995) concludes that the many difficulties and challenges facing nursing can be reviewed in light of a gendered analysis that draws attention to the masculinity of organizational and cultural life in which nurses occupy a particularly fragile place. Whilst Davies' (1995) analysis is largely at the macro level, the aim of this thesis is to build on her arguments, and those of others, to provide a micro analysis of the gendering of organizational culture and its impact on individual nurses. Through exploring the day-to-day lives of nurses sitting on LHG boards, this thesis is concerned with how nurses experience, make sense of and resist their organizational positioning as Other.

2.7 Chapter Summary

This chapter began with the argument that women's cultural and social position as Other has particular implications for nurses, most of whom are women. I then explored the relationship between gender and nursing in more detail, focusing on literature of particular relevance to this study. This included literature pertaining to the historical exclusion and marginalisation of nurses and nursing from policy decision making and to literature which explores the doctor/nurse relationship and nurses' contribution to decision making processes in the context of this relationship.

Finally, I have drawn on feminist theory to argue that organizations can be seen as gendered - reflecting and reproducing a masculine vision. This process is recreated daily through the ongoing interactions, relations and strategising of women and men. It is also recreated in the underlying logic that informs organizational practices and discourse.

The literature reviewed suggests that the organizational experiences of nurses on LHG boards are an important area of study. Little research has been done which focuses specifically on nurses' experiences in this context; these experiences are important given the significance of nurses' appointment to LHG boards and the opportunity this affords nurses to influence local health policy. The nursing and feminist literature indicates that nurses may well struggle to contribute fully and influence decision making processes.

The review also suggests that gender is a vital conceptual tool with which to explore and understand nurses' organizational experiences. Whilst there have been some important contributions to the debate on gender and nursing, this area has received relatively limited attention within the nursing and sociological literature. Given the strong cultural association between nursing and femininity, theory that draws attention to the masculinity of organizational culture is of particular relevance to the study of nurses' experiences.

In the following chapter I describe the research process, highlighting the research methods and methodologies used.

Chapter Three   The Research Process

3.1 Introduction

I begin this chapter by briefly outlining the theoretical perspectives that underpin the research. The main body of the chapter then details key elements of the research process including sampling, access, methods of data collection, ethics, and analysis and interpretation. Research theory and practice are closely interconnected and as such, discussion of these key elements addresses the theoretical as well as the more practical aspects of their application.

The broad aim of the research was to explore the role of gender in nurses' organizational lives as LHG board members. To reiterate, my research questions were:

- What are the experiences of nurses on the boards of LHGs?
- To what extent does gender shape and inform these experiences?
- How have nurses been able to contribute to the work of the LHG board and how has gender influenced nurses' contribution?
- To what extent do nurses themselves understand and make sense of their organizational experiences in terms of gender?

3.2 Theoretical perspectives

This section explores the theoretical perspectives which underpin the research. My approach was informed by feminist research, qualitative research and ethnography. The section concludes with reflections on my initial uncertainty regarding the methodological basis of the research.

3.2.1 Feminist research

This study is located within a feminist framework. A framework contains a set of assumptions and understandings, 'a basic set of beliefs that guides action' (Denzin

and Lincoln 1994 p. 26). Feminist theory and practice inform the aim of this study, the way I have chosen to undertake the research and the way in which I have analysed and interpreted nurses' organizational experiences and chosen to represent these experiences.

My research questions were influenced by feminist thought in a number of ways. My questions were concerned with understanding the ways in which gender power relations constitute nurses' organizational lives. As indicated in the literature review, feminist writers have highlighted the impact of gender on women's organizational lives and have argued for a greater recognition and understanding of the role of gender in shaping nursing and the experiences of nurses. I also wanted to explore how nurses made sense of their experiences as board members within the context of wider structural processes, in particular patriarchal processes. These questions reflect feminist concerns with women's oppression and lend themselves to feminist research, interpretation and theorising.

The question as to what constitutes feminist research is a complex one and subject to much debate, though it is possible to identify some central themes within feminist research. These include a concern with women's experiences; the drive to articulate the nature of gender power relations and how these relations are (re) produced and impact on women (and men); the use of feminist theories in analysing and interpreting research findings; a concern with the ethics of research, in particular the researcher/researched relationship (Maynard 1994). Kelly (1988) perhaps comes closest to the way in which I have interpreted and applied feminist research when she suggests that the difference between feminist and other social science research is, 'the questions we have asked and the way we locate ourselves within our questions, and the purpose of our work' (p. 6).

Issues relating to the debate on feminist research and the way in which I have chosen more specifically to locate my research as feminist, emerge throughout this chapter as I describe the research process in more detail. The next section outlines the approach I used to explore the research questions.

3.2.2 Qualitative research and ethnography

Given my particular research questions and the emphasis on exploring how nurses themselves made sense of and interpreted their experiences as board members, I decided to use a qualitative research approach. Qualitative research is difficult to define clearly and succinctly. Ely *et al.* (1991) point to the confusing array of terminology and definitions that exist: 'the terms naturalism, ethnographic method, qualitative research and interpretative research are sometimes used synonymously' (p.3).

I have found a number of texts helpful in arriving at a definition. Ely *et al.* (1991) and Denzin and Lincoln (1998) suggest that qualitative research can be understood as an umbrella term encompassing a range of different methodologies and practices. These are underpinned by an interpretivist philosophy, which is concerned with how the social world is interpreted, understood and experienced (O'Brien 1993). Ely *et al.* (1991) favour Sherman and Webb's (1988) definition of qualitative research and this is one that I too have found useful: 'Qualitative research implies a direct concern with experience as it is 'lived' or 'felt' or 'undergone'' (Sherman and Webb 1988, cited in Ely *et al.* p. 7).

The emphasis on an inductive, open ended approach to data collection and analysis, means that qualitative research is particularly useful in gaining insight into issues about which little is known. This was certainly the case in relation to the organizational experiences of nurses on LHG boards. Whilst I came to the research with certain assumptions with regard to gender and nursing, I wanted to explore how nurses themselves perceived and made sense of their experiences as board members. I was keen to understand the way in which they theorised gender and saw it as relevant to their organizational lives.

As indicated, within qualitative research numerous different methodologies and methods exist. Early on in the research I decided to use an ethnographic approach to the study. Ethnography has its roots in the classical tradition of anthropology, which is concerned with studying culture. Ethnography, like feminist research, has been understood and applied in a number of different ways. Varying interpretations of

ethnography have generated a range of work all claiming to be ethnographic (Skeggs 2000). For the purposes of this study, I shall be drawing on Brewer's (2000) definition. Brewer (2000) suggests that ethnography is characterised by its commitment to understanding people's actions and their experiences of the world through proximity and immersion in their everyday lives. What this means in practice is that researchers often participate directly in the lives of the people or cultures they wish to study. The intention is to explore and understand human behaviour and the meanings people attribute to this behaviour, from the inside.

At the outset, I was clear that as far as possible, I wanted to be involved in the daily organizational lives of LHG board nurses, in order to explore in-depth the complexities and meanings of women's organizational experience. This meant observing LHG meetings, participating in training and networking events for LHG nurses, talking informally to nurses and other board members, and a degree of 'hanging around', before and after meetings.

Ethnography has been widely used to gain important insights into organizational and occupational culture (Brooks and MacDonald 2000). I was particularly interested in exploring the processes whereby gender power relations were negotiated and constructed as part of nurses' organizational life. Taking an ethnographic approach would, I hoped, allow me to gain insight and understanding of these processes. As Fletcher (2002) suggests:

> The distinctiveness of ethnographic fieldwork is the opportunity to explore the ways in which organizational meanings and understandings are created, negotiated and aligned through interpretive interactions (p. 400).

At the time of planning my research there were times however when I was uncertain as to whether my methodological approach was the right one, as I discuss below.

3.2.3 Methodological uncertainty

When I initially began reading about research methodologies and planning my fieldwork, I became increasingly uncomfortable about aspects of the research. A recurring theme was my concern as to whether what I was doing *counted* as

ethnography. In particular, I wasn't able to get as close or as immersed in the lives of the research participants as I'd hoped and this uneasiness remained with me throughout the fieldwork. This issue is discussed in more detail in the section on sampling.

There were moments when I was similarly confused regarding the feminist approach I had taken. At the outset I was fairly confident about what doing feminist research meant, both in terms of the research process and for me personally as a researcher. However, as I began to look 'outside' feminist writing and to some of the other theoretical approaches to research, I became increasingly uneasy and confused about the relationship between feminist research and some of these other approaches. I no longer felt comfortable seeing my theoretical perspective as exclusively feminist - or at least I struggled to hold onto the 'feminism' of it. It seemed that what I was doing and how I chose to approach the research - as a feminist ethnography - could equally 'fit' with other approaches. For example, the following describes a grounded hermeneutic approach to research:

> Grounded hermeneutic researchers approach a particular problem from a concerned, involved standpoint; immerse themselves in the participant's world; analyse human actions as situated within a cultural and historical context; offer a narrative account of how a problem developed and is maintained; and offer directions for positive change (Addison 1992 p. 113).

With its focus on intimacy and action, many of the principles outlined above could equally apply to feminist ethnography - although I accept there are additional features of feminist research that are not identified. Nevertheless, for me, the boundaries between some of the various qualitative approaches to research are sufficiently blurred to make identifying a unique theoretical perspective problematic.

As the research has progressed, I have become less concerned about this – by actually 'doing' the research these issues have become less significant. I am clearer and more confident of the way in which I have chosen to interpret and apply feminist research. In addition, I have become less concerned with what might be construed as abstract debates regarding research methodologies (see Kelly *et al.* 1994) and more

focused on the stories being told by the women in the research and what I might learn from their stories.

The remainder of the chapter focuses on the way in which I conducted the research. I outline my sampling decisions; issues regarding access to participants and the field; methods of data collection, including interviews and participant observation; ethical concerns as they relate to my research; my approach to data analysis and interpretation. A summary of how I addressed the question of rigour concludes the chapter. As indicated, theoretical issues are woven through this section, so, for example, epistemological issues are discussed in some detail towards the end of the chapter in the discussion on data analysis and interpretation.

3.3 Sampling

I found the issue of sampling a complex one for several reasons. When I began my fieldwork in early 1999, Local Health Groups were in their infancy and there was no published research relating to the nursing experience of LHGs. I wasn't sure what events, if any, it might be possible or relevant for me to observe, or how easy it would be for me to gain access to them. In the event, I found myself quite limited as to what I could observe and participate in and this prompted me to reconsider my claims to be doing ethnography. I discuss these issues later in this section.

I conceptualised the research as a journey taken with nurses during their first years as LHG board members. I hoped to observe, and where possible participate in their LHG lives. I had to decide which nurses, which LHGs and what 'bits' of the journey I would select.

Sampling strategy relates to the issue of generalisability. The ability to be able to generalise, or to say something that would have relevance and meaning beyond my sample was important; I felt there was little value in carrying out research unless I was able to do this.

As Mason points out:

> I do not think qualitative researchers should be satisfied with producing explanations which are idiosyncratic or particular to the limited empirical parameters of their study.... Qualitative research should [therefore] produce explanations which are *generalisable* in some way, or which have a wider resonance' (cited in Silverman 2000 p. 103).

This argument is particularly relevant to feminist research, which emphasises the importance of bringing about change. I felt it important therefore to provide an account and analysis that would allow for some generalisation. For the most part, generalisation and representativeness, which are part of the sampling logic in quantative research, are dealt with differently in qualitative research (Lincoln and Guba 1985, Alasuutari 1995, Silverman 2000). Because of the small sample size in ethnographic studies, generalisations principally, though not exclusively, relate to the development of theoretical insights (Miles and Huberman 1994, Brewer 2000).

Brewer (2000) argues that generalisation is possible, as long as the ethnographer provides a clear account of the grounds on which generalisations are made. It is my intention to provide a reflexive account of the research process, which allows the reader to understand how and why I have come to certain conclusions. The issue of reflexivity is dealt with in more detail in section 3.7: Analysis and Interpretation.

In their overview of post-modern approaches to sampling, Denzin and Lincoln (1998) outline a rationale for sampling which seems to reflect my own. They suggest that individuals or cases are never just that – rather they 'must be studied as a single instance of more universal social experiences and social processes ... thus to study the particular is to study the general' (Denzin and Lincoln 1998 p. xiv). This is reminiscent of the feminist claim that 'the personal is political', as Acker *et al.* (1983) comment in relation to their own research:

> Although we view people as active agents in their own lives and as such constructors of their social worlds, we do not see that activity as isolated and subjective. Rather we locate individual experience in society and history, embedded within a set of social relations, which produce both the possibilities, and limitations of that experience. What is at issue is not just the everyday experience, but also the relations that underlie it and the connections between the two (Acker *et al* 1983 p. 135).

It is in this way that I hoped my sampling strategies might enable me to say something about the gendering of organizational culture and the wider social processes of women's oppression.

Sampling in qualitative research reflects the need for data that allows for detailed and in-depth exploration and analysis of the topic under investigation. One way of achieving this is to use 'purposive sampling'. Purposive sampling, a common feature of qualitative research, involves selecting cases purposefully on the basis that they are able to shed light on the research topic:

> ... the purpose is not to establish a random or representative sample drawn from a population but rather to identify specific groups of people who either possess characteristics or live in circumstances relevant to the social phenomenon being studied (Mays and Pope 1995 p. 110).

Theoretical sampling is a form of purposive sampling where the key concern is to select cases on the basis of the emerging theory (Silverman 2000). In theoretical sampling, as data collection progresses and theory develops the researcher asks, 'which data sources may confirm my understanding? Challenge my understanding? Enrich my understanding?' (Kurzon 1992 p. 33). A key feature of this sampling technique, which is associated with grounded theory, is the way in which it evolves throughout the research with sampling, data collection and theory construction occurring concurrently (Strauss and Corbin 1990). In addition, a degree of flexibility is necessary regarding the direction the research may take.

As the aim of the research was to explore nurses' experiences of life on LHG boards, I decided to use purposive sampling – I selected nurses who would be able to share those experiences with me. But my sample was also determined by other factors. As a student undertaking research, I had limited resources. The cost of travelling, the time available to me, and the fact that I was undertaking the research on my own, all contributed to my decision as to who and what I should select. Pragmatic considerations like these are important to acknowledge (Strauss and Corbin 1998).

At the beginning, my sampling questions revolved around which LHGs I should select and whether I should aim to interview as many LHG board nurses as possible,

or focus on a core group. Given the aims of the research, I decided to select a small group of board nurses, so I could follow their progress more closely during the period of fieldwork. I was particularly interested to see how nurses' organizational experiences developed and changed over time and how issues surrounding their contribution to LHGs might evolve. These factors necessitated a small sample of nurses who would be prepared to share their experiences with me, perhaps over a period of a year or two. The first phase of fieldwork took place in 1999. The second phase took place in late 2001/early 2002 (see Appendix 1).

I had initially anticipated undertaking two phases of fieldwork over a period of a year. However, when I became pregnant during the middle of the first year of study, I reviewed my plans. Having completed my first phase of fieldwork, I took maternity leave for six months. I then undertook the second round of fieldwork approximately 18 months later (see Appendix 1). In the event, this gap provided me the opportunity to discuss the ways in which nurses' experiences and thoughts had changed over a longer time period.

I had wanted my sample to include nurses from one Health Authority (HA1) in particular. I was already in close contact with the senior nurse for primary care who was well known and respected by the LHG nurses. I anticipated that this would smooth the way for me in terms of gaining access. In addition, the LHG offices of HA1 were closer to my home and work base – about an hours drive away. It therefore made economic sense to stay close to my work base to undertake the bulk of my fieldwork.

Selecting all the nurses on the five LHG boards in HA1 provided me with a sample of 10 nurses. I also approached two nurse board members from another LHG further a field in HA2. These nurses were selected because I had early contact with them and they were willing to take part in the research (see section 3.5: Access). I subsequently approached a nurse from yet another LHG in HA4, on the recommendation from Ann, one of the 'original' nurse participants - a sampling strategy known as snowball sampling (Burgess 1984). During Ann's interview we discussed the issue of gender and she mentioned a colleague who I then contacted. This colleague had apparently spoken about the difficulties she was experiencing as

an LHG board member, in particular around issues of gender and power. My sample of LHG board nurses in the first phase of fieldwork totalled 13.

The second phase of fieldwork began some two years after the first, in October 2001. I decided not to re-interview all the 13 nurses in my original sample. Three of the nurses I interviewed in the first phase had since left their jobs (and their LHGs) and moved out of the area. Of the remaining participants I decided to re-interview six.

It could be argued that not interviewing all (available) nurses in the second phase of research raises the potential for researcher bias. However, my sampling strategy reflected the logic and rationale of purposive sampling and cases were selected on the basis of emerging theory. For example, 'strategic thinking' emerged from the first phase of data analysis as a key theoretical issue. In order to better understand the meaning and implications of this, I felt it was important to revisit this issue in the second phase of data collection and I selected participants on the basis of how such an understanding might be enhanced.

I had also gathered a significant amount of data from the first phase of fieldwork and wanted to spend some time in the later phase interviewing senior nurses and general managers within LHGs - some of whom I had previously spoken to informally. This was important because I felt I needed to get a better understanding of some of the issues facing board nurses. My experience to date suggested that those occupying more strategic, senior roles within the LHG would be able to provide some additional insight into these issues. This meant I couldn't interview everyone in my original sample again for the second time.

In addition to the six original participants, I also decided to interview two nurses who had more recently joined their LHGs to replace those that had left. This meant that in the second phase of fieldwork I interviewed eight LHG nurse board members, two general managers (one of whom was a nurse) and one senior nurse working for an LHG (see Appendices 1 and 2).

Nurses (15) in both the first and second phase of the research were experienced, qualified nurses, midwives or health visitors working in primary and community

care. Fourteen were female, one was male. They were aged between 30-55 years, and all were white. Table 1 below outlines my interview sample, (phases one and two combined).

All Participants (23)	Interviewed in first phase (18)	Interviewed in second phase (11)
Becky (nurse)	√	√
Claire (nurse)	√	√
Ann (nurse)	√	√
Kim (nurse)	√	√
Viv (nurse)	√	√
Tina (nurse)	√	√
Linda (nurse)	√	
Maxine (nurse)	√	
Sam (nurse)	√	
Debbie (nurse)	√	
Sarah (nurse)	√	
Rose (nurse)	√	
Kate (nurse)	√	
Emma (nurse)		√
Charlie (nurse)		√
Louise (general manager)		√
Pam (general manager)		√
Karen (senior nurse)		√
Nick (GP)	√	
David (GP)	√	
Will (GP)	√	
Eve (GP)	√	
Richard (GP)	√	

Table 1: Interview Sample

3.3.1 When, where and what to observe

Sampling in ethnographic research also requires consideration as to when, where and what to observe (Burgess 1984). This was to prove problematic for me. Hammersley and Atkinson (1995) highlight the importance of collecting data at different times – to consider the more mundane routines of what goes on as much as the more exciting, interesting aspects of the topic under study. Similarly researchers need to take account of context and where possible access what Goffman refers to as the

'backstage' of the setting (Goffman1959, cited in Hammersley and Atkinson 1995 p. 52), a place where 'the performer can relax; he can drop his *(sic)* speaking lines, and step out of character' (ibid.)

I knew that I would be observing the LHG board meetings, but at the time, as LHGs had only been in operation for several months, I was not clear what other LHG activities I would be able to observe. Furthermore, LHG board members were all 'part time' and fulfilled many of their LHG board commitments - most notably reading various documents - in their own time at home, or on the ½ day a week allocated for the purpose. This limited the opportunities for observation.

I realised that I was not going to be involved in nurses' 'everyday lives' in a way that reflected my understanding of fieldwork in ethnographic research – it was more their 'once a month lives' when they met as a board. I was concerned how this would affect my claim to be doing ethnography. I was reminded of a comment by Skeggs (1994) writing about her experiences of undertaking ethnographic research:

> It was the length and intensity of the research that helped me define it as
> ethnographic (I now find it odd when people claim research that rests on a few
> months and some interviews to be ethnographic) (p. 73).

As the research progressed however, opportunities did arise to observe (private) sub-committee meetings and participate in various workshops and forums for LHG board nurses, which provided me with detailed and meaningful data. Interview data also gave me some insight into how nurses' experiences of LHG life related to and impacted on their work and personal lives. I was never as immersed in the lives of these nurses as I would have liked, but came to see this as inevitable given the role and function of board members.

Initially I wondered to what extent my lack of immersion in the field might diminish my claims to know and understand something of the organizational lives of LHG board nurses. Emphasis on immersion in the field within realist ethnography has been challenged by some post-modern critiques. These critiques undermine the notion that there is an objective, knowable reality 'out there' to be discovered (Brewer 2000). Immersion in the field and insider status do not necessarily result in a

more accurate picture of 'how it is'. Rather the picture is just one of many possible 'truths', providing not a privileged view of reality, but a partial one influenced by a range of factors, including the researcher's own experiences, values, and beliefs. *Reflecting* on these influences is seen as an important research strategy in addressing the question of what researchers can properly claim to know. These issues are discussed in more detail in the section on data analysis and interpretation.

3.3.2 Keeping an open mind

In theoretical sampling, as indicated earlier, case selection evolves during the course of fieldwork. Hypotheses are not formulated in advance (although as Alasuutari (1995) suggests this position can be overstated). Rather theory is generated from the data inductively and 'tested out' as the researcher aims to develop their understanding of the phenomena under study (Janesick 1998, Lincoln and Guba 1985). In this respect, keeping an open mind with regard to sample selection in ethnographic research is seen as important: 'the more open minded you are in gathering observations, the less you exclude, the richer your material will be' (Alasuutari 1995 p. 165).

Initially I found keeping an open mind difficult - as the following extract from my fieldwork journal illustrates. At the time I had been reading about grounded theory (Strauss and Corbin 1998) – a research methodology whereby theory construction is grounded in and built up from the data through systematic sampling:

> How can I adopt a grounded theory approach to data collection/sampling *and* do feminist research? I don't want to be open – my belief in women's oppression precludes me from adopting the openness required of grounded theory. It feels like what I am doing is hypothesis testing. The research feels too ideological (March 1999).

Gradually I became more confident in my approach and was able, in part at least, to resolve this tension and find a balance. I attempted to remain open to new and conflicting data and selected my samples on the basis of emerging theory, but this process was informed by my research goals and my overall theoretical framework. As Maynard argues:

> Whatever perspective is adopted, feminism provides a theoretical framework concerned with gender divisions, women's oppression or patriarchal control, which informs our understanding of the social world. It is disingenuous to imply otherwise. No feminist study can be politically neutral, completely inductive or solely based in grounded theory. This is a contradiction in terms (1994 p. 23).

The way in which my sampling evolved and my use of different sampling strategies at different times is detailed below.

Having interviewed four nurses, it became clear that in order to better understand nurses' experiences I should interview some of the GP board members. I had not originally intended to do so, but in the event this proved a very fruitful exercise. As Mills comments, 'men and masculinity are frequently central to organizational analysis, yet they remain taken for granted, hidden, unexamined' (2002 p. 299).

I decided to contact GP board members from three of the LHGs within HA1 (see Appendix 2). These LHGs were selected because my observational activities meant I had greater involvement with them, for example attending sub-committees. I focused on GP Chairs of the LHGs as I felt they would be able to provide greater insight than 'ordinary' GP board members into organizational aspects of the LHGs. As Chairs, they would perhaps have more interest in the contribution of individual board members.

I subsequently decided to interview two GP board members who were not Chairs - one because she was the only female GP within my core group of LHGs and the other, because he was a member of an LHG sub-committee chaired by one of the nurses. I anticipated that this would give him some additional insight regarding the nursing contribution. My GP sample thus consisted of three GP Chairs and two GP board members. GP participants were white and aged between 40-60 years. I decided not to re-interview GPs in the second phase of the research. I felt I had sufficient data from my original interviews and that there was much to be gained from prioritising nurses' experiences in the second phase.

It also became clear that I should access the sub-committees which were being established by some LHGs. This was where several board members felt much of the

work and decision making took place. I decided to focus on the sub-committees of two LHGs in particular – I would not have had time to attend all the sub-committees of all the LHGs in my sample, even if I were granted access. The LHGs I chose (LHG 1 and LHG 3) were the ones with which I had had most contact and which were the most convenient geographically. During the first phase of fieldwork I attended 11 sub-committee meetings (see Appendix 1).

Emerging theoretical concerns also prompted me to approach one of the nurses to request observer status on a sub-committee of which she was Chair. As she was one of only two nurses in my sample who chaired committees, I was keen to explore her experiences. However, she was uncomfortable about my attending and declined my request on the basis that she felt the group was too new and that she hadn't had the chance to ask everyone on the committee if they were happy for me to attend.

3.4 Access

At the beginning of my fieldwork I discussed my research with a number of key informants. During this time I was working part time for one of the health authorities in Wales. My then manager acted as my 'sponsor' (Hammersely and Atkinson 1995 p. 64), suggesting useful contacts, offering to write letters of introduction for me and ensuring I was invited to relevant workshops and networking opportunities.

From these early contacts I was able to plan my fieldwork and get a better idea about how feasible it would be to observe meetings and interview LHG nurses. It also provided me with an opportunity to 'sound out' some of my ideas and thoughts regarding the research.

3.4.1. Gaining access to participants

In February 1999 my manager invited me to attend a series of 'Skills Development' workshops for LHG board nurses. This was my first contact with the nurses I was later to interview. I found the encounter difficult - I felt very much an outsider and

was uncomfortable about the fact that they didn't have any choice over my attending 'their' workshop.

I introduced myself and the research and explained that I was keen to talk to them about their experiences of being on the board of LHGs. Their response was friendly, but not as enthusiastic as I'd hoped (see Appendix 3). I was preoccupied with how I came across and how I presented the research. For example, I became nervous when my manager, who knew my interest in gender, made reference to this and the various conversations we'd had regarding the research. I felt obliged to divulge more information about myself and my research interests than I wished. At the time, I had wanted to remain 'bland' and non-threatening – I felt disclosure regarding my feminist politics jeopardised that (although there was nothing in the nurses' responses at the time to suggest this would be the case).

I had intended these workshops to provide an opportunity for me to 'blend in' gradually, getting to know the nurses and to negotiate participation and observation. However, at the end of the first session, the group were told that there had been some opposition to the skills workshops from other LHG board members. The general managers of two of the LHGs objected to nurse-only training sessions. They felt that as LHGs were a new enterprise for everyone, board members should be training together. Given the limited amount of time available to the nurses for training and professional development, the workshop organisers suggested that the remaining six workshops be cancelled. The nurses focused instead on multi-disciplinary training organised by the LHGs. At the time I was disappointed. Whilst this incident provided me with important data, I was forced to rethink my strategy for gaining access to LHG nurses.

Several weeks after this meeting I attended an all Wales LHG nurse forum. This provided me with another chance to negotiate access and to plan my fieldwork. With so many LHG board nurses all in one room, the opportunities for data collection and gaining access were overwhelming, as my fieldnotes at the time indicate:

I felt like a kid in a sweet shop – all these nurses – how was I going to make best use of this opportunity? On reflection I'm not sure I did, but I wanted to take it slowly – to feel my way in. I wonder how a more experienced researcher would have used the situation (March 1999).

I spent most of the time talking to the nurses from HA1 – hoping to develop my relationship with them and to earn their trust and confidence. I came away from the day feeling that I had succeeded in this respect, but frustrated that I had not secured any interviews. Looking back, I find it interesting that I didn't just ask them. Now I think that they were waiting to be asked. My main concern at the time was to avoid rejection and avoid imposing on people. I was mindful of their workload and how they were trying to come to terms with their new roles and responsibilities. Much of their talk was of how little time they had - I didn't want to be another burden. As Hammersley and Atkinson (1995) suggest, citing Wintrob (1969), these concerns and fears are not uncommon in ethnography:

I was afraid of everything at the beginning. It was just fear of imposing on people... you want to retreat for another day. I'd keep thinking: am I going to be rejected?... I'd put off getting started in telling people about wanting to give a questionnaire (Wintrob, cited in Hammersley and Atkinson 1995 p. 114).

Some six weeks had passed since I had first met with the HA1 LHG board nurses and I was becoming anxious to 'officially' start my fieldwork and secure some interviews. Although I had been 'in the field' for a while and collecting data from a number of sources, sitting down with nurses and talking to them on a one to one basis was the moment I felt it would all really begin.

Attending an RCN workshop looking at changes in primary care afforded me the opportunity to discuss the research with two other board nurses from HA2. Following this discussion both agreed to take part in the research (see Appendix 4).

Feeling more confident I decided to write to the HA1 nurses asking them for an interview (see Appendix 5). It was important to me that I gain permission from the nurses in the first instance - if they felt I needed to ask permission from their managers, then I would do so. In the event none of them did.

I decided to write to three of the GPs to ask if they would be willing to take part in the research (see Appendix 6). I followed this up with a phone call to check they were willing to participate and to arrange a date and time for interview. All three agreed to take part. Two other GPs I approached directly. We had sat next to each other at several sub-committee meetings, and I was by now a familiar face at these meetings, so I felt confident using this approach. I agreed to send them some information about the research and to contact them later to confirm arrangements. Both agreed to take part.

3.4.2 Accessing LHG meetings

Local Health Group board meetings were open to the public. However, several of the nurses suggested that I should attend the LHG sub-committee meetings and they confirmed my impression that the 'real' work of LHGs took place in private, on the sub-committees. Gaining access to these meetings was, on occasions, frustrating and time consuming.

In LHG1, I discussed the matter with the general manager with whom I had previously arranged an informal interview. He immediately agreed that I could attend some of the meetings and he contacted the various sub-committee Chairs to let them know.

At LHG3, I was advised by several board members to approach the Chair of the LHG to ask permission to attend the sub-committees. I spoke briefly to the Chair at the end of a board meeting and followed this up with a letter requesting observer status at the five sub-committee meetings. Weeks passed and I heard nothing. I made numerous attempts to contact him and eventually succeeded. He said he was happy for me to attend these meetings but that I should check this out with the sub-committee Chairs first. I then wrote to them, introducing myself and the research (see Appendix 7) and explained why I wanted to attend the meetings. One disagreed, the reason given being the newness of the group and the need for group members to 'bed-down' before being 'observed'.

By the time I had been given permission to attend those of LHG3, all but one of the regular sub-committee meetings had been cancelled, pending a review of the sub-committee structure. In the event I observed four sub-committee meetings at LHG3 and seven at LHG1. The whole process of negotiating access to the sub-committees had taken about three months. The delay was made worse by the fact that it was summer, so several key people were away. On reflection, I should have begun negotiating access earlier – my reluctance to do so was in part attributable to my lack of confidence and the difficulties I had in asking permission to observe meetings. I found myself putting off making important phone calls until the pressure to do so was too great.

This is an important point. In my case, the opportunities for fieldwork were determined, amongst other things, by how I felt about the research and being a researcher. The 'thick skin and a certain imperviousness to rejection' that Cassell (1988) advocates, was for the most part beyond me (cited in Hornsby-Smith 1993 p. 54).

3.4.3 Gaining ethical approval and consent

Throughout the research I was guided by the ethical standards outlined by the British Sociological Association (BSA) (2003). Prior to interviewing LHG board nurses and GPs, I obtained ethical approval from the two Health Authorities concerned. In one case it was a straightforward matter of submitting a detailed application form; in the other, I was required to attend an ethics committee meeting to present my research. All those I interviewed were sent an outline of the research (see Appendices 5-7) and asked to sign a consent form (see Appendix 11) prior to being interviewed. As part of my interview preamble, I highlighted the terms of confidentiality and anonymity. When I returned the interview transcripts for comment, I reiterated the conditions of confidentiality and anonymity and asked participants to delete any comments they felt would identify them.

Later in the chapter (section 3.6) I return to the question of ethics to discuss some of the ethical issues I found particularly challenging. The next section details my methods of data collection.

3.5 Methods of data collection

The methods of data collection related to my research questions. As indicated earlier, I wanted to use methods that provided me with access to detailed information regarding the experiences of nurses on LHG boards. My fieldwork consisted of in-depth interviews, observation and analysis of LHG and other relevant documentation.

3.5.1 Interviewing as a method

My principal method of data collection was the use of in-depth, guided interviews (Fielding 1993). I decided to use in-depth interviewing for a number of reasons. It allowed me to explore in detail the range and nature of interviewee's experiences. The flexibility afforded by this approach was particularly relevant given that I was researching a new organization of services. I wanted the scope to pursue certain issues as and when they arose and I wanted to hear how respondents themselves made sense of their experiences. This involved a degree of intellectual 'to-ing' and 'fro-ing' during the course of the interview, which would have been hard to accommodate within a more rigid format, such as a structured interview. As Fielding (1993) notes, in-depth interviews:

> ...allow the interviewer to phrase the questions as they wish, ask them in any order that seems sensible at the time and even join in the conversation by discussing what they think of the topic themselves (p. 136).

This last point seemed especially significant given that I had wanted the interview to be an exchange of ideas and experiences in an attempt for us both to make sense of some of the issues under discussion.

I also chose this method of data collection because it was one with which I was most comfortable - not only in terms of my previous research experience, but also because in-depth interviewing enabled me to address an important feature of feminist research - that of political action - in a way that felt 'right' for me. Oakley (1981) encapsulates this approach to action when she states that, 'the primary orientation of feminist interviewers is towards the validation of women's subjective experiences as

women and as people' (p. 30). Certainly this was central to my approach to interviewing and I welcomed the opportunity to listen and respond encouragingly and positively to women's accounts of their experiences, a point I return to below.

In-depth interviews have been used widely by feminists. At a time when women's lives and experiences were relatively invisible within social research and theory, feminists were arguing for a more sensitive approach to research, which would allow for an open-ended exploration of women's own views and experiences (Maynard 1994). For many feminists, this involved a rejection of research methods such as surveys and overly structured interviews, which relied on predetermined questions and criteria to explain everyday lives and experience.

Feminists have also questioned traditional social science approaches to the interview relationship. Such approaches encourage distance and separation between researcher and participant in an attempt to obtain reliable and objective data. Feminists however, have argued for non-exploitative and reciprocal research practices, which undermine the hierarchical power relations within the interview relationship (see Oakley 1981). The application of these practices has largely been associated with the use of in-depth interviews.

Whilst in-depth interviews remain a common feature of feminist work, many feminists have begun to challenge the unquestioning use of this approach (see for example Finch 1984, Stacey 1988, Acker et al.1991 and Fonow and Cook 1991). These authors have called for a more critical stance on the use of interviews, highlighting the limitations as well as the opportunities inherent in such methods. For example, Kelly et al. (1994) suggest that the idea that face to face in-depth interviews provide the means by which reciprocity and a non-exploitative research relationship can develop, is flawed, and relies on a number of presuppositions, namely:

> That women want to share their experiences with another woman; that this is always of personal benefit; that the sharing of gender will enable any difficult or painful accounts to be dealt with sympathetically and effectively (p. 35).

With these points in mind, the question remains as to whether those I interviewed necessarily experienced the interview as the therapeutic encounter I envisaged. I shall be discussing this issue in more detail later in the chapter, in particular, in the sections on Ethics and Analysis and Interpretation.

The other important point to address in this context is the development of my research to include interviews with men – four male GPs and one male nurse. How did my decision to interview men 'fit' with the focus on women and women's experiences evident in much feminist research?

Highlighting their work on domestic violence and child abuse, Kelly *et al.* (1994) reject the suggestion that feminist research should only be *on* and *with* women. This was the position I too adopted. Whilst my focus remained primarily on female nurses' experiences, it became clear that in order to better understand these experiences and the way in which gender power relations operate, I needed to talk to GP board members, most of whom were men. The data I gained from these interviews provided a valuable insight into how GPs, from a position of relative power and status, made sense of their own (as well as nurses') experiences as board members. Kelly *et al.* (1994 p. 33) comment:

> If our concern is to understand women's oppression we need to target our intention on the ways it is structured and reproduced... Studying women's lives as a feminist means that male dominance, masculinity and men are always part of the research.

Returning to Oakley's (1981) point regarding the validation of women's subjective experiences in feminist research, the question arose as to whether and how I would validate men's subjective experiences. Would I listen and respond encouragingly and positively to men? In one sense I did, and came to see this as part of my attempts to establish rapport and trust with the participants. But on a personal and emotional level, I related differently to GPs. Historically, it wasn't their voices that have been silenced, although it was clear that they felt frustrated and dis-empowered by recent organizational developments in primary care. For example, I was less concerned when they complained about what they saw as the erosion of their power and control with the advent of LHGs.

I was keen to get them to reflect on their own (and as I saw it privileged) positions in relation to other board members and the way the board operated in general. For example, I asked them to comment on the way in which GPs were seen to dominate meetings, both in terms of 'air space' and in terms of the topics under discussion. I asked them to reflect on the obstacles and difficulties nurses were facing and what factors they felt might inhibit the nursing contribution. Their responses were illuminating and helped me to develop my understanding of medical power.

Increasingly within feminism there is a move away from rigid interpretations of what feminist research should look like. It is recognised that other research methods, including quantative methods, can be equally usefully applied as part of the feminist research endeavour. As Kelly *et al.* (1994 p. 35) suggest, 'rather than assert the primacy of any method, we are now working with a flexible position: our choice of method(s) depends on the topic and scale of the study in question'.

3.5.2 The Interviews

It was important for me to obtain an accurate verbatim account of the interviews so, with the participants' permission, I tape recorded all 29 interviews. On one occasion my tape recorder broke down, so I made notes instead. I made it clear that participants could turn the machine off whenever they wanted to, although no one did. The interviews lasted between one and two hours and in the first phase of fieldwork, interviews (13) were held over a period of six months. During this period I was also observing LHG board meetings (21), LHG sub-committee meetings (11), participating in relevant events such as the all Wales LHG Nurse Forums (6), and conducting informal interviews (not recorded) with key informants (10) (see Appendix 1). Interviews (11) in the second phase took place over five months.

Arranging dates for interviews proved difficult at times. Both nurses and GPs were very busy and on more than one occasion, interviews were cancelled with a delay of several weeks. For the most part interviews were held in quiet rooms at participants' work place.

I decided to transcribe all the taped interviews myself. Doing so helped me to become familiar with the data and I was able to begin to develop analytic themes (Fielding 1993). Within the interview transcripts I noted body language, laughter, pauses, points of emphasis, moments where participants struggled to express themselves and times where I felt I had led too much. These analytical and interpretative strategies were all significant in helping me make sense of the data, and to arrive at certain theoretical conclusions (see section 3.9 Analysis and Interpretation). I made notes in the margin of the transcripts and these were used to modify my topic guide for subsequent interviews.

Having transcribed the interviews verbatim I returned them to the participants for their comments and feedback. Of the 23 interviewees three nurses and two GPs commented. These comments were to confirm they were happy with the transcript and on three occasions, to clarify some of their responses. Transcribing the interviews myself from both the first and second phases of fieldwork was undoubtedly time consuming and at times tedious. I knew it would take a long time, but I was surprised by just how long.

3.5.3 The Topic guide

I began developing my interview topic guide by writing down thoughts and queries that related to my central research questions. These thoughts were informed by my review of the relevant literature, from my own experiences and from my early contacts with various key informants. Each point was written on a separate piece of paper and then amalgamated and rationalised into themes (Fielding 1993). These formed the basis of my initial topic guide (see Appendix 8). I also included probes under each question, which I could use depending on the responses of the interviewee. Questions fell into approximately six areas. These were:
- Background and reflections on the journey
- Working as a group
- Decision making
- The nursing contribution
- Gender
- Training and support

During the course of the fieldwork, my original topic guide underwent several revisions in response to emerging themes from previous interviews, my fieldnotes and my review of the literature.

Despite my attempts to identify relevant questions, there were times when I felt the interview hadn't gone well, and I was disappointed with the quality of data. On several occasions I felt I struggled to maintain control of the interview. Whilst I wanted to be flexible regarding the subjects covered, at the same time I did want to discuss the key issues in my topic guide. However, I sometimes found it difficult to respond quickly enough with the 'right' question or probe when interviewees raised unexpected issues or thoughts.

In part I think my uncertainty regarding my questions related to the fact that I was learning about LHGs at the same time as the nurses themselves. As such, I felt I wasn't as knowledgeable about some of the issues as I needed to be. This was particularly the case with regard to the potential of the nursing contribution and what it should, or could look like. Little had been written at the time which specifically addressed the nursing contribution to LHGs (or PCGs). Whilst there was a great deal of rhetoric in broad terms regarding the potential of the nursing input, few people, including the nurses themselves appeared to understand what this would mean in practice.

I wondered how this 'knowledge gap' would affect the quality of my data - if I didn't know, how could I ask the right questions? Whilst nurses appeared to be struggling to get to grips with their strategic role as board members, I was similarly struggling to understand what this new role would mean for them. My lack of strategic and management experience became relevant. As I commented at the time in my fieldwork journal, 'their lack of experience is my lack of experience'. I sought to address this issue in my discussions with a number of people, notably senior nurse managers - seeking clarification and understanding as to how they envisaged the nursing contribution.

3.5.4 Participant observation

Participant observation is a key feature of ethnographic research. As a method of data collection, it involves the researcher observing and participating in the lives of those they wish to study. The researcher participates, 'watching what happens, listening to what is said, asking questions' (Hammersley and Atkinson 1995 p. 1). In doing so, the researcher is able to gain some insight into the way in which beliefs, values and rules are constructed and negotiated as part of participants' everyday social lives. This approach fitted well with my wish to explore nurses' experiences as LHG board members in the context of the organizational culture in which they worked.

My observational fieldwork also informed my interview topic guide and allowed me to explore discrepancies between what nurses and GPs said at interview and what I observed (Mays and Pope 1995).

Drawing on the work of Gold (1958), several authors highlight the different observational roles that are adopted by researchers. These range from complete participant, to complete observer (Mays and Pope 1995, Burgess 1984). In practice however, the distinctions are more blurred and as Burgess (1984) and Bogdewic (1992) argue, fieldwork invariably involves the use of different observational roles at different times throughout a project.

Since I was unable to participate fully in the nurses' LHG lives, I more often assumed the role of 'complete observer'. This was certainly the case when I attended LHG board meetings and LHG sub-committees. Indeed, in order to gain permission to attend sub-committees, I was asked to formally request 'observer status'. I was able to participate more when I went to LHG Nurse Forums and networking events. In these situations I was able to question and to share experiences and understandings of LHG life with other nurses.

Not participating as fully as I wished meant that on occasions, I struggled to understand the rationale for certain debates, or to grasp the implications of decisions made at board or sub-committee meetings, as my fieldnotes at the time indicate:

I feel such a void in my understanding and I barely know how to ask the questions that might give me the answers (July 1999).

Whilst I made every effort to clarify these issues with key informants, with interviewees and by recourse to documentation and literature, for the most part I felt like an outsider - never belonging, never quite understanding, always one step removed from the 'real' experience.

Although mindful that a degree of 'detachment' in fieldwork can be useful in avoiding the dangers of 'going native' (Fielding 1993 p. 158), my feeling of alienation felt without reward. As Lofland and Lofland (1984) suggest in their discussion on the emotional stresses of participant observation,

> Marginality tends to be experienced as a chronic sense of loneliness, anxiety and perhaps even alienation ...there can be a continual and often subtle sense of separation between the observer and the observed that is painful and poignant (p. 35).

The following extract from my fieldnotes illustrates this point:

> I arrived 10 minutes early to the board meeting. I could see them eating their sandwiches and chatting in the boardroom. I hate this feeling of never belonging, people never knowing who I am, always being a bit of a mystery. I think if I had my time again I would have devised a research plan which took account of these things and allowed me to belong more somewhere, somehow (September1999).

My position as outsider sometimes fractured when I interviewed nurses or chatted with them before or after a meeting. There were moments when I felt my identity as a nurse and a woman enabled us to share feelings, experiences, and understandings of what it meant to be a nurse on an LHG board.

3.5.5 Overt and covert approaches to research

For the most part I was open about my role and the purpose of the research, though as Fielding (1993) notes, the boundaries between overt and covert approaches are blurred:

> ...the most faithfully negotiated overt approach inescapably contains some covertness, in that, short of wearing a sign, ethnographers cannot signal when they are or are not collecting data (p. 159).

I was more cautious in highlighting my concern with gender. During discussions I preferred to let the topic emerge and when it did so, I would then declare my interest. This felt appropriate because I wanted some indication of how 'present' and how significant nurses perceived gender to be as part of their organizational experience. If it hadn't arisen toward the end of the interview, I would then introduce the topic.

The extent to which I was open regarding the research was also dependant on the actions of others. For example, when observing private meetings, I was reliant on key individuals introducing me to other LHG members. Sometimes these introductions were inadequate and sometimes they were non-existent and at such times I certainly felt that my approach was more covert. This raised ethical issues for me regarding participant consent.

At one particular sub-committee meeting of LHG1, the Chair introduced me and asked the other members if they were happy for me to observe the meeting. I felt it was hard for people to object in such circumstances, although I could see some members looking a bit puzzled, perhaps wondering who exactly I was and what I was doing there. At such times I contemplated stepping in and explaining more about the research, but was reluctant to do so. I didn't want to undermine the Chair, I didn't want to take up any more of the meeting and I wanted to blend in and be as inconspicuous as I could. In situations like this I would make an effort to explain more about the research to those who were interested once the meeting was over.

At another meeting (LHG3), I had arrived early with one of the nurse participants who introduced me to the Chair of the sub-committee. I had previously written to him to request observer status at the meeting, but had not met him before. He commented that he had seen me at the board meetings 'taking notes' and assumed I was with the press. I reminded him that I was doing some research and he asked – jokingly - 'are you sure?' Despite the fact that I had never met four other members of the group, I was not introduced when the meeting began. My assumption was that I would be introduced as I had been at other LHG meetings. On reflection, I shouldn't have made this assumption, but rather addressed this issue with the Chair prior to the meeting starting.

One of the more difficult encounters in my fieldwork concerned my relationship with Linda, a nurse participant in my research. As well as being an LHG board member, Linda was doing similar research to me as part of a Diploma in Management Studies. Her study involved an exploration of the experiences of nurses on PCG boards and the first time we met, we talked in detail about our respective studies.

I met her for the second time as part of an all Wales LHG Nurse Forum meeting. The following fieldnote is an extract from our discussion over lunch.

> I mentioned to Linda that I was looking forward to coming to some of the meetings once they were open to the public. Linda said she was nervous of me coming: 'knowing what the research is about... I probably won't say anything if you are there; can't you come to ours (LHG board meeting) last?'
>
> I was a bit surprised by this. My instant response was to reassure her, but I knew this would be hard. She knew too much (about my research) and I couldn't pretend that I wouldn't be observing her. I said I would be observing the whole meeting and that in my experience, after a while people tended to get used to having someone observing them. This seemed to reassure her a bit. I reflected on whether I should have been as open about the focus of my research as I was last time. I don't want my presence to have that much of an impact – am I being naïve to think it would be otherwise? (March 1999).

There were several more instances when Linda expressed concern regarding my role and her involvement in the research. On each occasion I tried to address her concerns and reassure her as much as I could. As the British Sociological Association (BSA) ethical guidelines note, 'obtaining consent is not a once and for all prior event, but a process, subject to renegotiation over time' (2003 p. 3).

Some six months after the above exchange, I was accompanying Linda to one of LHG3's sub-committee meetings, of which she was member. The following is an extract from my fieldnotes that day:

> Linda sounded a bit fed up that I was coming: 'one of these days I'll go to a meeting when I'm not observed by either you or me boss!' I tried to reassure her and she said she understood, but this continues to be an issue for her and it makes me uncomfortable and reluctant to ask her to participate. I decided to ask her next time if *she* felt there was anything I could say or do to reassure her. At the end of the meeting, she was asking me about the research and gender and asked me what approach I was taking and in particular what I was looking at. She commented 'I don't suppose you'll tell me'. I tried to be as honest and clear about the research as I could (September 1999).

Linda's discomfort about being observed raised various ethical issues for me. As indicated, feminist researchers have traditionally sought to challenge the potentially exploitative nature of the researcher/researched relationship and I was keen to do likewise. However, whilst I checked with Linda that she agreed to me observing the sub-committee meetings which she attended (I did so prior to requesting formal observer status from the Chair), I was nevertheless sure that she would have preferred me not to attend. Despite this, I was unwilling to sacrifice my fieldwork opportunities to alleviate her discomfort. I never fully resolved this tension, but settled on the view that whilst I would do my utmost to address participants' concerns, there was a limit to how much responsibility I could take for participants' feelings and attitudes about their role in the research.

3.5.6 Fieldnotes

Throughout the period of observation I made detailed fieldnotes. As numerous authors have suggested, taking fieldnotes is a key feature of ethnographic research (Lofland and Lofland 1984). The purpose of these notes is to document as accurately as possible, events, situations and people's conversations and behaviour. These notes form the basis of eventual analysis and interpretation.

I kept a fieldwork journal which I took to meetings and whenever I was engaged in fieldwork. I used this to jot down my observations and thoughts at the time. I tried to do this at inconspicuous moments, but as indicated in my earlier discussion on participant observation, it became clear that some people were aware of my note taking.

As is common practice, I took brief notes during periods of observation, which I would later work up into full fieldnotes (Lofland and Lofland 1984, Fielding 1993). I made every attempt to do this the same day, but there were a few times when it was several days before I was able to do so. In these circumstances I would make more elaborate jottings on the day, and when it came to writing up the fieldnotes I would document the time delay and what effect I thought this might have had on the accuracy of the notes.

In writing up my fieldnotes, I would type my observations down the left hand side of the page. These observations were 'at the lowest level of inference' (Lofland and Lofland 1985 p. 65). I would then leave a margin on the right side of the page which was dedicated to my methodological and analytic reflections and thoughts (Bogdewic 1992). These included questions, emerging themes and theoretical links to literature or previous observations. My fieldnotes of meetings also contained a 'map' to indicate where people were sitting (Lofland and Lofland 1984). I would conclude my fieldnotes with an overall impression of the meeting, how I felt things had gone, and any negative or positive experiences.

I also used the journal to document my emotions and thoughts during the research. As Bogdewic (1992) suggests, accounts such as these 'track the intellectual and emotional journey of the researcher' (p. 64). My personal and emotional reflections regarding the research were not kept separate from the more descriptive accounts of my fieldwork. The two seemed inextricably linked. It was important for me to identify how my feelings at the time may have impacted on data collection and how I chose to record and emphasise certain things and not others.

The next section of this chapter addresses a number of ethical issues raised in relation to this study.

3.6   Ethics

Some of the ethical dilemmas I faced regarding informed consent and participant exploitation have already been noted in the previous section. In this discussion I shall focus primarily on the ethical issues I found most challenging, namely the feminist concern with political and social action as part of the research process, and the more universal issue of the politics of representation.

3.6.1 Making a difference?

As previously noted, an important aspect of feminist research has been the focus on political action and the desire to bring about change in women's lives (Maynard 1994). One of my principal ethical concerns was how, as part of the research, I could

bring about change for the benefit of the LHG board nurses, either individually or collectively.

Some researchers argue against research that is directed towards political goals. For example, Hammersley and Atkinson (1995) suggest that such goals, 'would increase the chances of the findings being distorted by ideas about how the world ought to be and by what it would be politic for others to believe' (p. 20). This argument overlooks the fact that all researchers come to their work with certain political and ideological values and beliefs that inevitably influence their research. As Ramazanoglu (1992) suggests in response to Hammersley's (1992) critique of feminist methodology:

> All researchers should be explicit about the politics of their research as it is more logical to accept our subjectivity, our emotions and our socially grounded positions that to assume that some of us can rise above them (p. 211).

Feminist research is no different from other research in that certain 'truths' are posited which may deny and obscure others. The principle concerns are to be as open and honest about how one has come to certain methodological or interpretive decisions, and to locate the researcher within the research account. As indicated in the subsequent discussion on data analysis and interpretation, such reflexivity has been a key feature of feminist research practice (Stanley and Wise 1990, Williams 1993).

Feminists have sought to bring about change in a number of ways, for example by generating knowledge that may contribute to the transformation of women's oppression, or as part of the research process itself through empowering research participants (see for example Opie 1992). I envisaged the interview relationships and fieldwork encounters with participants as an opportunity to value women's experiences, to share my own insights and experiences where appropriate, and to support the nurses in whatever way I could. Doing so was an important part of my attempt to bring about change, limited though it may have been.

A number of feminists argue that the potential of certain research practices to bring about change in women's lives is limited (see for example, Kelly *et al.* 1994 and

Glucksmann 1994). In her discussion of friendship, vulnerability and power in the interview relationship, Cotterill (1992) argues that attempts to empower women as part of the research process, although compelling, are perhaps unrealistic, patronising and inappropriate. Here she discusses her own research experiences:

> It is highly unlikely that the women in my study wanted me to do anything and would have been offended by any assumption on my part that I could.... Apart from a sympathetic ear I had very little to offer. I do not believe that the researcher has any role as a counsellor even if I possessed such skills and I was certainly in no position to give advice (p. 598).

Others share these concerns and argue that attempts to raise people's consciousness as part of the research process are questionable - doing so may not necessarily be to the benefit of all respondents, in all circumstances (Murphy and Dingwall 2001). Glucksmann (1994) also criticises the way in which feminists have focused on the research process itself, in particular the participant/researcher relationship, 'as if it were a form of political practice' and, as a consequence, are 'in danger of attempting to establish an egalitarianism in the research situation as a substitute for establishing it in the 'real world'' (p. 151). Feminists, she suggests, should identify the limitations of their research as a site of political activity.

Mindful of these issues, I sought ways in which I might bring benefits to those women I interviewed.

Kelly *et al.* (1994) suggest that one way of empowering women as part of the research process is through developing 'challenging methods' (p. 38). This involves questioning 'oppressive attitudes and behaviour' as part of the research process (p. 38). For example, through the use of open and general questions, participants are encouraged to reflect on and question their beliefs and values. Taking this a stage further, the authors suggest researchers explicitly 'raise/offer different ways of understanding experience' (p. 39). This practice has been particularly important in their research on domestic violence and child abuse.

The way in which I sought to empower participants and facilitate change, most resembles that advocated by Kelly *et al.* (1994). But it also relates to Opie's account of how she felt able to empower her research participants:

> Because the interviews were responsive to individual preoccupations there was an in-built therapeutic dimension to the process which I would also characterise as empowering. Some participants were able to reflect on and re-evaluate their experience as part of the process of being interviewed (1992 p. 64).

The following edited extract is from an interview with Sarah, one of the first nurses I interviewed. I have also included my analytic reflections at the time of transcription. The extract highlights my attempts to support Sarah in re-framing her experiences. It also raises questions about the benefits of my efforts.

Sarah had been talking about her routine on arrival for the monthly LHG board meeting. This involved making cups of coffee for other board members and handing out sandwiches:

> S: I am just thinking about all the daft things I do you know, like taking the 'clingfilm' off the sandwiches but then again Dr Wilson will give me the plate (A: he'll give you the plate?) to do this and I didn't think – it's only now that I've suddenly thought 'what am I doing!' (laughter) so I won't do that – I'll give him the plate at the next meeting ... But again it's this two fold thing, I know I shouldn't do it but I'm comfortable doing it, so I've got to stop that and find something else to be comfortable with.
>
> A: Or actually maybe just understanding why you may be doing it (S: yes) and thinking well it's okay for me not to do it, *it really* is okay. (S: yeah, that's it)
>
> S: Well, even this has helped, do you know what I mean? It has enabled me to see what I've done because I didn't think about it before until this interview, you know, that I've got to stop being this submissive female.
>
> A: And also not being too hard on yourself as well for doing that, because you know, I'm sure I would be just the same. I would be tempted to do that (S: yes)
>
> S: We've got a meeting on Thursday so I'm going to try it. (laughter)
>
> **Reflection**: Why didn't I pursue the issue of comfort more – this is exactly what I hoped to explore. I think because I was so focused on making her feel better and supporting her/taking action. I didn't stop to think about what she was saying in terms of my thesis. On reflection I think it would have been difficult to do both – i.e. explore and support at that moment. Supporting felt the right thing to do then.

This extract raises several issues. I was keen to validate Sarah's experiences but also to challenge her interpretation of events and to share my own thoughts and feelings regarding her situation. I was clearly directing her to a different course of action - one that as a feminist, *I* felt was more appropriate. The question is whether this was the right approach for Sarah. Whilst Sarah admits she doesn't want to be a 'submissive female', at the same time, she also finds aspects of this role comforting.

As my reflective note indicates, my research role shifted to one of advice giver. Contrary to Cotterill's (1992) feelings on the subject, at the time it felt the right thing for me to do, even though I was so focused on trying to reassure her, that I missed the opportunity to explore in more depth her need for 'comfort' and how I/we could make sense of this from a feminist perspective.

I wondered whether I was right to encourage Sarah to question her behaviour, despite feeling that I could offer little support to her afterwards. As Maynard (1994) points out, it is not always possible for respondents to act on the results of consciousness raising, a situation which might add to a feeling of disempowerment. I did offer a sympathetic ear if she ever felt the need and I sent her some information on assertiveness – an issue she felt she needed to address. I also agreed to raise the need for assertiveness training for board members with the relevant personnel at the Health Authority.

There were other times in the research project where I helped participants in similar ways, sending them articles or information. As the fieldwork progressed I felt that professional and personal development were becoming key issues for the nurses. With their agreement, I organised a one-day workshop to address some of these issues, and this was well received. What remains to be done is to ascertain how, if at all, participants feel they have benefited from taking part in the research - a task Kelly *et al.* (1994) argue is a neglected aspect of feminist research. Other than moments such as those outlined above in the interview with Sarah and the opportunity the interviews afforded nurses to talk about what was obviously a significant and challenging time in their work lives, I am doubtful of the benefit.

3.6.2 The Politics of Representation

> *'I made them 'speak' for me without even letting them know in advance what they would be saying'* (Aldridge 1991 p. 32).

The above quote, in which Aldridge reflects on the power differentials between researcher and participant, relates to one of the other main ethical issues I faced – that of the politics of representation. The way in which women's experiences are represented has been a particular concern of feminists who have argued against the subordination of women's voices and ways of understanding within research practice. For example, I was uncertain as to how to respond when my interpretation and representation of participants' accounts and experiences contradicted and challenged their own. Stanley (1984) describes this as the 'conundrum of how not to undercut, discredit or write-off women's consciousness different from our own' (p. 201).

I addressed this issue in various ways. I have attempted to critically reflect on my research role, 'to make myself visible in the text' (Murphy and Dingwall 2001 p. 345) and to leave a 'clear decision trail' (Sandelowski 1986 p. 34) regarding my methodological, analytic and interpretative decisions. As far as possible, in making sense of their experiences, I have used participants' own words and provided verbatim accounts of interview transcripts.

Another way of addressing this issue is for researchers to share their own analytic and interpretive thoughts with the participants, and to negotiate the various meanings with them (see for example Acker *et al.* 1983, Addison 1992 and Skeggs 1994). I sought to do this as part of the interview process itself. The following extract comes from an interview with one of the nurses during the first phase of fieldwork. We had been discussing decision making processes within the LHG board, and I commented that nurses appeared uncertain as to how decisions were made and uncertain as to their own authority within this process:

A: … so when you were saying 'I wonder when we will get to discuss the really serious complex issues within the borough', it sounds as if somebody else out there has got the answers and is in the driving seat

Becky: Well, I do feel like that at times, which is why I've taken to raising issues because it does feel like that at times, *but I don't think it feels like that only for nurses*, I feel sometimes even our medical colleagues feel like that, that it's being driven from elsewhere, so I don't think that's peculiar to nurses (my emphasis).

This challenge was key to my thinking at the time and forced a re-conceptualisation of some of the issues, including my decision to interview GPs as well as nurses. Discussions with nurses in the second phase of fieldwork again offered more opportunities for them to challenge and inform my interpretations of the data from the first phase.

I also gave participants an opportunity to comment on and reflect on their interview transcripts, but I did not share my conclusions with participants, or involve them, other than during the interview itself, in the process of interpretation. My reluctance in doing so related in part to my concern regarding their possible reaction. Acker *et al.* (1991 p.142) comment:

> Whether or not to confront groups or individuals with interpretations of their lives which are radically different from their own is an ethical question faced by anyone attempting critical social research. This is particularly true when the researcher's interpretation is not only different but potentially threatening and disruptive to the subject's view of the world.

This felt particularly relevant to me. A number of the nurses I interviewed were resistant to some of those questions and reflections, which suggested an alternative (feminist) interpretation. I was also uncertain as to how I would be able to negotiate the various meanings. Would my feminist interpretation be put at risk? Who ultimately had the last say? As Acker *et al.* (1991) suggest of their research, sharing the interpretative task was easier with participants who 'shared our world view; a common frame of reference provided the grounds from which a dialogue could proceed' (p.142).

As the research progressed I became more reconciled to these dilemmas and to feel more secure in my role as researcher and the one 'with the power to define' (Acker *et al.* 1991 p.142). Ultimately though this issue remained unresolved. I felt that it would

undoubtedly enrich my data and allow for the voices of those I interviewed to come to the fore, were I able to discuss my thoughts in more detail with the participants, but doing so felt beyond my confidence and experience. And as I think I began to realise, it is necessary to 'recognise the impossibility of creating a research process in which the contradiction in power and consciousness are eliminated' (Mauthner and Doucet 1998 p. 139).

Perhaps too it is a mistake to assume participants necessarily want to be involved in the analytic process (Mauthner and Doucet 1998), and that they necessarily object to researchers making sense of their experience in ways they might not completely agree with or understand. To assume we violate participants' reality in this way and to insist this results in their objectification, undermines participants' subjectivity. We need to ask participants how they feel about this, and perhaps explain the way in which, as researchers, we may interpret their experience. As Chase (1996) argues:

> The ethical problem raised by our interpretations is less that we usurp participants rights to self-definition than that in negotiating access, we fail to alert participants to the ways in which we will re-frame their versions (cited in Murphy and Dingwall 2001 p. 346).

Respondent validation as a strategy for ensuring research validity (as opposed to its ethical dimensions) is discussed in section 3.8 below. The next section of this chapter details the way in which I have analysed and interpreted nurses' experiences of life on LHG boards.

3.7 Analysis and Interpretation

Being explicit about analytic and interpretive processes is an important part of reflexive research practice. As Maynard (1994) suggests with regard to achieving rigorous feminist research:

> At the very least this rigour involves being clear about one's theoretical assumptions, the nature of the research process, the criteria against which 'good' knowledge can be judged and the strategies used for interpretation and analysis (p. 25).

I shall begin by briefly outlining some of the epistemological debates within feminism and in ethnography more generally, before discussing the theoretical assumptions that have informed the analysis and interpretation of my data. Having explored these issues, I will then outline the way in which I have undertaken the initial stages of data analysis and interpretation.

Data analysis and interpretation are not necessarily distinct stages. I have taken analysis to refer to the process whereby data is coded and categorised and interpretation as the sense making processes – the way in which I have come to certain conclusions. Inevitably the two are intimately connected, and to some extent occur simultaneously (Brewer 2000).

3.7.1 Epistemology

The question of what we can claim to know, and how we know it, is one which all researchers face. Epistemological questions such as these have been central to the feminist critique of what is seen as masculinist social science. Feminists have argued that it has been men's lives, and men's perspectives and views of the world that have shaped much of social science. Women's lives and experiences have been rendered invisible:

> Being excluded, as women have been, from the making of ideology, of knowledge and of culture means that our experience, our interests, our ways of knowing the world have not been represented in the organisation of our ruling nor in the systematically developed knowledge that has entered into it (Smith 1987 p.17).

Smith argues that knowledge produced in this way is treated as universal, 'unrelated to a particular sex as its source or standpoint' (p. 20) when in fact it is partial and sexed, reflecting as it does the understandings and views of men. It is precisely this partiality and purported value neutrality that feminists (and others) have challenged within social science.

The challenge from feminists is not simply about 'adding on' women's voices and experiences. Feminists such as Stanley and Wise (1993) encouraged others to question the framework - the underlying theoretical assumptions of 'normal' science

and in particular the privileged status of objectivity and rationality, commonly associated with the philosophical tradition of positivism.

Feminists have argued that objectivity as a criterion of generalizable knowledge is predicated on the denial and subordination of subjectivity (Smith 1987, Stanley and Wise 1993). Subjectivity is important to acknowledge, for women's personal experiences have relevance and meaning beyond the individual – they say something about the wider social world. Objectivity and subjectivity are not simple opposites, but intimately connected. The feminist claim that the 'personal is political' captures this relationship. It is precisely the personal experiences of women that have challenged the objective truth claims of masculinist science. As Holland and Ramazanoglu (1994) comment:

> Women's accounts of what their lives are like have forced reconceptualizations of social relationships and the nature of power; experience challenges the validity of 'objective' masculinist knowledge (p. 129).

Furthermore, some feminists claim it is the proximity and closeness of the researcher to the researched, rather than the 'distancing' required for 'objectivity' that allows for understanding and knowledge to develop in the research relationship (Mauthner and Doucet 1998). Rather than being seen as a source of bias, the closeness of the research relationship can help to establish trust and in so doing, help to generate meaningful data (Maynard and Purvis 1994).

The closeness I sometimes experienced with the research participants was one I valued. Invariably, I found articulating and making sense of nurses' organizational experiences involved an exchange of ideas, experiences and feelings. My own experiences as a nurse and a woman and my ability to identify with the women I interviewed has been a crucial part of the whole research process, although as Reay (1996) suggests, this can be problematic. Commenting on what she sees as her centrality to her own research, Reay argues that such a position, unproblematised, 'is no less a position of limited vision than standing in the wings' (1996 p. 65) – a point I shall return to.

The other critique of objectivity relates to the claim that knowledge devoid of researcher bias can and should be produced. This assumption denies the influence of the researcher's own beliefs and values and the way in which these fundamentally influence the research process. As part of their critique of masculinist social science, feminists have argued that production of knowledge must include an account of the researcher's own positioning in the research, their relation to the participants, and an account of the research process. The difficulties, confusions and the possible silences, as well as the theoretical and personal beliefs and experiences that underpin the research should be acknowledged. As Stanley and Wise (1993) comment:

> We suggest that the researcher's own experiences are an integral part of the research and should therefore be described as such... For feminists these experiences must not be separated-off from our discussions of research outcomes. To the extent that we do this we merely repeat the traditional male mystifications of 'research' and 'science' and by doing so we downgrade the personal and the everyday' (p. 60).

Such reflective practice is an important feature of feminist research and throughout the thesis I have sought to make explicit my beliefs and experiences and to reflect on the way in which they have informed the research. There are limits to how reflexive it is possible to be; as Holland and Ramazanoglu (1994) suggest, knowledge of self is not always easy for, 'we cannot break out of the social constraints on our ways of knowing simply by wanting to' (p. 133). The important point is to open up the research account in such a way that allows for scrutiny and judgment. Reflexivity can make an important contribution to validating and legitimising our truth claims (Brewer 2000).

3.7.2 The meaning of experience

I want to now return briefly to the issue of experience. The importance of taking seriously women's experience is central to feminist epistemology. However, the role and place of experience in producing feminist knowledge is less straightforward. Feminists have argued against oppressive research practices, which diminish and marginalize women's voices and their understandings, yet as several authors point out, this poses a dilemma in relation to interpreting experience:

As researchers we must not impose our definitions of reality on those researched...
but this aim poses an ongoing contradiction; ultimately the researcher must objectify
the experience of the researched, must translate that experience into more abstract
and general terms if an analysis that links the individual to processes outside her
immediate social world is to be achieved (Acker *et al.* 1991 p. 136).

Glucksmann (1994) supports this view, but goes further, calling for a less self-critical and self-conscious approach to this issue. As a researcher exploring women's work experiences, Glucksmann argues that it was *her* prime object and not that of the research participants to produce knowledge of women's subordination. And as the researcher, it was she who had access to other sources of information and material which allowed her to construct this knowledge:

In writing about the domination of women assemblers, I deployed many different
sources and kinds of data... Their accounts were thus the primary, but by no means
the only material relevant to generating an understanding of the dynamics by which
they were subordinated (Glucksmann 1994 p. 158).

So, whilst recognizing the centrality of nurses' experience in my research, I have found it important to go beyond simply reproducing and citing nurses' accounts and thoughts (see also discussion in section 3.6 Ethics).

My own experiences as a woman and nurse have also been central to the analytic and interpretative process. I was aware that I gained a great deal of satisfaction from recognising my experiences as similar to those of other nurses - as Reay comments of her research experiences, 'the affirmation of finding myself at the core of some women's accounts contains enormous power' (1996 p. 65). However, as indicated earlier, Reay also highlights the dangers of such proximity: 'I then had to address the issue of whether I was conflating their many and varied experiences with my own' (ibid.). Within my research account I have tried to remain alert to this possibility. The section on analytic and interpretative strategies below outlines some of the ways in which I sought to do this.

3.7.3 The nature of reality

Another important epistemological concern relates to how researchers understand the nature of 'reality'. In interpreting data, how certain are we that we can come to

conclusions which reflect the reality of peoples lives? As researchers what can we claim to really know? And can we ever fully understand and 'get at' this reality? The way in which these questions are addressed within research reflect two broadly opposing philosophical positions, namely realism and post-modernism, and overlap with the earlier discussion regarding objectivity (see section 3.7.1).

Realism suggests that there is some essential reality that exists independently of people's perceptions of it and that it is possible to directly access this reality, so that 'the social world is revealed to us, not constructed by us' (Brewer 2000 p. 30). Through the application of certain methodological procedures and rules it is possible to arrive at objective knowledge of the social world.

Post-modernists however argue that there is no single interpretative truth, no objective reality 'out there' to be discovered. Rather there are a number of socially constructed realities - a plurality of truths - and it is the researcher's job, as far as possible, to reflect on the making of these truths.

There are some similarities between feminist and post-modern approaches to research. Both share a concern to question critically who is claiming to know, what they are claiming to know and on what basis. As Skeggs comments, 'the fundamental question that constantly informs feminist research is always 'in whose interests?'' (2001 p. 437). These questions have been central to much feminist research in exposing the bias and prejudice within masculinist social science, but this approach has also been central to arguments *within* feminism. Black feminists for example have challenged white feminist theories of women's oppression by highlighting the silences and omissions in their accounts. These negate the experience and subjectivity of black women and the way in which women's oppression and racism interconnect (Hill Collins 1990, hooks 1991, James and Busia 1993).

There are difficulties for feminists in engaging whole-heartedly in post-modernism. At its extreme post-modern research seems unable to provide any meaningful conclusions that can help us to understand the world in which we live and to bring about social change. This is problematic for feminism, as Maynard (1994) comments:

> If one major goal of feminist research is to challenge patriarchal structures and bring about social change, however conceived, then the postmodern approach which eschews generalisations and emphasizes deconstruction can only have a limited role in that endeavour (p. 22).

As a feminist researcher, it has been important for me to be able to come to certain conclusions about nurses' organizational lives and to situate this knowledge in terms of gender power relations. At the same time I must acknowledge the limits and conditions of this knowledge. This position is one which Holland and Ramazanoglu (1994) describe as the 'middle way' between the two extremes of realism and post-modernism and one they suggest most feminists adopt. Within ethnography Brewer (2000) defines this as 'post postmodernism' (p. 142) and associates it with anti-realist approaches variously known as 'critical', 'subtle' or 'analytical' realism. Furthermore, Brewer suggests that, 'all but the most radical postmodern ethnographers are committed to establishing truthful knowledge claims' (2000 p. 122).

The remainder of this section explores the process of data analysis and the particular strategies I have used to analyse and interpret the data, and the criteria used to justify my interpretative decisions.

3.7.4 The process of data analysis and interpretation

As numerous writers suggest, analysis and interpretation of data is not a distinct phase but begins at the outset with the formulation of research questions and continues throughout the research process (Hammersely and Atkinson 1995, Miles and Huberman 1993, Coffey and Atkinson 1996). For example, as indicated in the previous discussion on my topic guide, early on in the fieldwork (and prior to any 'formal' analysis) I was analysing and interpreting data and modifying my interview questions accordingly.

There are many different approaches to data analysis and interpretation, and the exact procedures and techniques used vary depending on the aim of the research, the research questions, and the theoretical perspectives of the researcher (Hammersley and Atkinson 1995). Mauthner and Doucet (1998) argue that providing an account of

such things is a neglected area of feminist research, with few texts offering detailed information as to how data was analysed. They suggest that this may be because 'data analysis is our most vulnerable spot... writing about data analysis is exposing ourselves to scrutiny' (1998 p 123). The following account is my attempt to make this process explicit.

In analysing and interpreting my data I chose to use a combination of methodologies. Combining different approaches allows the researcher to explore different aspects and interpretations of their data (Coffey and Atkinson 1996, Cortazzi 2000, Savage 2000). My principal approach was that of thematic data analysis - a common approach in qualitative research. Thematic analysis is associated with realism. As Holstein and Gubrium (1997 p. 126) suggest: 'interviews are traditionally analysed as more or less accurate descriptions of experience, as reports or representations ... of reality'. This was consistent with my epistemological approach outlined above (the 'middle way') and with my sampling strategy. The aim of thematic analysis is to develop themes from the data using a system of coding and categorisation (Coffey and Atkinson 1996). Data are analysed for codes which are then grouped or collapsed into categories and then broader themes (for details see section 3.7.10).

My approach to analysis and interpretation was also influenced by narrative analysis. As the term suggests, narrative analysis is more focused on participants' use of narrative or stories in constructing their accounts. According to Coffey and Atkinson (1996) narrative approaches:

> ... enable us to think beyond our data to the ways in which accounts and stories are socially and culturally managed and constructed. That is, the analysis of narratives can provide a critical way of examining not only key actors and events but also cultural conventions and social norms (p. 80).

This approach reflected my concern to explore the way in which nurses made sense of and interpreted their experiences and the way in which individuals and organizations can be said to reproduce and construct cultural norms and social identities. As Cortazzi (2001 p. 385) suggests, 'in recounting events in narratives, tellers also directly or indirectly give their own interpretations and explanations of those events'.

There are a number of models and approaches to narrative analysis (Savage 2000, Cortazzi 2001). My intention was not to subject the text to a thorough going structural analysis - where structural properties or units of text are identified to aid in the analytic process. Rather, the way in which I analysed and interpreted the data has been informed by the underlying concerns of narrative analysis, but does not represent an example of detailed structural narrative analysis. As such, my approach has been more informal and as Savage (2000 p. 1497) suggests of her work, more 'intuitive'.

The following is an example of how I have understood and applied the two approaches to data analysis and interpretation.

Having undertaken several interviews, I became interested in the way in which nurses used particular words or phrases in describing their experiences. As Coffey and Atkinson (1996 p. 83) comment, 'a concern with narrative can illuminate how informants use language to convey particular meanings and experiences'. When discussing the decision making processes of the LHG board, nurses sometimes referred to the board, of which they were 'equal' members, as *they*, as opposed to *we*. The following extracts are from interviews with different nurses. It is worth noting that none of the nurses emphasised the word 'they' – it appeared inconsequential and their accounts were relayed in a rather matter of fact way.

*'**They** identified a need for a nurse on the clinical governance sub-group'.*
*'**They** always want the financial and the Health Authority perspective'.*
*'Oh yes, the Chairmanship of the sub-committee can be challenged, if **they** think it's a fait accompli and it doesn't have to be a GP chairing the group...'*

As well as the more literal interpretation of what each of these comments might suggest, a narrative approach to analysis allowed me to explore the linguistic characteristics of the accounts. I found myself looking at the interviewees' 'frame of explanation' (Silverman 2000 p.125). For example, I wondered what else the use of the term 'they' might signify? I began to think through these comments in relation to issues of inclusivity, ownership and control, legitimacy, perceptions of nursing identity – those of the nurses' themselves and other board members - decision

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making processes, and feelings of and concerns about powerlessness and responsibility.

As this example perhaps illustrates, it is important to recognise that the way in which I have chosen to interpret participants' stories or narratives reflects my own research interests, my concerns with feminist theory, and is informed by my own beliefs and experiences. Undoubtedly there are times when I haven't looked 'beyond', when others would have done so and in very different ways.

Combining thematic and narrative analysis has allowed me to explore different aspects of the data and as Savage (2000 p. 1499) suggests of her experiences in using both approaches, 'the different analyses do not lead to radically different interpretations – instead they offer different emphases on meaning'.

Before I began data analysis, I considered using computer programmes to help in this process. Whilst I acknowledged that using a software package could help me manage my data more effectively, I decided against this approach for a number of reasons. At the time I knew of no one who had experience of using qualitative analysis programs and being based some distance from the University where I was registered I had no immediate access to support or advice regarding their use. Perhaps more importantly analysing my data in this way felt uncomfortable. I was concerned that I wouldn't be as in touch with the data as I wanted. I was put off by what I saw as a rather mechanistic process, which wouldn't 'fit' with how I related to the data. As Brewer (2000 p. 120) comments: 'Critics contend that computers risk losing the ethnographers 'feel' for the data and thus threaten the humanistic intent to capture the phenomenon on its own terms'.

The remainder of this section outlines how I set about the task of data analysis and interpretation. Similar techniques and procedures were applied to both phases of fieldwork and to all sources of data.

3.7.5 Techniques of coding and categorising

I began by reading through each interview fairly quickly and without making notes. I hoped to get a 'feel' for the whole story being told. I wanted it to settle and sit with me for a while before I began the more detailed process of coding and categorising. I then read the interview transcripts again, several times, slowly, this time coding the data – noting key words, thoughts, questions, and analytic points in the margin.

Taking the process of data analysis a stage further, I looked for patterns and relationships between the codes. From this, a number of categories were developed which encompassed a number of different, but related codes. Categories were then grouped or collapsed into overarching themes. In the main, the themes related to key sections in my interview topic guide - for example: 'nursing contribution' and 'working as a group'. The categories were the link between the preliminary analytic codes I'd made in the margin and the themes. In the event I had six themes, each of which encompassed a number of different categories. The categories related either directly to phrases or comments made by interviewees, for example the category, '*GPs as business people*', or reflected more directly my interpretation of what was being said, as with '*strategies for managing (devalued) identity*'. As Acker *et al.*(1991 p.143) comment of their research, 'in the actual task of analysis we initially found ourselves moving back and forth between letting the data speak for itself and using abstract categories'.

When I came across data which challenged an earlier interpretation I would make a note of it. This is similar to 'negative' or 'deviant' case analysis (Brewer 2000 p.117 and Silverman 2000 p.180), whereby researchers are urged to identify and explore contradictory data and where necessary, revise existing categories and original formulations. Within the findings chapters I have provided a number of examples whereby interviewees own sense making challenged my own and 'deviated' from what I saw as dominant, emergent themes within the data.

When I was reasonably sure I had a comprehensive list of categories and themes, I colour coded each theme and allocated numbers to each category within the themes. For example, the theme, '*Nursing contribution*' was orange and had 11 categories. I

went through each interview highlighting the data with the relevant colour as it related to each theme. Alongside the vertical coloured line in the margin, I indicated the number of the category to which the data related (see Appendix 12). At the same time I transferred this information to index cards. Each card had the title of the theme and category. Summaries and extracts of interview data relating to the category were then listed with their page references. The name (pseudonym) of the interviewee was also put on the card alongside the extract. Each extract was lettered so that I could easily cross-reference my data. Thus everything that each interviewee said in relation to, for instance, the theme 'nursing contribution' and the category 'finding a voice' would be listed and referenced.

I had considered using the 'cut and paste' facility of the computer word processor to aid in this process (as opposed to using index cards), but, at the time this too felt antithetical to how I wanted to manage the data. I wanted to be able to retrieve the data easily and access a number of index cards at the same time – I wanted to 'see' it all in front of me – something I felt would be hard to achieve on a computer screen. In addition there was something about writing by hand that I found facilitative to the organic process of data analysis. In retrospect however, using the cut and paste facility would have saved time and is something that I would certainly consider doing in future.

To ensure I was consistent in the way I categorised my data, I wrote a definition of each category, using extracts from interviews as illustrations. I found myself returning time and again to these definitions to ensure that what I was about to assign to a particular category was appropriate.

Invariably there were instances where extracts pertained to more that one theme or category. Where this was the case I highlighted this next to the data in the cards with the relevant coloured number of the alternative theme or category. In such instances I might have written the same segment of interview data up to three times. Alongside the data I offered a brief explanation as to why I felt it fitted with other themes, should it not be obvious when I returned to the data at a later date. This was time consuming but I wanted to be sure that I wouldn't leave any gaps – that when it came

to more detailed interpretation, I could feel reasonably confident that I had all the data references to one particular theme or category.

I followed the same process of coding and categorising with my fieldnotes. Having completed this initial stage of data analysis, I had separate boxes of cards relating to 'interviews with nurses', 'interviews with doctors', 'interviews with key informants' 'fieldnotes' and 'my personal journey'.

Throughout the long process of data analysis I kept a record of what I called 'second wave themes'. These were thoughts, insights and questions that emerged as I worked through the initial interview and fieldwork data and which informed the second phase of data collection. Having analysed data from the first phase of fieldwork, I had 16 pages containing 57 separate, but related themes, for example, 'thinking strategically', 'articulating the value of nursing work', 'denying gender'. These themes remained relatively constant throughout the second phase of data analysis and interpretation and underpin the findings chapters.

3.8 A note on rigour

I have addressed the question of rigour at various points in this chapter as it relates to the different stages of the research process. In this section, I shall offer only a brief overview of the ways in which I have attended to the question of rigour.

There are a number of different approaches to achieving rigour in qualitative research. These reflect the aim and the different epistemological and theoretical underpinnings of the research (Sandelowski 1986). A starting point for me has been to acknowledge that the process of interpretation is only ever partial (Holland and Ramazanoglu 1994). Nevertheless, there are certain procedures I have adopted in order to maximise the rigour of the research. In doing so I have been guided by the work of Brewer (2000) and by feminist literature which emphasises the need for reflexivity within research accounts (see for example, Stanley and Wise 1993, Williams 1993 and Reay 1996). In the main these procedures reflect my concern to

be clear about what I have done and why I have done it, rather than a commitment to a rigid set of rules (see also Sandelowski 1993 and Rose and Webb 1998).

Providing a reflexive account of the research process has been central to ensuring my research is rigorous. Thus I have drawn attention the way in which my personal beliefs and values, my politics, biography and experiences have shaped the research (Williams 1993). I have also highlighted the problems I encountered in the research and the way in which I experienced the research process, and how in turn, this influenced the research (Brewer 2000).

I have sought to provide a detailed account of the process and strategies of data analysis and interpretation (Maynard 1994, Mays and Pope 1995a). As part of this process I have attempted to treat critically my own understandings and interpretations, as well as those of the people I interviewed (Brewer 2000). Respondent validation is one way of doing this and is seen by some as an important criterion of validity. However, as previously indicated I decided against this strategy in the data analysis stage. I understood the process of interpretation as subjective and contingent (Coffey and Atkinson 1996) and as such my data could be interpreted in different ways. As Philpin (2004) comments of her decision not to use respondent validation in her research, 'my findings were *my interpretation* of the nurses' actions and would not necessarily concur with their perceptions, but arguably would be no less valid for that' (p. 81 original emphasis) (see also critiques of respondent validation by Sandelowski 1993 and Silverman 2000).

Using a combination of data collection methods (primarily interview and observation) allowed me to test out emerging themes and understandings. Whilst accepting the limitations of 'triangulation' in getting a ''true' fix on reality' (Silverman 2000 p. 177), using a variety of methods nonetheless provided me with additional insight and understanding. For example, talking to nurses about their experiences of attending board meetings, then subsequently observing these meetings myself was helpful in illuminating some of the issues nurses raised, as well as highlighting others they had not mentioned.

Brewer (2000) also suggests that researchers 'show the complexity of the data... avoiding the suggestion that there is a simple fit between the social world under scrutiny and the ethnographic representation of it' (p. 54). Discussing negative or deviant cases (see above) is one way of doing this – another is to show the 'multiple and frequently contradictory descriptions proffered by the respondents themselves' (p. 54). Indeed, what I perceived as participants' contradictory accounts and sense making is explored in some detail in the research. I have also provided lengthy extracts of data (fieldnotes and interviews) which allow the reader to judge my interpretation of them (Brewer 2000).

Where appropriate, I have provided simple 'counts', which hopefully give the reader some sense of the typicality of particular experiences and viewpoints. Doing so helps address the criticism of 'anecdotalism' which, it is claimed, is evident in some representations of qualitative research (Silverman 2000 p. 177).

3. 9 Chapter summary

In this chapter I have outlined the research process as I have understood and experienced it. I have described and justified the theoretical perspectives and methodologies I have used and the way in which these have informed my research methods and my research practice. In particular, I have sought to illustrate the way in which this research can be seen as feminist research, reflecting the interests and orientation of a politics concerned with the way in which gender relations of power impact upon and shape women's lives.

In the following chapters I describe and discuss the findings of my research.

Introduction to findings chapters

The presentation and discussion of my findings are divided into four chapters. The four chapter headings, 'The Nursing Contribution: opportunities and challenges', 'The Nursing Contribution and Gender', 'Identity' and 'Medical Power' relate to key themes that emerged from analyses of interview and fieldwork data. Each chapter explores a different, but related aspect of the nursing experience of life on LHG boards. Inevitably there are areas of overlap between the chapters - for example the issue of identity is a strong theme running throughout the findings chapters. Given its significance however, a chapter has been dedicated to exploring the issue of identity in some detail.

In writing about and interpreting nurses' experiences, I have been aware of the difficulties in creating and maintaining a sense of nurses' individual journeys and biographies, whilst also subjecting nurses' accounts to thematic analysis. Such analysis has the potential to fragment narrative and render the individual secondary and incidental. As far as possible I have tried to contextualise nurses' experiences in terms of the individual nurses' biography and provide what I hope is sufficient detail to allow the reader some idea as to 'who' these nurses were and how, as individuals, they experienced life as LHG board nurses. My difficulty in doing so is compounded by the issue of confidentiality and anonymity, which is particularly problematic in such a small, highly visible group of nurses. Whilst more details regarding the personal histories, and characteristics of participants would have been helpful, my priority has been to protect the anonymity of those taking part in the research.

As some participants were interviewed twice, interview extracts are identified as interview 1 or 2. The phase of fieldwork in which the interviews were carried out is also indicated, e.g. 'Phase 2: Interview 1'.

It is important to note that chapter four, 'The Nursing Contribution: opportunities and challenges', is primarily concerned with 'setting the scene' and providing the reader with an overall picture of what life has been like for LHG board nurses. Whilst I

introduce some gendered analysis in this chapter, this analysis is developed in greater detail in subsequent chapters.

Chapter Four The Nursing Contribution: opportunities and challenges.

4.1 Introduction

Nurses' contribution as LHG board members constitutes a key area of inquiry in this thesis and is a useful starting point in exploring nurses' organizational experiences. From the outset I wanted to understand how board nurses were able to contribute to the work of the LHG board and the extent to which nurses had influenced decision making processes. In addition, I wanted to explore the way in which gender might impact on their ability to inform the work of the board. This chapter begins that enquiry and provides the reader with a 'feel' for the opportunities and challenges nurses faced when the boards were first constituted, and what the 'journey' has felt like for some. The role of gender in shaping the nurses' experiences, which is key to my analysis, is introduced in this chapter, although it is developed in more detail in respect of the nursing contribution, identity and medical power in chapters 5, 6 and 7.

In section 4.2 I start by looking at some of the nurses' personal reflections and observations of life as LHG board nurses, in particular early anxieties and concerns regarding their role and their potential to contribute. Sections 4.3 and 4.4 then highlight in detail the ways in which nurses feel they have contributed and how nurses and others make sense of and evaluate their contribution. As previously indicated, pseudonyms are used for all participants (see Appendix 2).

4.2 Life as an LHG nurse: personal reflections and observations of the journey

When I first interviewed nurses, I begun my asking them what had prompted them to apply for the post of nurse board member. Nurses responded in a number of ways. Two out of the 13 were approached directly by the senior nurse and asked if they would consider applying. The remainder had been more pro-active and on hearing about the posts, had found out as much as they could about the role and what was

expected of them. Many saw the new roles as a challenge, which allowed them to maintain their clinical involvement, whilst at the same time developing other skills. As Debbie, one of the board nurses commented, 'this seemed like an ideal opportunity to work at a different level, to look at the broader picture of health care, but maintain my hands-on work' (Phase 1: Interview 1).

The appointment of LHG board members with recent clinical experience was key to government policy. It was precisely this experience that was seen as important in devolving control and decision making to local level:

> Local Health Groups will be established to give GPs and other stakeholders the opportunity to take increasing responsibility for shaping health services to meet local need and by taking responsibility for commissioning local health care (Welsh Office *Putting Patients First* 1998a p. 37).

As board members, nurses would have the opportunity to help plan and develop local health policy – an opportunity several participants identified as lacking within their current roles and in nursing more generally. For Sam:

> This was something as nurses we had been jumping up and down about for years... that we did have a contribution to make, shaping the health care that's delivered (Phase 1:Interview 1).

As Sam suggested, critics have highlighted the relative absence of a nursing voice at a strategic level within the NHS, and have argued that such an omission overlooks the important contribution nurses can make to developing and shaping health services (Robinson 1992, Goodwin 1992, King's Fund College 1993, Department of Health 1994, Antrobus 1999). However, whilst the inclusion of nurses as board members is to be welcomed, their inclusion as *other stakeholders* (see above) perhaps reflects and reinforces what is seen to be the central role of GPs in the development of LHGs. Indeed, Sam expressed some concern about this, as the following extract suggests. When I asked her if she felt confident putting herself forward as a board member she said:

> No, no, not at all ... but the only consoling factor was that at that study day, there were nurses from the whole of Wales from various backgrounds, primarily community nurses, but everybody seemed of a similar sort of understanding - 'yes,

we want to be part of this, but are we going to be able to pull it off? Will we be an equal partner?' (Phase 1: Interview 1).

The question of equality is an important one and in many ways emerges as central to my exploration and understanding of nurses' experiences. Sam's comments indicate a degree of apprehension about nurses' ability to 'pull it off'. This anxiety would seem to reflect concerns regarding nurses' own individual abilities, as well as those relating to the more structural factors, such as the predominance of GPs on the boards – a point I later explore.

These reservations were echoed in the nursing press at the time. Articles such as 'Last among equals' (Willis 1998), 'Thirst to be equals' (Poole 2000), 'Excluded' (O'Dowd 2000), 'Marginalisation in PCGs' (Fisher-Smith 1999) and opinion pieces by Lipley (1999) and Sweet (1999) all highlight anxiety regarding the marginalisation of nurses and dominance of GPs within the new primary care organizations. Concerns regarding nurses' role as board members amounting to a token gesture were also highlighted by participants in Kaufman's (2002) study.

Sam's uncertainty about being on the board was shared by others I spoke to, particularly during the first phase of fieldwork. Whilst nurses felt excited at the prospect of being on the board and the opportunities this afforded them, they expressed some unease and insecurity about their role and their ability to make a meaningful contribution as nurse board members.

Concerns about medical domination though, were not the only ones. Whilst nurses felt their clinical experience and focus was enormously beneficial to the work of the LHG, their relative lack of experience in working at a strategic level was seen as significant. This was particularly the case for Kate, Kim, Becky and Viv (four of the 13 initially interviewed). As Kate explained:

> I was encouraged to apply by Gill (senior nurse). I didn't feel as an operational nurse I was in any way able to take on that strategic type of role ... it was someone saying I did have something to contribute as a practice nurse (Phase 1: Interview 1).

When probed at interview, concerns about 'not being strategic enough' were common. One of the main issues (at both first and second interviews) that nurses appeared to grapple with in terms of their ability to contribute and influence related to their need to become strategic thinkers. Understanding and articulating their day-to-day work and translating this to the language of strategy, was to prove an obstacle. Indeed, Antrobus (1999) identifies this as a key challenge facing nurses taking on leadership roles in health care planning and policy. Amongst the 15 board nurses who took part in the research, at the beginning, only Tina, a health visitor, felt comfortable in operating at a strategic level. Tina put her confidence down to her health visiting experience. This she argued had encouraged her to look at a broad population based approach to health care needs and services, which allowed her to move more easily between an operational and strategic focus. I shall explore in more detail the particular difficulties nurses encountered in this respect and how these might be understood in chapter five.

The above comments by Kate also suggest that support and encouragement from others, in her case the Health Authority's senior nurse, was crucial in giving practice nurses the confidence to apply (the support and development of practice nurses came within the senior nurse's remit of responsibility). Kim in particular, spoke of her lack of confidence and like others, expressed delight and surprise on being appointed to the board. Whilst she believed she had a great deal to bring to the board, she continued to have doubts as to her abilities. As she indicated at her second interview:

> I think we (nurses) need to have the assertiveness and confidence that we can contribute. That was something I always felt was difficult, to start off thinking - what am I doing here? I'm a little practice nurse sitting in her little surgery with 6000 patients. What can I contribute to the wide picture? (Phase 2: Interview 2)

This exemplifies a tension I think some nurses experienced. On the one hand, Kim expressed a belief that she did have something very important to contribute, whilst at the same time she experienced a profound lack of confidence about her role and legitimacy as a board member. As I discuss in chapter six, this tension runs throughout Kim's account of her experiences. During the interview she tried to make sense of the contradiction, lamenting what she sees as nurses' and nursing's profound

lack of self-worth. This was significant to me given my interest in looking at the way in which nurses experienced and made sense of their identity as nurses and women. Reflecting on what life had been like as an LHG board nurse, nurses appeared to share much in common. Phrases like 'stressful', 'invaluable', 'a steep learning curve', 'hard work and time consuming', and 'rewarding' were often used.

In terms of the rewards, the opportunities for personal and professional development were widely acknowledged. For example, one of the most valuable experiences for the nurses, in particular those working in general practice, was the opportunity to better understand the work of other health and social care organizations in meeting the needs of patients. Indeed, the promotion of partnership and cross boundary working is a key feature of *Putting Patients First* (Welsh Office 1998a). As Emma and Kim, both practice nurses, commented:

> I've learnt so much – I have a much better understanding of what is going on 'out there' (Emma: Phase 1: Interview 1).

> I think it's been invaluable – being a practice nurse you become quite isolated – you don't see the larger picture, but being part of the LHG, you take much more of a borough perspective, and not so narrow as just nursing, you take a more multi-disciplinary, cross boundary working (*sic*). And I'm much more aware of (how) collaborative working with other organizations can have such an impact on public's health (Kim: Phase 2: Interview 2).

The following extract illustrates clearly the significance of Kim's shift in thinking; in her words, 'something really stark made me think about things' (Interview 1). The board discussion had turned to the care of patients with depression and the social services representative to the board was challenging the other board members to think beyond medical explanations and treatment:

> He said, 'Look, all GPs can prescribe is anti-depressants, all the nurses can give as much counselling as they want, but', he said, 'all they might need is a field full of flowers in front of their desperate homes where there's nothing but rubbish tips and high grass and tyres and rubbish'. And he said, 'if we planted flower bulbs and put a park there, I bet the rates of depression would come down'.

> And I thought, I bet he's right, you know ... and I thought, hang on, my view to care has been very sort of, perhaps not just medical, because I have looked at the home environment, but never to that depth, or as broad (Phase 1: Interview 1).

Whilst all those I spoke to felt the experience had been worthwhile and invaluable, the 'journey' had proved more difficult than they had anticipated, as the following extracts suggest:

> It (the journey) has been harder than I imagined. It's nice to look back now and think 'Gosh I feel much better than I did even 18 months ago'. And that is a very satisfying feeling to feel that you have actually – the personal achievement has been there. So I think it's been a very worthwhile experience from the personal perspective and I think we have contributed a lot to the discussions and decisions of the board (Claire: Phase 2: Interview 2).

> It has been very, very up and down, to being really excited by everything, to see all the potential, to feeling totally despondent and definitely before my holiday in August I got to the point where I felt this isn't okay - I definitely need this holiday and I'll re-evaluate when I get back, because I'm not going to do it at any price. But I came back well rested after the holiday, fighting fit so… (Tina: Phase 1: Interview 1).

The obstacles and difficulties nurses encountered and the extent to which these impacted on their role varied according to the individual. Whilst acknowledging her early struggles, Claire for example, reflected positively overall on her contribution and time on the LHG. For others however, notably Tina, Becky, Ann, and Viv, the early optimism and enthusiasm they felt when they first joined the board had given way to a weariness and disillusionment. As Tina commented, 'I think all of us are getting quite battle weary; we want to go, but who else is going to come afterwards?' (Phase 2: Interview 2). This relates to concerns voiced by a number of writers regarding the continued enthusiasm of nurses, given what has been viewed as their limited levels of influence within the boards (of PCGs), (see for example Smith *et al.* 1999, Regen *et al.* 2001).

There were several reasons for despondency amongst those I spoke to. For some, the pressure of being a board member, whilst also maintaining a clinical caseload was great and was felt to significantly affect their ability to contribute - a finding supported by others (Audit Commission 2000, Dawes and Dobson 2001, Regen *et al.* 2001, and Wilkin *et al.* 2001). The half-day a week allocated to 'ordinary' board members to fulfil their duties was seen as woefully inadequate by all the nurses I interviewed. In reflecting on the limitations of his role, Charlie commented:

> I could do a heck of a lot more – because I am certainly committed – if I had time to do it. The half-day a week is a joke. You could easily spend half a week just attending meetings and feeding back to your peers (Phase 2: Interview 1).

This situation was compounded by the difficulty some nurses had in getting cover for their clinical responsibilities whilst undertaking board duties – an issue highlighted by other nurses (Sams and Boito 1999) and by the Audit Commission (2000): 'there is disparity across Wales in the time allocated to nurse board members for LHG duties and to gather data needed to make an effective board contribution' (p. 8).

In reflecting on their journeys as board members, several nurses also highlighted what they saw as a lack of progress by the board in some areas and this was a cause of frustration and disillusionment. Tina would frequently describe having to 'do battle' with various board members and LHG staff. Describing her main disappointments, she commented:

> I think having to fight all the time and maintain the passion ... I was fighting from the start.... It's been very easy to think 'life is too short, I'm off' – but you stay if you are driven and committed (Phase 2: Interview 2).

Tina's struggles related to a number of difficulties. These included what she perceived as a lack of corporate responsibility on the part of the board and the difficulties she felt she had in being heard as a nurse and woman. I will return to this last point in subsequent discussions, but perhaps the biggest difficulty she expressed was in trying to encourage a broader, more patient-centred approach to the board activities. This emerged as a key concern for many of those I spoke to and is also highlighted by several other studies. For example, in their evaluation of PCGs, Wilkin *et al.* (1999) conclude:

> Organizational changes need to be accompanied by changes in the culture of primary care. Individual patient care, medical models of health and professional control will need to be counterbalanced by a focus on populations, wider definitions of health, openness and collective responsibility (Executive Summary p. 2).

In particular, concerns regarding 'medical models of health and professional control' were raised by nurse participants. Nurses were frustrated by the way in which GPs and issues relating to general practice dominated the agenda and air space to the detriment of other important debates and perspectives. As Ann explains:

> I went in there feeling we were going to really achieve some wonderful things, because we had this opportunity. And I was surprised at the drawbacks with people's own personal – especially GPs' own agendas that they brought to the board (Phase 2: Interview 2).

This point was echoed by Becky:

> I think perhaps it's been, or at times it's felt like it's been dominated by professional issues rather than patients' issues... Obviously, you can't avoid the fact that it's been very medically dominated, but I do feel the medical contribution has been a good contribution... general practice is a very important part of primary care in Wales so you would expect there to be a huge input. But sometimes it is frustrating because you can't move the debate on from general practice (Phase 2: Interview 2).

The preoccupation of LHGs with medical issues and the interests of GPs is an important factor in nurses' organizational experiences. As Regen *et al.* (2001) conclude in their final report tracking the evolution and development of PCGs, 'most PCG/Ts continue to express concerns about an inappropriate dominance of the PCG agenda and meetings by GP board members' (p.1). The social and cultural positioning of nursing and medicine and the power and status accorded to each, is a recurring theme throughout this thesis. The ways in which nurses (and GPs) experience and make sense of medical dominance at board level is discussed in detail in chapter seven.

The difficulties and frustration experienced by nurses in their attempts to assert a patient-centred approach resonate with work which highlights the way in which nurses' efforts to implement nursing ideals and values as part of their day-to-day work may be thwarted (see James 1992, Wicks 1998 and Maben 2003).

The next section of this chapter provides a more detailed picture of how nurses have contributed to the LHG and some of the obstacles they faced.

4. 3 The nursing contribution: examples from practice

In trying to understand how nurses experienced life as LHG board members, I wanted to explore the specific ways in which nurses felt they had been able to contribute to and influence the work of the LHG. The following section provides details of nurses' responses to this question. I then explore nurses' own evaluations

of their contributions, as well as the views of GPs, general managers and a senior nurse.

All those I interviewed regularly attended board meetings - usually held monthly – and all were members of various sub-groups. Board meetings were widely acknowledged as rather formal events, where proposals and decisions brought to the board by the executive or via sub-groups, were 'rubber stamped' – a finding supported by Regen *et al.* (2001). The authors concluded that, 'PCG board meetings [are] essentially a forum for the ratification and approval of decisions, rather than the locus of discussion and debate' (ibid. p 84). It was on the sub-groups that nurses felt there had been more scope for debate and where they had contributed more.

4.3.1 A different (patient-centred) approach

When I asked nurses what it was they felt they could contribute and how they saw their role on the board, one of the key features they identified was nurses' ability to adopt a broad, holistic approach to patient care and services. This was invariably seen in contrast to GPs, who were viewed as coming from a narrower, more medically focused position. As the following comments suggest:

> I see part of it as nurses having, umm, a so much wider view of health than doctors do on the whole and this is widely written about, but it's perfectly true, they do focus very much on medicine, on drugs, on treatment, umm, and not so much on the wider aspects of health and I think nurses have a much broader view of what influences a particular individual and their health, so I think we can have quite an influence that way (Linda: Phase 1: Interview 1).

> I think in some ways nurses are best placed to know what is happening out there and to know what standard of care is being delivered. And I think as nurses you tend to treat people far more holistically than possibly GPs do… because you do build up a different kind of rapport with them, a different kind of relationship … as a PN or community nurse, you do deal with people more holistically, so it's not, 'right I'll put a plaster on that' or 'take these antibiotics and never darken my door again'. You look at other things that are impacting on their health as well as a particular issue they walk in the door with. And you also engage other agencies for example, pharmacy, meals on wheels, social services and other nursing disciplines (Sam: Phase 1: Interview 1).

The particular skills and perspectives of nurses identified in these extracts are supported by others who argue that nurses are well placed to make a significant

contribution to developments in primary care by virtue of their ability to adopt a more holistic, social model of health (Willis 1998, Morgan 1999, Kaufman 2002 and Walsh *et al.* 2003). By highlighting different priorities and by drawing on different frameworks of knowledge nurses can be seen to have challenged the dominant biomedical model of health (see also Wicks 1998). The following discussion illustrates in more detail what this challenge 'looked like', whilst chapter five develops a more detailed gendered analysis of the nursing contribution.

As members of their boards' clinical governance sub-groups, several nurses felt able to draw on this wider view of health and service development in discussions on the implementation of clinical governance initiatives in general practice. For example, Kim, Linda and Tina felt they had made an important contribution to the discussions on the different ways in which information can be gained with regard to assessing standards and quality in general practice. Their understanding of the complexities of patient care and how the roles of those other than GPs can influence the patient experience was, they felt, vital in shaping a more effective clinical governance strategy, a point picked up by Debbie:

> I questioned their idea of looking at GP practices one by one, which is what is intended to happen, without looking at the team attached to that practice - for instance you could not assess the service offered to diabetics through a GP, without looking at the dietician involved with that practice. You could not look at a GP's methods of getting their immunisation targets without looking at the health visitor. It should be done in total as a team (Phase 1: Interview 1).

In response to her questions, Debbie was advised by the Chair that Welsh Assembly guidelines stipulated that baseline assessments were to begin with staff working in primary care (that is, 'general practice'). In view of this comment, it is interesting to note that the Audit Commission (2000) highlighted precisely this issue in their evaluation of LHGs: 'Some LHGs excluded community nursing from their baseline assessments on the grounds that it was a NHS Trust clinical governance responsibility. This fails to recognise the need for integrated information on practice nurses and attached staff' (p. 10).

Kim also felt her emphasis on a team approach to assessing standards and quality of patient care and services represented a more inclusive approach - one that openly

recognised and valued the contribution and influence of others, including patients. Her suggestions resulted in her being asked to visit practices alongside the GP clinical governance leads. She welcomed this offer commenting:

> I can't see why other members of the clinical governance group don't go as well. An open approach to it. I mean I would look at things probably different to what a GP would look at. And possibly the lay member would look at wheelchair access and toilet facilities, you know, which is the whole - the most important part of it. I would say the most important part is, can you park? Can you get in the surgery? And can you hear when you are called? Can you get an appointment, you know. If you ask the patient and that's what we are supposed to be all about, that's probably the most important thing (Phase 1: Interview 1).

This extract also highlights the importance Kim places on the need for a patient-centred approach to board activities and discussions, something Debbie also felt very strongly about. In trying to explain to me what it was she felt nurses could contribute, she commented, 'I think our value is getting the *right* questions asked'. The following extract demonstrates what this meant for Debbie. Board members were discussing ways to address the prescribing budget overspend:

> A GP say will come up with some information, some work they may have done on that, very valuable work, looking at how money can be saved, *but* no mention of clinical governance. And that's where I come in and say 'we cannot isolate this as a totally financial saving issue. I agree wholeheartedly with all the information that has come before this board today, but, it has to go to the clinical governance sub-group, because when we are looking at the cost of drugs we are looking at repeat prescribing, we are looking at the methods of prescribing within GP practices, we are looking at inappropriate prescribing, we are looking at whether doctors see patients before they prescribe, we are looking at all these issues, whether receptionists are prescribing, not just the money saved, so this has got to go to clinical governance'. And it went to clinical governance. You see, this is why we are there, seeing clinical governance in that, you see the patient in that (Phase 1: Interview 1).

Becky made a very similar point:

> I mean, the things I find I don't make any contribution to at all are the financial aspects, umm, in as much as I don't know what formula they use to decide how much budget somebody should have for prescribing for example, so I don't make a contribution to that aspect of it. My contribution keeps coming back all the time again to, what's been prescribed? Why is it being prescribed? Should it be prescribed? (Phase 1: Interview 1).

Both these extracts suggest a focus on quality issues. Asking the 'right questions', to use Debbie's phrase, involves nurses taking a more critical stance and using their

own nursing experience and the experiences of patients, to look at the processes and systems involved in episodes of care or service delivery (see also King's Fund College 1993 and Department of Health 1994). And these are important issues in developing and implementing any clinical governance strategy.

There were other areas of board work such as the development of the Health Improvement Programme (HIP), which also provided an opportunity for nurses to make an important contribution. As indicated, the literature suggests that this is an important area of influence for board nurses (Antrobus 1998, Kaufman 2002). For example, Kate spoke of how she had drawn upon a broader, 'less black and white' *(sic)* understanding of issues being discussed by board members in relation to their HIP. Kate's experiences in bringing this perspective to the board are discussed in more detail in chapter five.

Whilst nurses felt they had contributed generally to the discussions at board and sub-group level, many felt their contribution and influence would increase when more nursing related topics were debated and when they were involved in specific pieces of work. This sentiment is echoed by nurse respondents in Regen *et al's* (2001) study, in which nurses felt they had a 'higher level of influence with regard to specific pieces of PCG work rather than upon the PCG as a whole' (p. 78).
For example, at the time of her second interview Becky had a pivotal role in the co-ordination of the community nursing services review in her LHG and saw this as her principal achievement. Using her experience as a community nurse, she felt she had the opportunity to influence commissioning and policy decisions in a way that reflected the experiences of patients and acknowledged the day-to-day issues and difficulties in delivering such a service:

> And what I am pleased about is that I have been able to ask them (the secretariat) to look at that in very pragmatic ways – you know day-to-day issues, work with the Trust, talk to nurses, not just senior people, but talk to those who are going about the job everyday… what we are going to do is do workshops and involve people from secondary care, ward sisters, people who use district nursing services. And I think, asking them to look at that and looking at the evidence in the literature of how people have reviewed community nursing services in the past, particularly under fundholding, and asking them to use a reasonably sound methodology then. So being able to influence that really – that's been very interesting (Phase 2: Interview 2).

Ann gave the following account at her second interview:

I think in the two and a half years the greatest contribution I gave was to influence the HIP. Around the issue of teenage pregnancy in our area, which I worked closely with the consultant in public health on the board - she had an interest in teenage pregnancy as I did and we knew that was an issue in our area and as a result of that, we had an emergency contraceptive pilot ... and I was very involved in that because that was an ongoing project. It started in three areas in the borough, but was then extended ... and the Assembly were very supportive of it and it was actually put forward for an award – a HIP award for Wales so that was quite an achievement (Phase 2: Interview 2).

Claire identified one of her main achievements as contributing significantly to a diabetic project in her area: 'That has had a lot of nurse involvement and that is really satisfying to see that our care of the diabetics has improved through the audits we have done' (Phase 2: Interview 2). In particular, Claire had contributed to discussions about how the care and management of diabetic patients could be improved in general practice and how the role and contribution of nurses was central to this, 'because 99% of it is done by nurses'.

Reflecting on her key achievements, Kim highlighted the way in which she had contributed to multi-disciplinary training and development programmes as part of the LHG's clinical government framework. Kim had encouraged practices to address the training and development needs of their staff, arguing that patient care was dependent on well trained and supported nurses: 'if nothing else, I can think I've turned a few light bulbs on and made them think about their nurses in their practices' (Phase 2: Interview 2).

4.3.2 Challenging

Much of what nurses appear to have done is to challenge certain preconceptions regarding the legitimate focus of LHG activity and the understanding around some of the issues. Nurses have encouraged the board to adopt a more critical, broad, patient focused perspective. As the literature suggests (see for example, King's Fund College 1993, Department of Health 1994 and Kaufman 2002), these are precisely the skills nurses can and need to bring to such debates. Their ability to 'speak many languages' (Goodwin 1992 p. 9), their operational experience and intelligence, and their understanding of how health and social services fit together are all important skills. In addition, in asserting a different way of 'knowing', one centred on the

experiences of patients and grounded in nursing experience and understanding, nurses have openly challenged traditional biomedical knowledge and practice.

Nurses also challenged the way in which certain decisions were made, and questioned issues relating to the process of board working. For example, Charlie felt one of his main contributions was to successfully lobby for nurse representation on the executive committee of the LHG, where he felt many of the key decisions were made.

Kim persuaded members of the secretariat to visit practices to gain a better understanding of how delays in payments in relation to primary care development plans impacted on the individuals concerned. Their response to these visits is revealing:

> **K**: I said, 'well, what I'd like you to do is to come out to the practices and see what it is *really* like. Instead of sitting behind your desk and saying, 'Oh you can't do that,' come out with me and see what it's really like and where the need is and listen to the practitioners who need the money today for the patients, to deliver what we *said* we want to deliver anyway'.
>
> And actually some of the senior managers have been coming out to practice visits with me, which is a real step forward. And they *cannot believe* – they see these practices on their desks every day and they read the problems they might have, they read the quality problems, but you can't see – and one of them actually said, 'it's not seeing, it's actually *feeling* the issue out there'. So I think that's a positive way in which we have changed things (Phase 1: Interview 1).

Kim's suggestion that others accompany her to the practices enabled them to gain a better understanding of some of the difficulties faced by practitioners and the need for responsive policies. Given that not everyone will be willing or able to visit practices personally, the challenge for nurses on LHG boards is to capture that 'feeling' in words – with the touch, sound and sight that such feeling implies. As Antrobus (1999) suggests, this is important if nurses want to use their operational knowledge and experience to inform policies and strategic decision making. However, Antrobus (1999) also concedes that finding the language to do this, particularly in relation to nurses' caring role, is problematic. As I shall suggest in chapter five, these difficulties can be seen in the context of a masculine

organizational culture, which obscures and denies the value of caring work and where language of a caring nature struggles to gain expression.

Several nurses also challenged the way in which lead roles within the LHG were appointed. Kim challenged the GPs on her board when it was clear they had met prior to the board meeting to select the clinical governance lead (CGL) – something which should have been decided by the board as whole, as she explains:

> I challenged that at the meeting. I just said I was really disconcerted at the fact that I thought we were working as a local health *group* – I didn't realise that it was (*unclear – one word missing*) for GPs to operate separately from the rest of the team. And actually we've got a very good optometrist on the group who's very well spoken and she shared the same views, as did the Director of Social Services. And we said we felt that for the group to continue and work well it had to stop (Phase 1: Interview 1).

Tina similarly challenged the appointment of the Chair at her LHG under equal opportunities policy, when it became clear that GP board members had preselected the Chair. Tina also questioned existing strategies for ensuring quality and clinical effectiveness in primary care. For example, Tina disputed the audit criteria used for GP payments on the basis that they did not reflect or encourage improvements in patient care. Listening to Tina, it seemed her experiences of life as an LHG nurse were dominated by challenge. She talked about her need to constantly remind the board to 'broaden things out', and admitted that:

> I bag things to make sure I've done them and that perspective has gone in. So it's a continual thing all the time. There isn't one big thing in particular, apart from my presence, and the fact that I challenge all the time (Phase 1: Interview 1).

As Tina infers her presence as a nurse/health visitor is also symbolically important - just 'being there' was significant. Those I spoke to agreed that their role was also about raising the profile of nursing and nurses by highlighting the way in which nurses from a range of disciplines could contribute and were contributing to improvements in patient care.

Kim felt she was also able to raise her profile as a nurse at the board's away day. Each member was asked to tell the others a bit about themselves and their personal history:

I said what I'd done and what my interests were and they said to me, 'I can't believe' – and this was a GP actually – 'I can't believe that a nurse has done so much, education wise in general practice, as a practice nurse'. And I looked at him and said 'that is an *awful thing* to say; I'm really offended, why do you think ...?' 'Well, we never thought of a practice nurse needing degrees and things' (Phase 1: Interview 1).

A similar comment was made by one of the nurses in Regen *et al's*. (2001) study. Commenting how she felt their presence on the boards had improved the image of nurses, especially amongst GPs, one nurse observed, 'It's like the GPs are saying to you, 'you are articulate and fair – you are not like a nurse!'' (p. 90).

These extracts raise important issues about the image and identity of nurses and nursing. The question of personal and professional identity is crucial to understanding the way in which nurses make sense of and experience life as board members and is discussed in more detail in chapter six. It is also addressed in chapter five, where I explore in more detail the relationship between the nursing contribution and gender identity.

The next section of this chapter sets out to examine how the nursing contribution was viewed. This includes the views of nurses, the views of GPs, a senior nurse and LHG general managers, as well as my own reflections.

4.4 Reflections on the nursing contribution

I shall begin this section by exploring the way in which nurses made sense of and evaluated their contribution.

4.4.1 The nursing contribution: nurses' views

When I first interviewed nurses some six - nine months after LHGs went 'live', I asked them how they would judge their efforts to date and if they felt they were fulfilling their potential as nurse board members. There was a consensus that they weren't contributing as fully as they would like for a number of reasons. As new organizations, many LHGs were preoccupied with internal organizational issues and constitutional matters. As Wilkin *et al*. (1999) conclude in their study of PCGs, in the

first six months: 'Simply getting the PCG board to work as a cohesive, corporate body encompassing a wide range of professions and interests was felt by many to be a major step forward' (p. 57).

Work on the core functions of LHG activity, such as the Health Improvement Programme, commissioning, and clinical governance received less attention initially and it seems these were the areas that nurses felt most able to contribute to. In addition, as previously indicated, the LHG agenda was dominated by GP concerns such as prescribing budgets and GMS finances - issues which in the main provided fewer opportunities for nurses. As Claire commented, 'there haven't been as yet issues which directly relate to the patients or nursing in our area' (Phase 1: Interview 1).

However, Becky, Debbie and Kate presented compelling arguments as to why nurses should contribute to *all* board discussions. As previously outlined, it was their patient-centred, critical, broad approach that they saw as invaluable in informing debate and discussion. And as Linda argued, whilst there were areas of particular interest to which she could contribute, she also felt it important for nurses to contribute more widely:

> I mean I don't know anything about orthopaedic services, or eye services, that's not to say that when we discuss them at the clinical governance meeting I can't still make a contribution, as I said, in terms of how we go about things and what are the patients' perspectives – what they actually need (Phase 1: Interview 1).

The extent to which nurses felt able to contribute more broadly to LHG discussions, was influenced by a number of factors. The different levels of confidence, training, and support and the different experiences and skills of each nurse were relevant. The group dynamics of each LHG and the role and influence of key board members, in particular the Chair and general manager were also important to consider. The extent to which they encouraged and responded to individual board members was highlighted by several nurses as an important factor in facilitating their contribution. Nurses also felt they initially lacked confidence and clarity with regard to their role on the board, a finding supported by Dawes and Dobson (2001) in their evaluation of nursing leadership in PCTs. Kate also highlighted the importance of having a sound knowledge base with regard to the various issues under discussion – something that

took time to acquire. As the Audit Commission (2002) suggest in their review of LHG development, board members were: '... often concerned about their individual ability to contribute to debates and decision making. These concerns frequently relate to a lack of understanding of specialist issues such as finance and commissioning' (p. 8).

In response to my question, only one nurse - Kim - appeared to argue that nurses' efforts were also circumscribed by what might be seen as more political and social factors:

> I think it's going to take time, I don't think we're there yet. I think for several reasons: one, we've never been very good at it - at speaking out and being vocal - because we've never been involved enough, that's the problem; and two, I still think there's lots of people out there who don't really understand what our actual role is and how much we actually do, what nursing actually is (A: people 'out there'?)
>
> K: meaning all the other, perhaps people on the board (Phase 1: Interview 1).

Significantly, in the above extract, Kim identifies nurses' exclusion from the policy making arena as contributing to nurses' lack of confidence and skills in 'speaking out'. She also highlights the invisibility of nursing and nursing's lack of value and worth (I will return to this debate in chapter five where I explore in more detail the difficulties and obstacles faced by nurses in articulating the value of their work and the implications this has for their role as LHG board nurses).

The way in which nurses made sense of their experiences was a key concern of mine – in particular I wanted to explore the extent to which nurses saw issues of power and identity as relevant. Whilst such connections were made by a number of nurses, for the most part, they were relatively scarce and rarely unsolicited.

It is worth adding that two GPs, Nick and David both seemed to agree with Kim's point that the nursing contribution wasn't perhaps as significant as it could have been in certain areas, because nurses had not previously been involved in policy and strategic decision making:

You know, none of the nurses will have had any practice of fundholding level negotiation and discussions and what's been going on at a higher political level, you know, boards, HA board level, because none of them have been involved there (David. Phase 1: Interview 1).

Fundholding was very much GP focused; district nurses didn't, you know, contribute to fundholding; district nurses just, they were district nurses. There hasn't been any strategic role or strategic involvement of district nurses, or practice nurses for that matter. In the NHS over the last 10 – 15 years it's very much, I mean fundholding was GP fundholding, you know, so the GPs have decided what to do with district nurses (Nick. Phase 1: Interview 1).

Nick's comment that fundholding GPs *'have decided what to do with district nurses'* is also interesting. Whilst fundholding GPs had some influence as commissioners of community nursing services, the extent to which GPs have determined district nursing practice and priorities would, I think, be questioned by nurses.

4.4.2 Progress second time round

When I interviewed nurses for the second time, they had been board members for approximately two years. For the most part they appeared more confident about their role and contribution. They seemed more certain and sure of their value and worth. One basic message remained the same. It was their focus on and understanding of patient experience, their grasp of the day-to-day operational issues, and their ability to think beyond a medically defined health care agenda that they saw as important. As Kim and Ann commented:

At the LHG level we forget the most important person isn't mentioned and that's the patient. Well, I think the nurses can always say 'Well, hang on a minute'. It's very political, it's very business, it's always on about funds, they've got all the strategies in place, but they've forgotten one important person in it - the patient - and I think we as nurses are the advocate for patients (Kim. Phase 2: Interview 2).

We keep patients as a focus, because very often you come through to the end of the board meeting and think hang on, was a patient ever mentioned there? Were the public - was health mentioned, was there anything? I mean, if you are not really focused on keeping your feet on the ground, as far as the patient being the pivotal, central person in all of health, then actually it can be lost, totally consumed by the politics, and by just the financial agenda, and that's where nurses *must* – they are crucial. As long as they do keep that focus (Ann. Phase 2: Interview 2).

For some of the nurses there was also a feeling that gradually things were changing – that nursing perspectives and attitudes were beginning to have an impact. For

example, Becky felt that her push to get the board to move away from professional concerns and refocus on the implications of decisions for patients and what it would mean at grass roots level was being heeded. As she said, 'I do feel others have started to take that on board' (Phase 2: Interview 2). Tina commented on the influence she and the lay member had in promoting a more inclusive and participatory approach to the work of the LHG as evidenced in the documentation produced by the LHG:

> Well, it could be anything that comes forward, things that go forward for commissioning, local health action plans, reviews of services, where we've said they have to be more inclusive if they are reviewing a service. 'Have you talked to the users?' A lot of the public participation stuff I can see myself and the lay member, 'Oh (...)'s word has got in there as well'. So I can see the influence (Phase 2: Interview 2).

However, not all nurses were as positive or optimistic about their contribution. Viv in particular expressed her disappointment at not being able to influence more. Whilst she felt she had been able to contribute to the general discussion at board level, she commented, 'I still don't think I personally influenced anything' (Phase 2: Interview 2). Viv appeared to attribute her difficulties to a number of factors. The LHG had witnessed a big turnover of board members and the general manager, with whom Viv had a good relationship, left to be replaced by someone whom Viv felt was less sympathetic to nursing and nurses. Having initially struggled to gain confidence at this level, Viv acknowledged these changes had left her feeling unsettled and unsure of herself. It is also evident that she never really felt comfortable operating at board level, preferring to volunteer for what she saw as the more grass roots, 'hands-on' work of the LHG.

4.4.3 The nursing contribution: my reflections and thoughts

This section explores some of my own thoughts with regard to the nursing contribution. In particular, I shall be drawing on observational data to reflect on the influence and impact of board nurses.

During my fieldwork and in the early stages of data analysis, I had initially felt rather unsure as to precisely *how* nurses had contributed to the work of the LHG. I had struggled to come up with clear, tangible and powerful examples, which mapped to

the core functions of the LHG. My uncertainty perhaps matched that of nurses during the first phase of fieldwork and reflected the general uncertainty surrounding the role and function of LHGs at the time. Revisiting the interview and fieldwork data as part of the process of writing up, it appeared that nurses had made some important contributions to the work of the LHG and by their own assessment, exerted some influence.

Nonetheless, these data also suggest that nurses were not always able to contribute as much as they would have liked (or as I would have hoped), despite attempts to do so. Nurses' relative lack of participation and influence is also discussed by Regen *et al.* (2001) in their final evaluative report on PCGs. The authors concluded that 'only a minority of nurses participated in an active manner in discussions or challenged their colleagues at board meetings' (p. 78). They also highlighted the enthusiasm of nurses compared to other board members, but questioned the sustainability of nurses' commitment, given their relative lack of influence.

Wilkin *et al.* (2000) and Dowswell *et al.* (2002a) similarly concluded that nurses lacked influence on the board. In assessing the influence of PCG board members, Wilkin *et al.* (2000) asked each member to rate the influence each individual or group had on board decisions using a five-point scale. General practitioners, the Chair and the chief officers (PCT equivalent to the LHG general manager) were perceived to be the most influential, whilst nurses, social service representatives and lay members were perceived (and perceived themselves) as far less influential. Both reports used a rating system where board members were asked to score their colleagues, although Regan *et al.* (2001) also used observational and interview data. Further evidence of nurses' (and others) lack of influence comes from Linck *et al's* (2001) study of LHGs. The authors conclude that internal partnership working within LHGs was hampered in part by the unequal power and influence of board members: 'The Executive Committee and, to a degree, GPs within LHGs were attributed by many to be the decision makers within LHGs' (p. 34).

My experiences of having observed board meetings and sub-committees and from what nurses had said, led me to conclude that nurses' visibility and the extent to which they contributed to discussions varied greatly. For example, Kate, Claire,

Rose, Sarah and Maxine appeared very quiet and seldom spoke at board meetings, whilst others, like Becky, Kim and Tina, appeared far more confident and vocal. At a HIP sub-committee meeting I observed, Becky dominated the debate; I wrote in my fieldnotes at the time that, 'her comments were coming thick and fast – I could barely keep up with her' (October 1999).

There were several occasions when I observed board meetings and hoped nurses would comment, but came away disappointed. The first was at LHG3, where the board were discussing the appointment of a new clinical governance lead as the present lead was resigning. The nurse board member present that day had been on the board for 18 months. The CGL outlined alternative arrangements in some LHGs where the role was shared between a number of board members representing the different professions. Despite this, the focus of the debate hinged on whether there were any *GPs* willing to take on the role. No one challenged this. Whilst they may have been unwilling to put themselves forward for the role, I nonetheless hoped the nurse board member present would point out that it didn't have to be a GP – after all there were several boards where the CGLs were both nurses, something they would have been aware of. That this went unchallenged legitimised medical dominance within the board.

This situation was all the more troublesome for me given that subsequent discussions with the board nurse present that day revealed their biggest frustration to be 'the GPs' and GPs' inability to recognise the contribution of other health care professions.

The second example was at a board meeting of LHG4. The board had been live for nine months. The discussion centred on the draft of the local HIP. The Local Authority representative was concerned that the HIP did not reflect previous sub-group discussions, which highlighted the importance of socio-economic and environmental factors in addressing inequalities in health. The following extract is taken from the notes I made during the meeting. Inevitably, I have not captured everything that was said at the time. These notes are reproduced here to capture the broad flow of the debate.

LA rep (Chris) challenging. Not happy with the way it has been presented. It seems the board previously met (? at their development day) and discussed the HIP/role of the LHG. Chris felt that the priorities/issues identified there, were not reflected in the HIP. Factors like housing, drugs and alcohol, socio-economic factors
He felt there had been a change to the action plan.
General manager defending: focus on what we can achieve. Local professionals / various people had been consulted and she felt that they needed to incorporate their views, otherwise they would think the consultation exercise a waste of time.
Chris not convinced. Too much focus on disease/traditional approach to health improvement. 'I thought we had moved away from that'. He thought they were, or should be focusing anew on the determinants of health e.g. environmental and socio-economic factors, which he didn't think were reflected in the HIP.
GM reiterated her point – focus on what can be achieved and need to acknowledge what local professionals - those responsible for delivering the services - feel is important.
Chris: part of the problem seemed to relate to how you defined the role of the LHG. He suggested that they would have to agree to disagree.
Chris: what they were suggesting went against the national move toward recognising the relevance of broader socio-economic factors.
GP: it was hard for the board to know how to address the broader aspects – the social determinants of health; how does the government imagine we can do anything about wealth/underlying causes? Could they say as much in the HIP? Murmurs of agreement from other board members.
Chris fell quiet after this. He didn't have much support from the rest of the board except the voluntary rep. made some comment in support.
Neither board nurses (Rose and Claire) said anything.   Fieldnotes, November 1999

This particular discussion was one of the liveliest debates I observed at the LHG board meetings. The topic was just what I had anticipated LHGs debating and getting to grips with – it was central to the core function of LHGs and touched on one of the key issues facing the health service – tackling inequalities in health.

However, I was concerned that support for Chris' views was not more forthcoming, particularly from the nurses. Given nurses' insistence that they brought a different, more holistic focus to the discussions, which challenged the traditional medical model of health, I would have expected them to have been more supportive.

There were perhaps a number of reasons for Claire and Rose's silence. To begin with they may well have been in agreement with the rest of the board and felt no need to challenge (unfortunately, I was unable to check this out with them at the time). Both nurses acknowledged they lacked confidence in operating at board level and the fact that the rest of the board, and in particular the GM, appeared to be of a different view, may have made it difficult for them to challenge.

Claire had indicated in our first interview that she felt nurses were perceived as 'second class citizens' on the board and they were doubtful whether their 'voices would be heard' – factors likely to affect their confidence. Katila and Merilainen (1999, see literature review) argue that women's silence in group discussion reflects (and reproduces) gender relations of dominance and subordination. Pam, the GM of LHG6 highlighted precisely this issue and indicated that she adopted a number of strategies, such as 'planting' questions to enable the more active participation of women on the board.

It is also worth noting that a number of reports highlight the difficulties experienced by LHGs and PCTs in addressing 'needs assessment' in relation to the HIP and have called for more training and development around these areas (see for example, Wilkin *et al.* 1999 and the Audit Commission 2002). This view is also supported by Wyke *et al.* (1999) who call for training in 'prevention-focused' (as opposed to reactive, 'demand led') needs assessment (p. 406). Interestingly, the limited influence of social service representatives on PCG/Ts boards has been attributed to the difficulties of board members in thinking more widely about health needs (Coleman and Rummery 2003).

At the same meeting, the board discussed the establishment of the Nursing and Community Services Group (see next page). Comments in the left hand side are taken from the notes I made during the meeting. Comments in the right hand side are my thoughts and reflections immediately after the meeting.

Claire (nurse) gave a brief overview of the group.	I was unsure from the board papers or from what Claire said what the role and remit of the group was.
GP Chair asked if board members had any questions. He said this several times. No one said anything.	I felt that he was pushing the board to question the nurses.
GP Chair: 'what was the feeling from the group thus far, what topics did they want to look at?'	
Claire: 'palliative care and equipment in nursing homes.'	
Dentist: were they going to be looking at health education?	
Claire: 'we could do ... anything is possible' (smiling).	I thought this a poor response. Their lack of confidence and nervousness comes across. I felt they should have given a much stronger account of what the group was for. It seemed clear that people were asking these questions because they weren't entirely sure ... (or is that unfair, was it that I wasn't sure)
GP1 picked up on the issue of nursing homes. Concern about excessive prescription requests for dressings and Fortisip (40 boxes!) from nursing homes. Murmurs of agreement from around the table. If the group were to look at regulating the requests, that would be a good thing.	
Claire: 'we hadn't thought about that.'	
GM commented that there were regulations/protocols in place which formed part of the registration and regulation of nursing homes. She implied these would address GP1's concerns.	
Visiting senior nurse commented that it was the GPs who signed the prescriptions (*and therefore their responsibility to ensure good prescribing practices?*)	This wasn't really developed into a direct challenge. Left hanging
GM mentioned that nurse prescribing was on the way in. No comment from anyone else.	
GP Chair joked that they had lots of ideas – if the nurses needed any. Claire muttered something about sticking to the easy things at first – straight forward equipment (syringe drivers etc).	

Table 2: Extract from fieldnotes of LHG4 board meeting (November 1999).

There were several aspects of this debate that frustrated me. I felt Claire's initial explanation of the role of the Nursing and Community Services Group was poor. She failed to identify the importance and relevance of the group to nursing and how the function of the group related to the work of the LHG as a whole. It seemed GPs were coming up with ideas, which reflected *their* concerns. The fact that the nurse board members didn't challenge this (although the senior nurse began to do so) was disappointing.

Simply having a slot on the agenda presented nurses with the opportunity to raise their profile – to speak and fill the public space with their voices. As the notes indicate, at the time I felt they came across as unconfident and in need of direction and help to define their work and role.

Reflecting on my disappointment, I am struck by several things. Firstly, because of my belief that nursing and nurses remain undervalued, I am concerned that nurses do well and come across and contribute in a way that I think does nursing and nurses justice. Secondly, my own experiences as a lay representative on a local PCT taskforce are relevant. At taskforce meetings, I remember being unsure of when or how to contribute. I struggled to understand how the various different strands of PCT activity came together and related to the work of the taskforce. I would hesitate before seeking clarification, hoping that it would become clearer as the discussion developed. Often I felt I had missed the opportunity to ask or challenge. I believed I had a lot to offer, and considered myself confident enough to make my views known. However, had I been observed I imagine my contribution would be classed as 'weak'.

My observational data highlighted the need for nurses to have experience of and be confident in operating at board level, something nurses themselves recognised as essential. The different factors that contributed to nurses' lack of confidence and the difficulties they sometimes faced in participating and making themselves heard, is discussed in more detail in the final sections of this chapter, and is addressed again in chapters five and six.

4.4.4 The nursing contribution: views of general managers and a senior nurse

I was keen to explore the way in which other board members judged the nursing contribution. I discussed this with a senior nurse from one of the LHGs (Karen) and three general managers, Pam, Louise and Rita. Louise and Rita both had a background in nursing. I had interviewed each of them informally early on in the research (see Appendix 1) and formally interviewed Pam, Louise and Karen during the second phase of fieldwork when LHGs had been in operation for three years.

One of the main points to emerge from these discussions was that the nursing contribution varied greatly depending on the individual concerned. Louise commented: 'Some of them have really blossomed and others perhaps haven't had the time or skills to move on'.

When asked what it was they thought nurses could bring to the board, the GM's and Karen's comments echoed what nurses themselves had told me. Keeping the board focused on the experiences of patients, and challenging the board to think broadly about the role of the LHG - 'that its business is more than paying rations to GPs' (Louise) - were seen as important. Louise also saw a great opportunity for nurses to contribute to discrete pieces of work, drawing on their operational experiences and their understanding of the health and social care interface.

Karen argued that she wanted to see nurses looking at board papers and asking themselves, 'Where does nursing fit into this?' 'How can nursing contribute to this issue?' This would require nurses to challenge traditional approaches and solutions to problems and identify different ways in which nursing and nurses could address some of these issues and improve patient care and services. Louise reiterated this:

> What I want to see is nurses in the discussion saying, 'We want new solutions to, say, some of the emergency capacity problems: why are you allocating more money for more beds in more hospitals, why aren't we doing x, y & z?' And I think what I am looking for is for the nurses to actually come with those creative solutions to the board, to offer alternative models. That is what I would be encouraging (Phase 2: Interview 1).

Whilst there was agreement that nurses on their boards were doing some of these things, all four expressed disappointment with the nursing contribution: 'I don't think nurses have grasped the opportunities they were given – they haven't really put nursing on the map the way it should've been... That disappoints me' (Karen). Louise felt that nurses needed to be more pro-active: 'They have learnt to comment, but not to be involved or participate or lead, and I think that's the next step for them'. Rita commented that the nurse board members 'were struggling with how to operate on the board, how to behave and how to bring things up on the agenda'. She was critical of nurses for being 'too operational'. For Pam, it was nurses' lack of 'global thinking' and their need to become *more* patient focused that were the issues.

There were a number of reasons which they felt contributed to nurses' lack of influence. The main one related to nurses' lack of management and strategic experience – a point also made by Kaufman (2002) and Smith *et al.* (2000).

> I think one of the problems is taking people or practitioners and asking them to fulfil *what is effectively a strategic function* and to prepare them for doing that while they are doing the job, and I think that is very difficult. And not exactly achievable (Karen. Phase 2: Interview 1 my emphasis).

> We recruited F and G [grade] nurses then put them onto a board so they had to learn a whole new set of behaviours in full view of the rest of the board. And that was an uncomfortable journey. Some of them leapt at the opportunity, but overall I don't think it was a helpful way forward.... Because you need to have people who are grounded in reality and very much patient focused, but who wouldn't be intimidated by the board type of meeting. Whereas the people who were recruited hadn't been in anything grander than their own team meetings before. They were daunted and it's taken them some time to move on (Louise. Phase 2: Interview 1).

Louise in particular felt that the nursing contribution had been significantly affected by the lack of management experience, a situation compounded by a recruitment process which failed to specify core skills necessary for the job. Not being in a position to recruit nurse managers (guidance stipulated nurse board members were to be working in clinical practice) effectively put nurses and nursing at a disadvantage, particularly when compared to other professional groups, notably GPs, who, as GPs themselves acknowledge, have far more experience of working at this level.

Whilst recognising their lack of management experience and the impact this has had, the majority of nurses felt very strongly that nurse board members needed to be based in practice – at least some of the time. In stipulating that nurses were to be recruited from practice, it appears that the policies themselves, whilst providing opportunities for clinical nurses, have to some extent limited the potential nursing contribution.

Significantly, Louise, Pam and Karen also highlighted the way in which nurses' professional training and socialisation had exacerbated their difficulty in contributing to the board. Louise argued that nurses were trained to conform and co-operate - a view supported by Mackay (1993): '... nurse training is an object lesson in submission' (p. 43). Pam also argued that the doctor/nurse relationship, in which nurses were subordinate to doctors, had contributed to nurses' lack of confidence on the board. These issues are discussed in chapter six where I explore the relationship between gender and nursing identity in more detail.

4.4.5 The nursing contribution: the views of GPs

I hadn't initially planned to interview doctors, but as the fieldwork progressed it became clear that it was important to do so. I was keen to ascertain what GPs thought about the nursing contribution and how they felt nurses could contribute and influence the work of the LHG. I hoped to gain some insight into how doctors viewed nurses and nursing and I wanted to explore the way relations of power were constructed and reproduced discursively in their accounts.

Three of the five GPs interviewed felt nurses were struggling to some extent and gave a variety of reasons for this, the principal one being their lack of experience in operating at board and strategic decision making level.

Will, the Chair of LHG3, commented that he felt nurses were generally quieter than GPs. They were faced with having to learn more, and as previously discussed, the agenda items reflected GP concerns: 'I'm sure they'll have a greater say if we have the community nursing and health visiting budget – they can influence things then' (Phase1: Interview1). Even so, he went on to argue that nurses needed to contribute

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to 'non nursing' issues as well. Ensuring they did so was, he felt, partly his responsibility as Chair, but, as he admitted, 'I know at times we get led by the doctors too much'.

Richard, the Chair of LHG4, described nurses' efforts as 'light'. He thought they were struggling to get to grips with 'committee work' and 'all the jargon and the whole world of health administration' - something nurses themselves identified as difficult in the early days (see also Smith *et al.* 2000).

I was particularly struck by what David had to say about the nursing contribution. After a long pause, he said he felt the nursing contribution was 'less street-wise in the NHS sense'. I found this comment intriguing. I felt I instantly knew what he meant. The phrase I think encapsulates a host of skills, including the critical, political and strategic thinking skills which are sometimes poorly developed amongst nurses. As David subsequently commented, 'Becky could talk to you about palliative care, you know, be really good at identifying gaps in it, but relatively weak at defining solutions' (Phase 1: Interview 1). This was something Becky acknowledged she found hard. David also commented that whilst Becky had 'great aspirations', they reflected a degree of naivety in terms of what was achievable and realistic, although he conceded that debating such issues was important:

> It's challenging, you know, it's good. We look beyond the horizon, even if we are not going to get over there. I think it challenges the orthodoxy, you know, especially GPs, you know, are very orthodox, they are not radical about anything by and large, but that's been good, that they're prepared to challenge (Phase 1: Interview 1).

David put nurses' difficulties down to their lack of experience and absence from policy and strategic decision making debates within primary care, which had hitherto focused on the needs of GPs. However, the difficulties to which Richard and David refer not only reflect the relative absence of nurses from policy debate - itself a gender issue - but perhaps also reflect the obstacles nurses face in contributing to debate within an organizational culture in which nursing values struggle for recognition. Commenting on this dilemma, Davies (1995) suggests that when nurses talk about their work and the changes they would like to see, they are accused of

being "unrealistic', 'sentimental' or 'muddleheaded'' (p. ix). This issue is discussed in more detail in chapter five.

Will also highlighted a tension between the different approaches and perspectives of nurses and doctors. He agreed with my observation that the nursing contribution appeared to represent a broader, more patient focused approach, adding it was also 'less financially biased' and less cynical than that of GPs:

> GPs are probably more focused on what we feel we can influence – whilst it may be important, we ain't going to spend thirty minutes discussing it – we can't change it anyway …What you have to try and do as an LHG is direct that type of work to a group which is going to influence it the most, so that having a load of GPs sitting on that sub-committee is going to be counter productive. One, they will be cynical… It's not because it's less value – the work's got to be done in another field. And I think that's where the nurses are right, they can bring a more holistic approach to that and I think it's important that the board does think widely and laterally and does come up with good ideas (Phase 1: Interview 1).

Whilst recognising the importance of a more social, holistic model of health, Will suggests it is not one with which doctors in general are prepared to engage. This work is pushed to the fringes and left to others – notably nurses. Will's comments relate to the wider organizational culture within health care in which alternative discourses on health – associated with nursing – struggle for expression and compete with the dominant biomedical model of health associated with medicine (see James 1991, Smith 1992 and Wicks 1998). Will's extract perhaps illustrates the way in which relations of power between doctors and nurses and medicine and nursing, as expressed through these competing discourses, are played out at a local level within the LHG.

Given the dominance of the biomedical model of health it would seem unlikely that alternative ways of talking about and understanding the issues would be viewed as equally valuable by the board. The extract from my fieldnotes of the board meeting at LHG 4, where the board were discussing the HIP (see section 4.4.3), supports this and suggests that boards may not always take alternative approaches and discourses seriously. Will's comments also appear to overlook the fact that whilst GPs may not be directly involved in the discussions, their relative power and status on the board and as board members means they still exert considerable influence over whether proposals are developed and become a reality.

Will's suggestions also rely upon nurses to some extent 'championing' this approach and being able to do so clearly and convincingly - something I have previously highlighted as problematic.

I was also interested in what Eve (female GP) had to say about the nursing contribution. I found it hard to draw her on the subject and she seemed rather perplexed as to why I should be pursuing this line of enquiry. Eve felt nurses had been 'very helpful', adding, 'it's good to have nurses on the board, they've been very useful in clinical governance... I don't think we could do it without them'. She went on to give some specific examples of nurses' involvement:

> Well, for instance, when we did baseline assessments, I had a nurse with me each time at the practice visits. We've got four nurses on the clinical governance group and, er, if I want anything done then the likelihood is that I'll bounce it off the nurses first before going forward, because a lot of clinical governance is about audit and of course the nurses are doing a lot of that with chronic disease management and so on (Phase 1: Interview 1).

Eve's use of language is particularly interesting. Re-reading these comments I am left feeling that for Eve, nurses represent a useful 'add on' - a resource and source of support to the main 'movers and shakers' within the LHG. For example, to whom is Eve referring when she states that 'we' couldn't do it without 'them'? If, as I have understood it, 'we' refers to the board, then Eve infers that nurses are not really part of the board. Her comment that 'it's good to have nurses on the board', might suggest that nurses are an optional extra. Eve's comments imply that 'the board' and 'the GPs' are virtually synonymous.

Similar issues with regard to the medical perception of nursing are raised by Wicks (1998) who highlights the way in which doctors in her study identified nursing skills in terms of those, 'which serve the medical focus, especially in relation to information gathering' (p.136). The nurse as 'information giver' was also highlighted by Manias and Street (2001 p.446) in their study of nurse-doctor interactions (see literature review). The servicing work of nurses' here reproduces a gendered division of labour between nurses and doctors. In Eve's account, nurses' skills are seen as indispensable, yet nurses themselves appear as marginal to the main game. This is reminiscent of Rosser and Davies' (1987) study of women in NHS administration.

The authors highlight the way in which the contribution of women administrative and clerical staff is seen by others as 'vital' and 'indispensable' (p. 65), yet, as with Eve's analysis of the nursing contribution, it is narrowly defined and in terms which suggest a mechanistic utility. The full range of skills and abilities of these women is unacknowledged, poorly rewarded and rendered invisible.

4.5 Chapter Summary

In this chapter, I have attempted to convey some of the enthusiasm and commitment of nurse board members, as well as their struggles. I have highlighted the different ways in which nurses feel they have contributed to the work of the LHG. Nurses appear to have articulated and called for a different approach to LHG discussion and debate. This approach is often seen as unique to nursing and nurses, in contrast to that adopted by others, notably GPs. Their efforts have focused on encouraging the board to adopt a broader, more patient-centred approach to health care. Nurses appear to have drawn upon their intimate knowledge and understanding of patients' experiences to inform the decision making process and to highlight the needs of patients, as opposed to other professional concerns. I have also discussed the nursing contribution in light of comments from other board members which suggest a consensus that nurses' lack of experience and their lack of management and political skills have weakened the impact of their contribution.

The appointment of nurses to the boards of LHGs offered a unique opportunity for nurses to contribute to health policy making and debate. However, nurses have faced a number of important challenges as LHG board members. The emphasis on a bio-medical model of health, the lack of time, the demands of their clinical work, medical power and control, and their lack of managerial and strategic experience have all limited nurses' ability to influence and shape the work of the LHG.

In making sense of the data I have found myself moving back and forth between what might be seen as straightforward gender-neutral explanations, to more critical gendered analyses. For example, the difficulties nurses have in contributing can be seen as 'simply' a lack of appropriate experience. But a feminist interpretation,

informed by the work of Davies (1995) and Pringle (1989b), suggests that the difficulties relate to nurses having to operate within an organizational culture in which the management, political and 'board working' skills deemed necessary, reflect gendered (masculine) norms and values. These norms and values deny the 'feminine', and position nurses/women as 'out of place'.

Despite the evidence to support a gendered analysis, there were times when I questioned the legitimacy of my feminist interpretation. My uncertainty in this respect perhaps reflects what Cockburn (1991) refers to as the difficulty in thinking beyond and outside the limits of hegemonic, masculine discourse 'because in doing so one is made to seem eccentric, extremist, flying in the face of reality' (Cockburn 1991 p. 169). Cockburn's argument symbolizes an important challenge for feminism and it is one that I faced in analysing and representing nurses' organizational experiences from a feminist perspective.

The remaining findings chapters further explore the issues raised in this chapter (notably those relating to the nursing contribution, identity and medical power) through the lens of gender to highlight the way in which gender is critical to understanding nurses' experiences. The next chapter begins this analysis by focusing in more detail on the way in which the nursing contribution can be seen as gendered, and highlights the implications this has for nurses' ability to influence health policy.

Chapter Five The Nursing Contribution and Gender

5.1 Introduction

Where the last chapter provided an overview of nurses' reflections and observations of their time as board nurses, this chapter develops the theme of the nursing contribution in more detail to shed light on the way in which gender can be seen as an important factor in the organizational experiences of nurse board members.

The chapter builds on and develops the literature on gender and nursing to provide additional insight into the difficulties nurses face in their attempts to influence and shape health care, by locating nurses' experiences in the context of masculine organizational culture. As indicated in the literature review, the way in which nurses articulated their worth and contribution to the work of the LHG within an organizational culture in which nursing is devalued and subordinated was central to my inquiry. Drawing on the literature on gender and organization, my concern in this chapter is also to highlight the way in which everyday processes and practices contribute to the gendering of the organizational culture of the LHG. Such an approach adds to literature which provides a macro analysis of nurses' exclusion from policy debate (see for example Davies 1995 and Antrobus and Brown 1997) by rendering visible the way in which nurses' and nursing's exclusion from the policy making arena is played out on a daily basis.

Listening to what nurses were saying, I was increasingly struck by how features of the nursing contribution appeared intimately related to issues of gender identity. Firstly, the relationship can be examined in terms of the way nurses *feel* about themselves as nurses and as women and how this impacts on their ability to contribute and find a voice. This is discussed in more detail in chapter six. Secondly, and one of the main themes of this chapter, is the way in which participants frame the nursing contribution in terms of the skills and qualities seen as unique to nurses and nursing and which relate to their identity and experiences as women. This relationship is outlined in section 5.2, in which I suggest that aspects of the nursing contribution can be seen to reflect and reproduce the gendered labour of women in

organizations. This analysis is then developed further in section 5.3, where I explore in some detail the way in which nurses themselves theorise their contribution in terms of gender. Attention is given to the way in which some nurses understand their identity and experiences as women and nurses to be of particular benefit to their role as board members. The 'fit' between nursing values and perspectives and policy guidance in relation to the role and function of LHGs is also discussed.

The second half of the chapter (from section 5.4) focuses in more detail on the implications of such a gendered analysis in terms of nurses' attempts to influence the work of the LHG. In particular, the gendered values and perspectives nurses bring to the board are framed in the context of a masculine organizational culture in which 'feminine' values and ways of being appear marginalised. Part of this dilemma relates to the difficulty nurses appear to have had in translating their skills and knowledge to the strategic function of the LHG. In addition, the difficulties some nurses experienced also relate to the problems in articulating care and the value of caring – a struggle in which gender is deeply implicated.

5.2   Making the links between the nursing contribution and gender

Amongst the research participants there was a general consensus that nurses contributed something different, something unique to the work of the LHG. As indicated in chapter four, this was often defined in terms of nurses' ability to adopt a broad, patient-centred, holistic approach to the provision and development of services. In many ways these qualities reflect the ideology of the 'new nursing' (Salvage 1992), which signals a move away from:

> ... the biomedical model, which views intervention as the solution to health problems, towards a holistic approach enabling patients active participation in care. The patient is seen as a whole person for whom all aspects of healing work are crucial (p.12).

In reflecting on the board's progress, nurses also emphasised the importance of collaboration, interpersonal relationships and group process. For example, Karen the senior nurse on LHG6 highlighted the way in which Ann had brought 'a different flavour' to discussions on clinical governance with her focus on 'process and people issues'. This was in contrast to what she saw as a more medical perspective to

clinical governance, which focused on 'the harder side of things, the outcomes, the numbers - a uni-disciplinary focus' - a point also made by Debbie (see chapter four section 4.3.1). Karen also argued that 'nurses are good at facilitating, listening… they are flexible and adaptable'. Again, this was in contrast to GPs who were seen as more 'rigid'.

Nurses' orientation to process and interpersonal issues was also reflected in their concern with the way in which board members functioned as a group and with the organizational and personal developmental needs of LHG board members and of the LHG as a whole. For example, nurses emphasised the importance of establishing and nurturing good working relationships between board members, and as a board, with their colleagues in practice. Nearly all nurses felt it important to get to know their colleagues better and believed this would have a beneficial effect on the working of the board. There was a sense of frustration that there appeared little opportunity or general willingness to do this. Tending to group process and team working did not appear to be a priority for the boards as a whole or for the secretariat who were largely responsible for the day-to-day running of the LHG. For example, Sarah had suggested a team away-day to the GP Chair of her LHG, but he had thought this unnecessary. She did not pursue the matter. Early on the fieldwork I observed a PCG board meeting where the nurse representative was a lone voice in wanting a team away-day sooner, rather than waiting 'until they had something concrete to discuss', as others – principally GPs suggested. Whilst team-building events did take place in most LHGs, these were not until the boards had been up and running for some time, often in the second year.

When asked about this, Pam - the GM of LHG2 – commented that LHGs were under great pressure to complete their HIPs and meet a series of deadlines for the Welsh Assembly Government (WAG), which left them little time to do other things. During the fieldwork I was certainly aware of the pressures LHGs were under and the amount of work they faced. Nonetheless, a statement of value and worth was being made in placing the personal and organizational development needs of the board and board members as secondary and in judging the success of these new organizations on the basis of what can be seen as rigid outcome and performance criteria (e.g. completing the HIP on time). Similar issues are raised by Metcalfe and Linstead

(2003) in their analysis of team working theory and practice. The authors highlight the privileged and (gendered) status of performance in teams, arguing that: 'The relational and processural dynamics of teams, the soft components of team behaviours, something which we link to traditionally feminine qualities, were underplayed, ignored and constructed in relation to the masculine' (p. 114).

It seems that the values and skills associated with the hands-on everyday caring work of nurses are to some extent transposed from the clinical setting to the board level; the skills and qualities that nurses claim they bring to the LHG reflect those typically associated with women. These 'soft' skills (Fournier and Kelemen 2001 p. 273) emphasise co-operation, intimacy, communication, emotionality, and a focus on relationships and interpersonal skills (Metcalfe and Linstead 2003) – skills which are also central to holistic nursing practice (Kitson 2004). Such skills were seen in contrast to those of the GPs on the board, reflecting a stereotypical gendered division of labour.

Nurses' orientation to 'process and people issues', their emotional labour and their focus on relationship building are not only central to nursing work, but are typical of women's domestic and organizational labour more generally. Whilst organizations are dependant upon such labour, this work goes largely unrecognised and unrewarded (Rosser and Davies 1987, Daniels 1987, James 1989, Pringle 1992, Davies 1995, Scott and Thurston 2004). This may help explain the general ambivalence towards attending to group process and the inter-personal and relational elements of LHG board working.

Caution is needed, however, in positioning the nursing and medical contribution in terms of polar opposites and a simple care/cure dichotomy. In the *Future Health Worker,* Kendall and Lissauer (2003) comment that: 'There are often deeply held views about the specific contribution different professionals make to the process of care, which are in turn closely related to the practitioner's personal and professional identity' (p. 7). Yet, they argue, the skills and attributes of different professionals are often shared. This point is well made by Williams (2000) in her study of nursing and medicine in primary care. Williams suggests that both nursing and medicine share core values 'about care, holism and compassion' (p 95), though these core values

have been shaped and interpreted differently by virtue of the different histories and development of nursing and medicine in primary care.

In the literature review I highlighted the intimate relationship between nursing work and gender identity. My focus here is to explore the way in which nurses' organizational experiences as *board* members (as opposed to their experiences or work in say clinical practice) can be seen as gendered. To help shed light on this issue I have turned to feminist research on women managers and women in male dominated occupations. Within such accounts, the relationship between women's organizational and gender identity is a recurring theme.

In this section I have suggested that elements of the nursing contribution reflect and reproduce the gendered labour of women in organizations. The next section develops this theme to explore in more detail the different ways in which nurses frame and make sense of their contribution in terms of gender.

5.3 Nurses theorise gender

Several of the nurses I spoke to felt that their contribution (and that of others) reflected gendered values and norms. In a particularly significant extract, Kate highlights what she sees as the 'maleness' of the board:

> Even their conversation is male. It kind of centres around, you know, they like the kind of *rational* issues – the black and white issues, whereas I think to some extent, some of these issues are shades of grey, aren't they? And even though it may sound woolly, it's going to be harder to sell some of these things because it may appear to come from that *female side of thought*, you know? And I get that sense, you know? (Phase 1: Interview 1, my emphasis).

Kate associates masculinity with rationality, and uncertainty and complexity ('greyness') with femininity. She speculates that within the male organizational culture in which she is positioned, an approach that is grounded in the 'female side of thought' will struggle for recognition. The following extract from Kate's interview perhaps demonstrates this. The sub-group were discussing teenage pregnancy - one of the LHG's key issues targeted in their HIP.

K: I mean they've put teenage pregnancy onto the HIP and the practice development group I was in, they were rambling on and on about teenage girls, until I said, 'Oh I think there's boys involved'. But nobody mentioned boys ... when they said they were going to look at teenage pregnancies on the HIP I just thought that was such a big, big subject and ... And I just get a sense that that quick fix (more contraceptive services) isn't the answer and like you said, the whole issue of who is it a problem for? Is it our problem because it isn't our expectation of life? But is it really a problem if people want to stay exactly where they are?

A: What was the response like when you said, 'there's boys involved'?

K: Somebody said, 'Oh, Kate's a feminist, look'. I said, 'I'm not being sarcastic I'm being real'. They were blaming girls.... But I did feel the need to say, you know.

A: Well done (Phase 1: Interview 1).

This extract raises several issues. Kate's comments can be seen to challenge a dominant discourse around teenage pregnancy – that of women being to blame. This discourse was very much evident at the time, when concerns regarding rates of teenage pregnancies were regular news items. Kate's attempts to highlight the complexities of the issues, suggesting other important considerations such as socio-economic factors and issues relating to personal identity and self-esteem, were met with some ridicule; in effect they were not taken seriously. But as Kate subsequently commented, it is precisely that kind of understanding and awareness that she hoped for and saw as necessary on groups such as these - a view supported by others (see for example Morgan 1999).

The 'accusation' that Kate was a feminist is also significant. One way of understanding this response is to turn to gendered organizational theory. As previously discussed, Acker (1992) argues that a number of processes underpin the gendering of organizations. These include: 'The interactions between individuals, women and men, women and women, men and men, in the multiplicity of forms that enact dominance and subordination and create alliances and exclusions' (Acker 1992 p. 253).

Listening to Kate's account, it could be argued that she was being excluded. Her comment threatens an alliance – it challenges masculine hegemonic views of women's sexuality and women's role and responsibilities with regard to their fertility. Her appeal to a more holistic, social model of health also challenges a reductionist biomedical model. The retort that she is a 'feminist' (as understood in

derogatory terms) implies she is being unreasonable and emotional – that is, not masculine.

But in making a challenge at all, Kate was also transgressing certain organizational 'rules' and norms, which stipulate gender-appropriate attitudes and behaviours. These norms reflect (and reinforce) social and cultural codes of femininity and masculinity. As a woman and nurse, Kate was expected to display characteristics stereotypically associated with femaleness, such as co-operation, loyalty, passivity (Gutek 1989). As Kerfoot and Knights (1996) observe, 'to be assertive is a violation of what it means to be feminine' (p. 97). The put down can be seen as an attempt to restore the 'gender order' (Gherardi 1995).

I witnessed similar negative responses to a nurse's contributions during my early fieldwork. I had been observing the first public board meting of a local PCG. The nurse board member spoke on three occasions. On one occasion, she asked whether plans to tackle prescribing practices included nurse prescribing. The GP concerned said he 'hoped not' to which several board members laughed. There was no further discussion. On another occasion the nurse board member disagreed that they should delay a team away-day until later in the year. Again, her challenge was greeted with laughter from some members. I felt these responses undermined and belittled her contribution and credibility.

Kate's experiences reflect the need for women to 'manage' their gender identity in order to 'fit in' within organizations. Should they fail to do so, women risk facing a range of punitive action (Sheppard 1992, Marshall 1984). This issue is discussed in more detail in chapter six.

Interestingly, a similar debate regarding teenage pregnancy took place in another LHG, in one of the sub-groups Kim attended. Again Kim was highlighting the complexities of the issue, adopting what she saw as a broader, more critical approach. In this case, however, her challenges appear to have been supported by others and met with little objection.

> They said teenage pregnancy must be put in the HIP. I said, 'Hang on now I don't agree with that,' because why are we looking at teenage pregnancy? Is it because it's costing us money? My perception is that it's a bit of a hassle – it doesn't look good on your figures and your targets especially when the government have said they want it reduced by about 50% by the year 2005 … We said this, if an 18 year old gets pregnant, it may be something she has planned, you know. Is it a problem for her? Is it a problem for a 14 year old who comes from a very loving background whose parents are very supportive? I said, 'Shouldn't we be looking at teenagers and

sexual health/relationships?' So actually they changed that. I said, 'I'm not happy to have teenage pregnancy... sexual health for young people – fine, but not...' (Phase 1: Interview 1).

I think the different experiences can in part be explained by the different levels of confidence of both nurses, their different biographies and personalities, and by the make up and leadership of the particular groups within which these discussions took place. However, it is important to note that in both cases, nurses felt strongly about the issue and drew upon a more critical approach to health and social care to question the prevailing view of teenage pregnancies as a 'problem'.

The next section highlights how several nurses felt their identity as women had been of benefit in terms of their contribution to the LHG.

5.3.1 Contributing to the board: how being a woman helped.

Like Kate, Tina also felt her contribution related to her identity as a woman and reflected what she saw as 'the female perspective'. This perspective hinged on two aspects. Firstly, the way in which women are socialised from an early age to acquire certain social skills: 'Talking to people, picking up on body language, not being so focused, or competitive and having that sort of stuff validated'. Secondly, in terms of the skills women have which encompass a broad, more inclusive approach. Tina drew on her post-graduate studies to make sense of this:

> It's a bit like, I can remember when I was doing women's studies, how the oppressed work - and the elite don't know how the oppressed work, they just oppress them, but the oppressed have to know everything about everybody to survive. *And I actually think nurses have got that, and I think women actually have got that, so that we understand a lot more of that.* That's what I felt about the medical profession, they are incredibly – I was really gob smacked by how insular they were, and how they were totally protected and blinkered - they had no clue (Phase 2: Interview 2, my emphasis).

I think Tina's comments raise several issues. Tina suggests that female socialisation encourages, amongst other things, an interest in the feelings and needs of others - the implication being that these qualities are transferred to the board and expressed in nurses' concern with inter-personal issues and group process as outlined in the previous section. The social skills to which Tina refers are similar to those outlined

by Daniels (1987). In her analysis of the relationship between women's unpaid domestic labour and paid work, Daniels draws attention to women's role and skill in the construction and maintenance of interpersonal relations and what she refers to as the work of 'making community' (1987 p. 412) – work which is central to the social fabric of life. Women, she argues, are trained in these skills:

> Their practice comes from weaving the fabric together in their friendships, families and work settings. The skill at this weaving comes from attending to the background comforts that make interaction pleasanter, from watching out for hesitances, likes and dislikes of others in the social setting and trying to accommodate them (p. 413).

However, as previously indicated, this work goes unacknowledged and undervalued. As Scott and Thurston (2004) point out, citing Fletcher (1999), organizations 'use female socialisation as a free resource, simultaneously requiring and devaluing support activities' (p. 486).

This analysis can be developed further by drawing on Gherardi's (1994) work to suggest that the skills nurses bring to the board relate to the remedial work women perform by virtue of their transgression into the male public world of work. Gherardi (1994) argues that women maintain a discreet organizational presence by taking organizational roles which 'express their femininity and the continuity of maternalism' (p. 602). Gherardi's comments are also discussed in more detail in relation to nurses' experiences in chapter six.

Tina also suggests that by virtue of their subordinate position within health care and within society in general, nurses/women develop certain adaptive skills and survival strategies and these are (usefully) applied in other areas, for example on the board. In contrast, the more powerful oppressors, (men/doctors) have no need to develop such skills. In the context of board relations, GPs are seen as blinkered and inward looking, and as Gillam (1999 p.58) argues in relation to their public health role, 'reluctant to move beyond the surgery door'.

Sam also conceptualises nurses' contribution with reference to gender and raises very similar issues. Sam argued that women's (and by implication most nurses')

'biological' advantage allowed them to 'keep more balls in the air' - to multi-task - and during debate and discussion, to 'chuck in what happens in life':

> Women are able to set their mind to numerous tasks - you do tend to change the nappy whilst you are cooking tea and taking the washing in, whereas blokes tend to have a particular mind-set and just deal with one particular issue at once. I think with regard to decision making and as we said looking at holistic issues, women have a lot to contribute because they are able to think, 'Oh yeah, this is not just about issue A' - we are able to think, 'Ah yeah, but the impact of that and the impact of that.' And I think we have instinctively, intuitively, I think women - we have a lot to bring, and because we are able to do that, I think we are able to do that well. And look at multi-issues (Phase 1: Interview 1).

For Sam, women's 'natural' ability to 'keep more balls in the air' and synthesise a wide range of views and perspectives – skills evident in women's domestic labour as wives, mothers and carers – provides nurses with the skills needed on the board and accounts for nurses' orientation to a more holistic, social model of health. Women's ability to 'chuck in what happens in life' is perhaps also because they are so intimately involved in the making of social life – as Daniels (1987) above suggests. An important feminist argument has been to highlight the way in which the skills women acquire by virtue of their unpaid caring labour in the home are drawn upon and used within paid employment, reflecting and reproducing a gendered division of labour (see for example Daniels 1987, James 1989 and Waerness 1992). Ungerson's (1983) writing is also relevant in the context of this argument. She suggests that the skills and tasks of caring reflect those commonly associated with mothering. In relation to board working, two in particular are noteworthy. They include:

> High levels of social skill in for example talking to their clients – be they very old or very young – and listening to their clients in order to assess their present and future needs;

> Skills in information gathering about other services, and ability to manipulate other services on the clients' behalf (p. 64).

These skills 'fit' well with those required to develop and commission services that are responsive to the needs of the local population – a core function of LHGs.

The argument that nurses contribute certain unique skills to the board by virtue of their gender identity and gendered experiences can be seen as one way in which

gendered subjectivities and gender power relations, in particular the sexual division of labour, are constructed and reproduced within LHGs. Bolton (2005) makes a similar point in her study of gynaecology nurses. Bolton highlights the way in which nurses actively 'do gender' (p. 175) as they draw upon their identity as women and their experiences and knowledge as mothers, partners and daughters, to support the claim that they bring uniquely feminine qualities to their work.

5.3.2. Contributing to the board: how being a nurse helped

My interview with Becky further illustrates the way in which nurses' contribution to the work of the LHG can be seen as gendered. Becky did not make explicit reference to gender during this part of the interview – it was her experiences as a nurse that she identified as being of particular relevance. Nonetheless, gender would appear to be relevant to her experiences. We were discussing what she felt she had been able to contribute to the board over the previous two and a half years.

> **B:** Well, I sometimes feel nursing is … it's not as clearly defined as some of the other professions. The medics seem to know their cut off point; the physiotherapists know their cut off point. They have a much clearer understanding of where their role starts and where it ends. I don't see nursing like that. I see nursing – nursing seems almost to hold everything together. You are never quite sure as a nurse where you start and where you finish in a consultation or in a package of care because there are grey areas.
>
> There are grey areas that I feel some professionals step away from, whereas nurses tend to get tangled up in it – either willingly or unwillingly. And that's the contribution that nursing brings … You know, I sometimes think that isn't really my responsibility, but it's landed in my lap, and I'll have to deal with it.
>
> **A:** so how does that translate to LHG level?
>
> **B:** Well, I think what it brings to it is this understanding of the big picture, much clearer. I feel as a nurse I can begin to empathise with the social side of things and the medical side of things because I am dipping into those things all the time. Dipping in, working with those people. So when there is a debate about a package of care for somebody, a clinical pathway of some description, to have an understanding of all the components is essential. And I think nurses do that better than anybody. The problem for nursing I think is when they don't do that, when they are adamant that they will keep their professional hat on … I feel I have made a contribution because I can take my district nurse hat off. And I don't think all nurses can do that – I don't do it all the time – I feel when I leave it on, my contribution to the debate is weakened (Phase 2: Interview 2).

Like Sam and Tina, Becky also highlights nurses' concern with the 'wider picture' and nurses' orientation toward a more holistic approach to discussion and debate, but she offers a different explanation as to why this is. Becky argues that nursing's professional boundaries are more blurred than those of others and suggests that as a consequence, nurses find themselves taking on work and responding to the needs of patients and the organisation, which do not appear to be their responsibility. Becky suggests that her experiences of operating in 'the grey areas' have afforded her a broad understanding of the different services available, and the way they operate and inter-relate.

Gender is implicated in Becky's account in a number of ways. Becky's comments relate to the on-going gendered struggle within nursing to professionalise. The problems of defining nursing care and lack of clarity regarding the professional boundaries of nursing work result in nurses plugging the gaps and getting 'tangled up' in the 'grey areas' which others are free to 'step away from', leaving nurses in a position of 'responsibility without power' (Davies 1995 p. 145). Becky's comment that 'you are never quite sure as a nurse where you start and where you finish … because there are grey areas', perhaps also draws attention to the difficulty nurses face in embracing a professional model which fails to take sufficient account of the messiness, emotionality, complexity and ambiguity of caring work (Davies 1995).

In calling for board members to take their 'professional hats off', Becky acknowledges the limitations of (masculine) professional thinking as characterised by introspection, independence and autonomy (see Davies 1995 and my earlier discussion in chapter two, section 2.6.2). Her comments would appear to support Davies' point regarding 'the sheer impossibility of rigid job demarcations when the paramount issue is to remain alert to the needs of the patient … and to find an appropriate way to meet these…' (Davies 1995 p.147).

Indeed, Becky saw it as vital that somebody take on the role of encouraging and facilitating board members to 'get out of our little cubby-holes and see the wider picture' – a role she acknowledged she tried to fulfil. As Parkin (1999) comments in his discussion on partnership in PCGs: 'Community nurses' broad repertoire of knowledge, experience and flexibility in approach can span the health/social care

interface, break down inter-professional barriers and enable matrix working' (p. 194).

Although she didn't mention the word 'corporacy', it seems clear that in part, this is what Becky was calling for - that board members put aside their own personal and professional interests and work together for the benefit of patient care. Becky's comments are important because the values and concerns she expressed to some extent reflect those outlined in government health policy at the time. The following section explores this in more detail.

5.3.3   Policy implications

Putting Patients First (Welsh Office 1998a) marked a new beginning for the NHS as 'a service rededicated to patients to ensure ... they have a voice in the way services are provided and developed' (p. 3). The White Paper emphasised the need for greater co-operation and collaboration between those responsible for meeting the health and social care needs of patients and the community:

> This White Paper ... seeks to establish this collaborative approach with organizations whose decisions on community services, housing, employment and the environment considerably affect the health of the people (p. 5).

> ... the Government's aim is to put teamwork and collaboration back at the heart of the NHS in a programme of co-operative activity... (p. 7).

Working in collaboration, the NHS is required to be 'people centred, managing its services for the benefit of patients and informed by patients' views' (p.7). Such collaboration means that 'competition, fragmentation, avoidable bureaucracy and insularity will be brought to an end... this will require a new commitment to partnership at every level' (p. 8).

These extracts are interesting, because they suggest a move away from those organizational features typically associated with masculinity (bureaucracy, competition, distance, autonomy and hierarchical relations), whilst endorsing those culturally associated with feminine values (collaboration, self-sacrifice, co-operation) – values evident in Becky's comments above.

This shift in focus and the emphasis on a more social as opposed to medical model of health poses a challenge to male, medical authority and power, and would appear to offer nurses an important opportunity to influence and inform the work of the LHG. However, the potential for partnership working and for change to existing gendered power relations between doctors and nurses and medicine and nursing was undermined by policy guidelines. In awarding GPs numerical advantage and key leadership positions, Welsh Office (1998a, 1998b) guidance made it clear that medical dominance within the new primary care organizations was to be preserved.

It is also noteworthy that within these publications there appears little guidance or advice as to how the ideals of partnership, collaboration and teamwork will be achieved. There is no explicit acknowledgement of the inequities in power and status amongst those expected to work in partnership, or recognition of the complexities and emotional and relational effort involved in such a project. Questions remain as to who does the 'work', or the emotional labour of partnership? Who breaks down the professional barriers? Who looks out for the community good?

With their emphasis on a broad, patient (as opposed to professional) centred approach to care, and their focus on relationships and the skills of 'making community' (Daniels 1987 p 412), it appears this work was of particular concern to nurses. But if, as I have argued in chapter four, the values and perspectives espoused by nurses sometimes struggled to gain expression and influence, the implementation of government policy as outlined in Putting Patients First (Welsh Office 1998a) may be in doubt. Effective partnership working, to some extent, appears dependent upon the relational and collaborative work typically undertaken by women, yet as I have suggested, this work is neither valued nor supported within masculine organizational culture.

Similar issues are raised in relation to partnership working by Scott and Thurston (2004) in their study of Canadian health systems. The authors studied two partnerships, one between a large Health Authority and a number of private health care providers, the other a partnership between three community-based feminist organizations tackling domestic violence.

The authors point to the way in which partnership working has become part of international health policy discourse. However, confusion and ambiguity remain as to its precise meaning and many challenges exist to turn partnership rhetoric into reality. Scott and Thurston (2004) contend that formalized health systems, embedded with patriarchal and bureaucratic practices and relations, fail to support and in effect 'disappear' (p. 500) the relational work central to the development of sustainable and effective partnerships. This was seen in contrast to the feminist organizations in which a conscious effort was made to foster and nurture collaboration and interdependence and to openly acknowledge and address power imbalances. The authors conclude:

> The invisibility of relational practice in organizations perpetuates the myth that organizations can function and grow by emphasising principles of rationality and individuality... It is in silencing relational practices that the gender power dynamic emerges (Scott and Thurston 2004 p. 486).

Listening again to Becky's account, I was struck by how she seemed to have transformed what I viewed as an occupational disadvantage, to her advantage and to the LHG's benefit. I believed that nurses' adaptability and flexibility, their positioning in ill-defined support roles and their efforts to 'willingly or unwillingly' plug the gaps in care reflected the relative powerlessness of nurses and nursing. Yet Becky (and others) drew on these experiences to provide what they saw as a valuable contribution to the LHG.

Becky, Tina, and Sam talked about the particular skills and attributes of nurses on the board in a very positive light and that they did so seems important. However, from a feminist perspective, the expression of such skills and attributes is problematic because it contributes to the gendering of organizational culture, legitimising and reproducing gendered norms and ideals of behaviour in which women's worth and work remains obscured and devalued (see also Witz 1994, Due Billing and Alvesson 2000 and Bolton 2005). As Gherardi (1994) comments:

> Whenever we try to describe what is "different" about women's position in organizations or when we attempt to set "female values" against "male" organization, we fall into a ridiculous trap. We fail to realize that we are celebrating the attributes of femininity as the second sex (p. 598).

This issue resonates with a point outlined at the end of the previous chapter. It highlights the difficulty in thinking and talking about identity and ways of being in terms which do not subordinate and de-value women, whilst operating within the confines of masculine logic and discourse (Irigaray, in Whitford 1991).

I want to conclude this section by exploring the experiences of Viv. Our interview afforded me another opportunity to investigate the relationship between gender and the nursing contribution. Viv had struggled to come to terms with her strategic role on the board and was disappointed that she had not influenced and contributed more to the work of the LHG. Viv saw herself as more of a 'one to one doer'. She found the formality of the board, and what she saw as the distancing from the everyday experiences and lives of patients, problematic. The following extract exemplifies this tension for Viv:

> I know a group was formed with learning disabilities people and I know I have said to enough people in the (LHG) office here, I *want* to be involved, I want to *do* things with people. So they said would I go down to that group, because they thought it was just my cup of tea, because the people that actually met were those clients with learning disabilities. So one of the other managers and I went along to the meeting and it *probably was the meeting where I felt most at home, because there were people in wheelchairs, there were people stuttering and stammering, people with 'Downs' who weren't able to speak and it was, oh, on the coal face* (Phase 2: Interview 2, my emphasis).

Viv's account suggests she feels comfortable with and finds pleasure in intimacy, connectedness, dependency, physicality and emotion – features associated with femininity and the caring role of nurses and women. For Viv, these features stand in sharp contrast to her organizational life as an LHG board member, which was usually dominated by board and sub-committee meetings, divorced, as she saw it, from caring work and emotional involvement, which had 'meaning' and gave her satisfaction and pleasure.

Sitting on the board she appeared to feel out of place. As she subsequently commented, 'I think I want to be with my patient more than I want to be around the table'. That the two seemed so unconnected for Viv is also significant because, as discussed above, the rhetoric of Government policy in relation to the establishment

of LHGs is precisely concerned with putting patients first (Welsh Office *Putting Patients First* 1998a*)*.

Viv's comments appear to demonstrate the tension that exists for some nurses in coming to terms with LHG life and an organizational culture which can be seen to reflect masculine ideals of distance, autonomy and abstraction, and in which there appears little scope to express and be immersed in the issues with which the majority of nurses are most familiar, and are of most concern to them.

So far in this chapter I have developed some of the ideas from the previous chapter to argue that the nursing contribution to the LHG board can be seen as gendered. Nurses' contribution is characterised by their commitment to the ideals of holism and their concern to highlight the complexities and the different influences and relations in the provision of patient care and services. They have also been concerned to address inter-personal and relational elements of board working and have argued for greater co-operation and collaboration between board members themselves and between the wider stakeholders. In this sense, their contribution can be seen as gendered, reflecting as it does the values and skills developed in the domestic sphere and typically associated with women.

All this takes place within an organization (the NHS) underpinned by masculine rationality - a rationality in which emotion, interdependence, and intimacy are suppressed (Pringle 1989b, Benjamin 1990, Davies 1995, Kerfoot and Knights 1996). Yet it is precisely nursing knowledge, grounded in the close working relationships with patients that nurses and others believe to be so central to their role as board members (see for example, RCN 1999, Kaufman 2002) and which is key to enabling the board to fulfil its function. Indeed, in an evaluation of progress in the first year of LHGs, the Audit Commission (2000) concluded: 'Some community nurses, in particular felt excluded. Contact with patients in their own homes gives them a valuable perspective on local health needs, but it was claimed their views are often dismissed as anecdotal' (p. 8).

It seems clear, as I suggested in the previous chapter, that nurses have met with some resistance at an individual and organizational level in their attempts to espouse an

alternative view. As Witz (1994) argues in her analysis of the nursing challenge to medicine, it is difficult to imagine such a challenge being successful, given that the vision of 'new nursing', 'pivots around people-centred and caring skills which are saturated with gender bias and systematically undervalued precisely because they are performed by women' (p. 39).

Nurses' experiences can be seen in the context of competing rationalities evident within health care. The male-oriented 'scientific and technical-economic rationalities' (Smith 1992 p. 193) dominate the organizational culture of the NHS, in which nurturing rationalities, characterised by a concern for human need and as expressed by the caring labour of women, may struggle for recognition (see also Scott and Thurston 2004). As Davies (1995) comments in her critique of the masculine bureaucratic ideal: '... there might be quite other styles of decision making, modes of rationality that will be difficult to articulate as alternatives because they draw on qualities assigned culturally to the feminine' (p. 56).

The remainder of this chapter explores this issue in more detail to develop additional insights into the relationship between the nursing contribution and gender. In particular, I explore some of the problems nurses themselves appear to have had in articulating and translating the value of their work to the concerns and focus of the board and locate these difficulties in the context of gender.

5.4 Articulating the value of nursing

Listening to nurses talking about their organizational lives as board members, it was clear that some experienced difficulty in articulating the value and worth of their work and translating this to the political and strategic LHG agenda. Nurses appeared to lack the strategic skills to translate the knowledge and understanding they had into convincing arguments that would effect change. This issue raises a number of questions.

Why did some nurses appear to find this aspect of their role so hard? What is it about nursing that might make it so difficult to talk about and translate to strategy?

Why is it that strategic thinking appeared so distanced from and unrelated to the caring concerns of nursing?

5.4.1 The problem of strategy

The lack of political and strategic skills of LHG board nurses was raised by a number of participants. The requirement that nurses in a position to influence and shape health policy (such as those on LHG and PCG boards) need to be able to think strategically and to exercise political and critical thinking skills is highlighted by a number of authors (Goodwin 1992, Antrobus and Brown 1997, RCN 1999, Antrobus 1999, Hayes 2003). Nurses in these roles are encouraged to draw upon their nursing expertise and knowledge and express this in a way that has meaning and influence at a strategic level. For Antrobus (1999), strategic skills are about nurses' 'ability to translate the knowledge they hold on the needs of individuals, to the needs of populations within a local health strategy' (p 53). Such nurses are also expected to demonstrate a broad political awareness, interpreting the LHG agenda and wider health policy and translating this to the everyday clinical concerns and issues facing nurses and patients.

The importance of nurses being able to acquire these skills is outlined by Antrobus and Kitson (1999) in their analysis of the skills used by nurse leaders:

> ... having interpreted nursing knowledge derived from nursing practice to the domains of political, academic and managerial, the external contextual relationship involved nurse leaders subsequently translating nursing to the language and priorities of politics, academia or management. The art to this translation seemed to be moving nursing from the invisible to the visible, so that in the translation the ideology and values of nursing were not lost, whilst nursing was positioned within mainstream thinking so that it acquired power and influence (p. 750).

As indicated in the preceding sections, the extent to which nurses felt able to draw on their nursing experiences and knowledge, and influence the strategic work of the LHG varied. Tina and Debbie, both experienced health visitors (HVs) appeared to be quite confident in this aspect of their role. Debbie spoke of her growing confidence and compared her approach to that of her HV colleagues: 'they are talking child

development and I'm thinking of long term agreements and where that will fit in'. (Phase1: Interview 1).

Tina acknowledged the importance of being able to operate at a strategic level and attributed her own skills to a combination of previous committee work, her domestic experience, her 'voracious' appetite for information and her ease with people at different levels and positions within organizations and society:

> I may well be talking to sort of assembly members or MPs one minute and going back and sorting out a mum within half an hour, and I think there is also an element of the fact that I am a mum and I have demanding children and a very demanding life and I'm also a health visitor. I go into work and deal with huge, complex, human situations and I do that all the time and I have to think about the shopping and the ironing and I think all those skills are wonderful – thank goodness I've got all that, but it actually helps (Phase 1: Interview 1).

Kate was less confident however. She compared her experiences with those of her nursing colleague on the board whom she felt was more able to operate at a strategic level by virtue of her management experience: 'she's thinking resources - now I'm not thinking like that ... we don't think like that do we, as operational nurses?' Kate described the effort involved in switching from an operational to a strategic focus: 'you're between the two really.... you're doing your clinical work and the next minute you'll be there at a meeting' (Phase 1: Interview 1).

Kim admitted to feeling anxious about her strategic skills at the outset: 'I was mostly worried about the budgeting, commissioning skills and actually was I strategic thinking enough?' Her confidence though had grown over time and she highlighted the importance of nurses being able to operate comfortably between an operational and strategic focus.

It was Becky who appeared to find this aspect of her role particularly difficult. The following extract describes her early experiences of getting to grips with LHG documentation and her difficulties in understanding the range of issues discussed at board level. Becky had been discussing the value of nursing and how she endeavoured to maintain a patient focus at board meetings:

I think probably for me because it's so new, and so early for me and I'm trying to get my head around the things I am unfamiliar with, things like the strategies and how they put these documents together, um, some of that more important part of me gets left behind. And all of sudden it will re-emerge and something has triggered it off, and I think when I have come to terms with that, when I get more experienced in being part of a forum like that and dealing with those strategic issues, then I think *my true nursing voice will develop*. I think I can do it, but I don't think I am doing it as well as I should do at the moment. Because I am trying to learn the unfamiliar things and acquaint myself with them (Phase 1: Interview 1, my emphasis).

There are a number of different readings of this extract. One reading might suggest that Becky is getting to grips with the various board procedures and learning how to function as a board member. As her confidence grows and she becomes more skilled at moving between an operational and strategic focus, she will be able to contribute more fully. An alternative, feminist reading might suggest that the difficulty she finds in expressing her 'true nursing voice' (as perhaps embodied by a caring, collaborative, patient-focused approach) reflects the contradiction and conflict inherent in trying to assert the value of that which appears devalued within a masculine organizational culture.

This culture embodies masculine rationality as expressed through formality, detachedness, impersonality, and the denigration of the feminine (Pringle 1989b, Davies 1995, Kerfoot and Knights 1996, Ross-Smith and Kornberger 2004). In the context of the health service, it is also a culture in which nursing knowledge struggles to gain credibility and legitimacy. As Hagell (1989) suggests, nursing has a distinct knowledge base which 'stems from the lived experiences of nurses as women and as nurses involved in caring relationships with their clients' (p. 226) and as such, resists categorisation and definition within masculinist science and management.

Antrobus (1997) raises a similar point when she highlights the difficulties nurses have in operating within the clinical effectiveness agenda: 'The present context, through this agenda is demanding a language of outcome and certainty, which has the effect of reducing an holistic concept into a fragmented and mechanistic construct for the purposes of others' (p.452).

To return to Becky's discussion, there appears little space on the board for matters of a caring nature – at least the 'language' of caring appears at odds with the 'language'

of strategy. Becky's difficulties are compounded by the formality and impersonality of the various bureaucratic procedural and linguistic rules of the board (for example, those relating to the presentation of board papers), which further distance her from the daily experiences and concerns of patients that underpin her nursing voice.

The following extracts illustrate this dilemma and the difficulty Becky had in trying to express her everyday caring concerns in a way that would have meaning and influence. Becky lamented what she saw as the disconnection of the strategic function of the LHG from the everyday operational issues:

> How will we ever deal with the individual experiences of patients, or will it always be done in a big strategic way? How do you influence the big strategic issues with your knowledge of the everyday?' (Phase 1: Interview 1).

For Becky, the two modes seemed in opposition and conflict. On several occasions throughout the interview she questioned the legitimacy of her approach:

> I sometimes think, well maybe I am too basic, maybe I am bringing people back to, um, too much to the coal face and the nitty gritty. But then I think if you are really going to improve quality to patients it's going to be done by individual people, isn't it? (Phase 1: Interview 1).

Listening to Becky, it appeared she valued deeply the nursing knowledge and insight she gained from her clinical experiences and the importance of an operational focus in improving patient care, but she understood it wasn't enough, or at least it lacked something. It needed changing, translating. Becky's struggles resemble those of Viv, who as indicated in the previous section, found great difficulty in operating in a context she saw as divorced from the intimacy and connectedness she so valued.

I would argue that the difficulties Becky and others face will not be resolved by further training and development around leadership and strategic thinking, useful though that may be. Neither, I would argue, are these difficulties simply a reflection of the tension between a top-down public health agenda and a bottom-up approach to policy and service development, grounded in individual patient experience (Goodwin 1992). The problems need to be viewed in the context of a society and organizational culture in which the words, feelings and experiences of women (nurses) struggle to

gain expression and meaning. This point was well made by Tina in our second interview. I was keen to hear how she made sense of the difficulties nurses experienced in informing the strategic function of the LHG:

> A: Nurses appear to struggle to translate what they feel passionately about in terms of health inequalities and what should be done – they don't know how to translate that into a meaningful discourse or message or action that … (interrupted).
>
> T: The men will accept!

Significantly, a number of authors have highlighted the relationship between strategy, strategic management and masculine rationality (Knights and Morgan 1991, Kerfoot and Knights 1996, Ross-Smith and Kornberger 2004). In their exploration of managerialism and masculinity, Kerfoot and Knights (1996) draw attention to the centrality of strategy to contemporary management discourse. They argue that a focus on strategy (being 'proactive and future oriented' p. 82) reflects a masculine drive for control and conquest and a preoccupation with 'ordering the world' (p. 82). They comment that strategic management:

> … involves a disembodied and emotionally estranged conception of reason … that attaches itself to a ceaseless pursuit of strategic goals, the attainment of which confirms the promise, though rarely the reality, of a secure masculine identity (p. 83).

Reference to a rationality that is 'disembodied and emotionally estranged' resonate with Becky's comments above and relate to the earlier point regarding a masculine rationality in which a focus on everyday, intimate, caring concerns such as those expressed by Becky, seem out of place. Kerfoot and Knights' argument allows the struggle Becky and others had in operating (and gaining influence) within the linguistic and discursive practices of strategic and health policy planning, to be seen in the context of masculine organizational culture.

At Becky's second interview, I reflected on her early struggles to interpret and translate her nursing knowledge to the strategic function of the LHG. In what, on reflection, was a leading statement, I suggested that she had appeared 'alienated' from the process:

B: I think you are absolutely right, yeah; I probably was alienated and probably still am at times. I don't say the right things at the right time. I can only speak and think in a pragmatic way, on a day-to-day basis. I'm not always clear about how to get across what it is I want to say in order for somebody to think about changing something as a result of what I think. *I don't know what it is I don't do.*

Long pause...

I'm listened to and I do contribute and I think my contribution is valued. On the other hand, *I don't think my contribution is structured enough and I don't know how to turn that contribution which is valued, into action then for something to happen.* I'm trying with this Community Nursing Services Review. There are times when I think I am not doing this very well. I should be doing something different. I don't know how to do it. I think there are some nurses who do, maybe those that are executive nurses, I don't know.... (Phase 2: Interview 2, my emphasis).

This account appears to highlight Becky's lack of confidence in operating at a strategic level. It can also be read as more than that. She comes up against an organizational culture in which her language and her way of understanding are experienced as inadequate. Whilst she sees her contribution (which is grounded in her operational experiences) as being valued, it nonetheless lacks influence. Becky appreciates that she has to change something, but, 18 months on, still doesn't know what it is, or how to do it. She continues to see the problem as hers – it is her lack of experience and skill that is the issue – it's a battle she has to overcome.

I think Becky's account also illustrates the 'work' which this dilemma presents. Acker's (1992) analysis of the gendering of organizations is relevant here. As indicated in the literature review, Acker argues that organizations create various images, rules, and ways of being and of understanding the world, which reflect and legitimise gender divisions. Further gendering occurs as individuals make sense of and negotiate these various structures and meanings. However, as Acker argues, 'such internal mental work helps to reproduce divisions and images even as it ensures individual survival' (p. 254). As Becky struggles to find the words and means to communicate in a way that makes sense to others she is nonetheless partaking in and legitimising an organizational culture which marginalizes certain ways of being and forms of expression, whilst privileging others. In this way, gendered power relations, which continue to exclude and silence women, are reproduced on the LHGs. As Ross-Smith and Kornberger (2004) suggest, when organizational members participate in and practice the discourse of strategy, 'the

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identity of these subjects and the organizational reality they enact ... is masculine'
(p. 295).

The nature and significance of the obstacles nurses face in their attempts to influence
health care policy and decision making within organizations is clearly spelled out by
Antrobus (1997) and Antrobus and Brown (1997). In their discussion on
commissioning and nursing, Antrobus and Brown (1997) reflect on the absence of
nurses and nursing issues from the health policy arena. They argue that
commissioning (a core function of LHGs) has clear implications for nursing practice
and provides a key opportunity for nurses to influence patient care and services at
both a strategic and operational level. However, within the 'rationalist culture of new
public management' (p 313) achieving such influence is problematic:

> A new language is therefore required that does not lose nursing's essential value
> system, yet fits the context of power and politics, targets and indicators, as part of a
> scientific and objective approach to healthcare. The challenge for nursing remains, to
> function within a context that refuses to value caring (Reverby, 1987) whilst
> influencing that context with clearly articulated arguments that translate the nature of
> caring into the language of the market (1997 p. 313).

I think this is precisely the problem nurses face. I also wonder how possible it is to
overcome it, if we view nursing as being experienced, constructed and defined in
opposition to a 'scientific and objective approach'? Nursing stands as a powerful
metaphor for the irrational, the subjective, the emotional, and the feminine - all that
is denied and positioned as out of place within masculine organizational culture
(Davies 1995).

The difficulties in translating the nature of caring to the strategic function of the
board is also compounded by the difficulty in defining and articulating 'nursing's
essential value system' and what it means to care. The following section explores
this issue in more detail.

5.4.2 Articulating care and the value of caring

The problem of articulating and conceptualising care in relation to nursing is
discussed by a number of authors (see for example, Roberts 1983, Benner and
Wrubel 1989, Attridge and Callahan 1989, Smith 1992, James 1992, Davies 1995,

Wicks 1998, Bergen 1999). It was this issue which Louise (a nurse and general manager of LHG7) identified in our discussion on the challenges facing nurse board members:

> There hasn't been a tradition of articulating what the nursing contribution to care in general has been. It's very difficult to pin that down for researchers so the nurse in the street might find that difficult (Phase 2: Interview 1).

The RCN's recent publication *Defining Nursing* (RCN 2003) also highlights this issue, commenting on the difficulty encountered by project participants in defining elements of nursing and in articulating the nature of nursing knowledge.

When I first asked nurses what it was they thought they could bring to the LHG as nurses, many struggled to answer. I found I had to probe and sit with silence whilst we both sought the words and language we needed. It took several 'goes' to arrive at the kind of questions and responses that seemed to make sense, but even then I don't think we were always sure that we had 'got it right'. I experienced this tension again when it came to data analysis and interpretation. I found I had to work hard to unpick and unravel nurses' accounts in order to appreciate the nursing contribution.

Wicks (1998) highlights a similar research experience in her study of nurses and doctors at work:

> When asked directly to talk about an area of excellence in their work which they felt proud of, most nurses went quite literally blank. This forced me to review my interview methods with a view to coming at their attitudes and practices in a more indirect way. I then found that discourses around skill were, in a sense, woven into the picture of work and knowledge (p. 145).

Wicks (1998) draws on the work of Ungerson (1983) to locate this issue in the context of gender power relations. Wicks suggests that the difficulties nurses have in articulating and naming the skills of caring, relate to the 'masking and veiling of skilled [nursing] work' (p.144), which is portrayed as simply the intuitive caring labour of women. In addition, Reverby (1987), citing Graham (1983), argues that "'Caring touches simultaneously on who you are and what you do''. Because of this duality, caring is an unbounded act, difficult to define, even harder to control' (p. 1).

The problems facing nurses can also be interpreted in light of women's absence from the means of knowledge production (see for example Smith 1987). As Marshall (1984) comments:

> Women's absence from this process has contributed to their invisibility and to the omission of their meanings – either in terms of symbols or structures of thought – from language and science.... In speaking and writing, women are therefore using what is to them a foreign language, because it does not include direct reference points for their experience. Women must engage in a *translation process to convert their meanings into male terms and forms of speech in order to express them in socially understood and accepted terms* (p. 51 my emphasis).

Perhaps this is the dilemma nurses' face in their attempts to articulate and then translate the value and meaning of their work at board level. Not only might nurses struggle to define and name what they do, but when they succeed, it doesn't 'fit'. Becky's comment that she 'can only speak and think' in a certain ('pragmatic' and 'day-to-day') way and that this way appears to lack power and legitimacy may reflect this dilemma. If women are denied by the 'patriarchal linguistic order' (Irigaray 1993 p. 20), then this has particular relevance for nurses, who, by virtue of their work roles, embrace cultural conceptions of womanhood:

> Patriarchal cultures have reduced the value of the feminine to such a degree that their reality and their description of the world are incorrect ... This accounts for the fact that women find it so difficult to speak and to be heard as women. They are excluded and denied by the linguistic order. They cannot be women and speak in a sensible, coherent manner (ibid. p.20).

Indeed, this is perhaps the predicament to which Louise refers when she comments in relation to the nurses on the board of which she was general manager, 'it's almost as if they find it difficult to speak'.

In trying to make sense of the difficulties some nurses experienced in operating at a strategic level, participants also raised a number of other issues. For example, as indicated in the previous chapter, Louise and Karen both highlighted nurses' lack of political and management experience and skills and the detrimental affect they understood this to have on nurses' ability to think strategically. However, highlighting nurses' lack of skill and focusing on the need for greater training and development around these issues (see for example Goodwin 1992 and Antrobus

1999), risks obscuring the oppressive practices and relations within which nurses are expected to perform and operate.

This point is well made by Davies (1992) in her analysis of management style in nursing. The thrust of her argument is to challenge the 'gender talk' (p 239) evident in a number of nursing and sociological texts. Davies (1992) calls for a more thoroughgoing gendered analysis that moves away from a theory of gender attributes (nurses are passive, hierarchical, bitchy, collude with their oppression) to a theory of gender relations that takes account of the many and complex ways in which such relations are maintained and reproduced at the level of organisation. Davies (2004) expresses similar concerns in her recent review of political leadership within nursing. She suggests that whilst political leadership development for nurses is useful, focusing on the failings of individual nurses is not helpful. Instead, nurses 'need to be able to acknowledge the power of external forces and the way in which these may work against even the most skilled and aware' (p. 236).

Charlie, an experienced community nurse offered another perspective on the difficulties nurses' faced in informing the strategic function of the board. He agreed with my observation that nurses found this hard and referred to the medically-led agenda and the 'diversity of nursing' as contributing factors. He made the broader point that strategies for meeting the National Service Framework (NSF) and clinical governance targets reflected a medically-led agenda.

> **C...** certainly it's easier for others like doctors, dentists, opticians and pharmacists ... because some of our work in the community isn't as tangible as, say, a doctor or dentist seeing so many patients, so many dental patients having treatment, or are on a certain drug, whereas with us, it's less so. It's less easy to prove your worth.
>
> **A:** So it's not as easy to articulate the value of what you do?
>
> **C:** Because of the diversity of nursing to start with. I mean if you've the doctor representative there, it's a lot easier for him to say 'Well, the other twenty GPs in the area are saying this', as opposed to someone like me saying, 'Well, this is what some of the HVs are saying, this is what some of the DNs are saying and this is what maybe some of the PNs are saying'. But it doesn't happen like that a lot of the time. A lot of the time it's Fiona and myself thinking, 'Well, how would nursing - how could we best approach this from a nursing perspective?', which isn't always the best way of doing it. The Nurse Forum is there to help, but it doesn't always work that way, so to take forward what you are saying is very, very difficult. Because you have such a diverse profession in nursing anyway, plus the fact that some of the

things we do aren't tangible ... It's much easier for other people to prove their worth ... and it can be a weakness. I don't know how we can get around it to be honest, but it's certainly a weakness as I see it... (Phase 1: Interview 1).

This raises several issues. Firstly, it relates to the earlier point regarding the challenge in articulating the value of nursing and Antrobus and Brown's (1997) comment regarding the difficulties nurses face in operating within a world of 'power, politics, targets and indicators' (p.313). The worth and value of nursing work is rendered invisible when set in the context of medically defined criteria and as Antrobus (1997) suggests, 'Feminine values in a masculine defined market and management style is *(sic)* fraught with difficulties of representation'(p. 451). Nursing is obliged to adapt and fit in. The difficulty it has in doing so compounds nursing's marginalisation and invisibility; as Charlie indicates, it's less easy for nurses to prove their worth.

Charlie also suggests that the diversity of disciplines within nursing limits the ability of the two nurse board members to influence the LHG agenda from a nursing perspective. They are required to identify the nursing contribution to health care - something I have previously argued is problematic - and to do so in such a way that captures the different philosophies and priorities within the various nursing disciplines. Rafferty (1992), Billingham and Glasby (1998) and Kaufman (2002) also highlight these differences within the profession as an important issue for those representing nursing at policy level. In addition, Charlie speculates that presenting a plurality of voices and perspectives carries less influence. In this respect, nursing is at a disadvantage when compared to GPs, who can rely on some consensus of opinion with regard to the burning issues they face as a distinct group of board representatives.

The difficulties nurses have also need to be considered in light of findings which suggest that a lack of strategic thinking skills is an issue for *all* board members:

> There's a lot of work to be done in developing the board, getting them to understand their roles and to think strategically (chief executive cited in Smith *et al.* 2000 p. 43).

PCG's priorities for health improvement reflected national priorities, but there was little evidence that these have yet been translated into clear local strategies or targets (key finding from *National Tracker Study*, Wilkin *et al.* 1999 p. 62).

A further difficulty between GPs that SSRs (Social Service Representatives) highlighted was GPs relative lack of experience in thinking strategically about the needs of a population, rather than the clinical needs of their individual patients (Coleman and Rummery 2003 p. 278).

Indeed, that nurses were not the only board members to struggle was reiterated by several of the GPs with whom I spoke. During the interviews, I asked about the difficulty nurses appeared to have in operating at a strategic level:

> But it is a difficulty for GPs as well - we come from the same mindset really. (This mind set related to the fact that nurses and doctors were both practitioners and 'not trained to think in terms of populations'). (Richard. Phase 1: Interview 1).

> Well, I think none of us know how to do it... the nurses are as good or as bad as anybody else (Eve. Phase 1: Interview 1).

David felt the board needed more help and support from the Health Authority in developing the skills and knowledge to fulfil its strategic function:

> We could be more informed. And that particularly applies to the lay people, some of the GPs and some of the nurses, you know. 'Cause if you are not facilitated and able, then you can't contribute to the extent - you bring your clinical experience to it, but that has to be balanced with a bit of strategic understanding and that isn't there, you know. So what happens is people get bogged down on sort of operational issues. (David. Phase 1: Interview 1).

This is precisely the point made by Harvey (1994) who argues that strategy is a poorly understood and applied concept in the NHS.

In light of my earlier thoughts, I wondered how to make sense of these comments. I think there are a number of issues. Clearly as practitioners not accustomed to operating at a strategic level, board members are 'in the same boat'. However, the experience of having to develop and utilise those skills perhaps means different things for different people depending on their confidence, credibility and power within the organisation.

For example, as Charlie indicated above, the medically-led agenda and GPs' previous involvement in commissioning would appear to provide them with more scope to influence. And as Regen *et al.* (2001) concluded in their final evaluation of PCGs, medical dominance of the PCG agenda and meetings remained an issue. This needs to be set against their findings in relation to nurses:

> The nursing contribution to PCG board working is highly valued, but concerns surrounding the influence of nurse board members remain (Regen *et al.* 2001 p. 75).
>
> More needs to be done to facilitate the contribution of nurses to PCG/Ts at a strategic and policy level (ibid. p. 84).
>
> While nurses were pleased to be involved in the work of PCGs, they remained much less influential than their GP colleagues... (Wilkin *et al.* 1999 p.14).

For nurses the difficulty they have in operating between the grass roots and the strategic seems to go beyond a simple matter of learning the right words and phrases - it can be experienced as deeply problematic and contradictory. Nurses' marginal status perhaps also detracts from what they say – a situation unlikely to be experienced by GPs, who occupy a powerful organizational and social position. As Smith (1987) suggests: 'There seems to be something like a plus factor that adds force and persuasiveness to what men say and a minus factor that depreciates and weakens what women say' (p. 30).

Finally, because individual men and GPs also struggled to adjust and develop new skills as board members does not, I believe, undermine the argument that organizations, such as LHGs, reflect and reproduce a masculine organizational culture. Rather I think it illustrates the complexities involved. Individual men and those whose interests are best served by the various rules and procedures reflected in the organisation are similarly required to fit in and adapt. But a range of factors make it easier for them to do so, and in this case any difficulties they have are ameliorated by their significant professional, numerical, and gender dominance and the advantages these bring. It is worth noting that as a male board member Charlie believed his gender identity held little advantage. He argued that he was seen as 'just a nurse' – his nursing identity overriding and negating the benefits of his identity as a man. This issue is discussed in more detail in the next chapter.

5.5 Chapter Summary

In this chapter I have focused on the nursing contribution to explore in more detail the role of gender in nurses' organizational experiences. In particular, I have highlighted the way in which nurses' gender and occupational identity and experiences are reflected in their various approaches, values and interests as board members and how this contributes to the ongoing gendering of organizational culture as nurses call upon and reproduce gendered subjectivities and relations.

The chapter draws attention to the devalued and subordinate status of the caring work of women and the impact this has in terms of nurses' ability to contribute to the decision making process, particularly at a strategic level. Given that the nursing contribution reflects skills and values typically associated with women, nurses' attempts to influence within an organizational culture reflecting a masculine vision are fraught with difficulty. Interpreting the concept of strategy as a gendered (masculine) concept, this chapter suggests that calls for nurses to develop their strategic thinking skills in order to exert greater influence within policy making are highly problematic.

To return to the quote from Antrobus and Kitson (1999) cited at the beginning of section 5.4.1, if board nurses are to fulfil their potential and contribute fully to the work of the LHG, then it is essential that they articulate clearly the values of nursing and move nursing 'from the invisible to the visible'. But this chapter suggests that translating nursing to the language and priorities of others is not as effortless or as straightforward as the above extract implies. For some, it represents an enormous challenge of thinking oneself 'in' - as Rich (1979) suggests, of 'having to tell our truths in an alien language' (cited in Marshall 1984 p. 51). This chapter demonstrates not only that gender is critical to understanding the organizational experiences of nurses as LHG board members, but also the importance of analysing these experiences in the context of masculine organizational culture.

The difficulties nurses have in contributing to the board implicate gender identity in other ways too. As indicated in the introduction of this chapter, participants' self-

image as women and nurses also impacts upon their experiences as board members and their ability to contribute and find a voice. This is the subject of the next chapter.

Chapter Six   Identity

6.1 Introduction

The previous chapter and this chapter both address nurses' experiences in terms of
their devalued and subordinate identity within health care and the implications this
has in terms of nurses' ability to contribute to the work of the LHG, but they do so in
different ways. Chapter five highlighted the way in which participants drew on their
experiences as women and nurses to *inform* the nursing contribution, and the
particular difficulty nurses faced in articulating nursing values within an
organizational culture in which such values are marginalised and rendered invisible.
This chapter focuses on nurses' own understanding of what it feels like and what it
means to be a woman and nurse on the board, and how nurses' self-image and sense
of self impact upon their organizational experiences and in particular, their ability to
contribute to board activity. The extent to which nurses view their occupational and
gender identity as related is also explored.

My interest in these issues arose from my review of feminist literature which
highlights the significance of personal identity in women's organizational
experiences. The difficulties facing women in a masculine organizational culture are
particularly marked for nurses. As previously argued, nursing identity is closely
related to femininity – as such nurses embrace cultural conceptions of woman as
Other. This chapter contributes to an understanding of how individual nurses
experience and negotiate this dilemma.

The chapter is divided into four main sections. The first section (6.2) explores
nurses' perception of the meaning and impact of gender in terms of their identity as
women (and men). Whilst some felt their gender identity was relevant, others did
not. However, nurses' accounts in this respect were often contradictory and
ambiguous.

Section 6.3 continues to explore the role of gender, but in the context of nurses'
occupational identity. I have sought to understand nurses' accounts by highlighting

the interrelationship between nursing and gender identity. This relationship was something only a minority of the nurses within the study acknowledged.

In section 6.4, I outline the way in which nurses drew upon a range of strategies in an attempt to cope with and manage their devalued gender and occupational identity. Section 6.5 concludes the chapter with a discussion on how we might make sense of the ambivalent and contradictory position of gender in nurses' accounts.

6.2 Gender identity: meaning and impact.

The purpose of this section is to look in more detail at the way in which the nurses themselves theorised gender as a feature of their organizational experiences. In particular, I wondered how aware or how conscious nurses were of their identity as women (or men) and the extent to which they felt their identity as women (or men) informed their organizational experiences. For example, I wanted to explore whether nurses' gender identity was experienced as disadvantageous in any way. Did being a woman (or man) matter?

My thinking on this subject has been influenced by the work of Marshall (1984) and Sheppard (1992). Both authors highlight the contradictory place of women managers within organizations. One of the principal findings of Marshall (1984) and Sheppard (1992) was the way in which women were compelled to 'manage' their gender identity in order to 'fit in' and pass as legitimate organizational members. Their work also addresses the extent to which the women themselves view their gender identity as being relevant to their experiences. This was something I was particularly interested in exploring in relation to nurses.

Marshall (1984) and Sheppard (1992) highlight the contradiction and confusion evidenced in participants' accounts when they talked about their identity as women and the impact this might have had. Marshall comments:

> As a group, the managers were strongly against identifying themselves as disadvantaged ... I realized that despite my espoused detachment there was a sense in which I somehow disbelieved the speedy majority response that being a woman was not important. Intuition told me that this was an incomplete answer at best... I

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soon realized too that the managers themselves contradicted this response in comments about gender and their awareness of it and often passionate discussions of attitudes or behaviour they adopted to overcome the disadvantages of femaleness. These were clues that I should probe more deeply. As I drew together relevant elements, a more complex picture, with conflicts between different levels of expression, emerged (1984 p.149/150).

This was very similar to my experience of talking to nurses. The majority denied they were disadvantaged because of their gender, even if they did acknowledge gender was relevant in other ways. I too doubted nurses when they said this. My 20 years experience as a nurse, my conversations with others during this time, my reading, my observations, and my own feminist philosophy compelled me to look beyond what was being said to make gender visible. I too found the picture that emerged complex and at times contradictory.

As Marshall (1984) had done, I decided to leave any mention by *me* regarding the relevance of gender until late in the interview. I wanted to see if *nurses* identified this issue as important. If nurses had not mentioned gender, I would then introduce the topic in the interview as follows: *One of the things I am interested in is the role of gender in nurses' experiences of being on LHGs. Does that bring anything to mind?* Depending on the response, I would probe further and ask whether they felt being a woman had an impact on their experiences and whether as board members, they were aware or conscious of their identity as women.

During the initial interviews, two of the 15 nurse participants, Tina and Kim, mentioned gender as significant and discussed their identity as women without my raising the issue. After I had introduced the topic, a further six nurses acknowledged that in different ways and to varying degrees, gender was relevant to their experiences. The remaining seven felt it was irrelevant and played no part in their organizational lives. As indicated above, what struck me about some of the comments was the way in which gender appeared (to me at least) deeply implicated in nurses' organizational lives, yet was denied by nurses. For example, several nurses highlighted the doctor/nurse relationship as relevant to their experiences, but rejected my tentative suggestion that this relationship could be seen as gendered. Charlie argued that the relationship was defined more by 'professional issues', whilst Debbie felt that it was 'GPs' ownership of patients' that determined the power relationship

and 'not gender'. The individual and collective lack of power and status of nurses and nursing was identified by all the nurses, but few saw this situation as having anything to do with gender. This issue is a recurring theme throughout the chapter and one I shall be discussing in more detail in section 6.5.

6.2.1 Gender as relevant: unprompted responses

Tina frequently referred to gender as a key element in her organizational experiences. As indicated in chapter five, Tina felt her identity as a woman was significant in terms of the way in which she contributed to the work of the board. But it was also important in other ways. Tina commented that she was 'always' conscious of her identity as a woman when she attended LHG meetings – an awareness which she attributed to having done an MSc in Women's Studies.

At our first interview Tina recounted her experiences of attending an executive meeting and describes her shock at the way the meeting was conducted. Tina had been asked to support the executive (comprising all men except herself) on an issue of which she had no prior knowledge or understanding. She had refused until she was properly informed. Her actions were met with some hostility, which she attributed to the fact that she was a lone woman confronting men within a male dominated culture. Tina claimed that thinly veiled threats to her position as an executive board member were made. She described 'getting foetal' as she felt increasingly under attack:

> It's going to be very, very difficult because you are one person coming up against a whole culture, but it's male dominated, it's patriarchal, it's all those things...

> So that has been an eye opener, but I know about it theoretically because my MSc is in Women's Studies, so I thoroughly understand it, but *it is very different when you're in amongst it and you realise it's a clash between cultures* who have a completely different set of, um, mind sets, attitudes, beliefs, even though you are the same race and even though you are probably the same class – I think class comes into it as well – um, and gender definitely comes into it, because, you know, you have to make yourself heard, because you can be ignored (Phase 1: Interview 1, my emphasis).

I think this extract highlights several issues. Tina's reference to a *'clash between cultures'* resonates with the discussion in the previous chapter. She expresses feelings of shock and alienation when faced with what she perceived as the maleness

and masculinity of the LHG. In spite of what she sees as important similarities with other members of the board, it is the difference and 'otherness' which she feels and experiences. And whilst her academic background enabled her to make sense of these experiences, the reality left her feeling overwhelmed. Being confronted with and having to operate effectively within such a culture was to prove a huge challenge for Tina.

Whilst Tina clearly felt that being aware of gender and the role it played in shaping her experiences was essential ('knowledge is power'), such an awareness may not be without its drawbacks, as Marshall (1984) and Muff (1982c) suggest: '...for those nurses who have become *conscious*, who seek change, the struggle is a daily one and takes its toll' (Muff 1982c p. 148).

Kim also mentioned gender without prompting. She had been talking about the way decisions were made on the board and how she thought everyone had an equal say.

> **K:** I'm quite lucky because I thought, 'Ooh, how many women are going to be on it - but we've got quite a few women, we've got, um ... about eight women, almost half.
>
> **A:** And does that make a difference?
>
> **K:** I think it does actually; I mean initially we all used to group together - the women. It was myself, the other nurse, the voluntary member, the lay member and the optometrist. We all used to group together. And then they started splitting us up and I think that's the best thing they've done, and since then our rapport with our male colleagues has improved... (Phase 1: Interview 1).

Whilst gender is initially seen as relevant in terms of the ratio of women to men and the way each grouped together, such gender divisions assumed less relevance and importance as board members got to know each other. Certainly, participants frequently cited getting to know their colleagues as an important factor in overcoming traditional divisions and obstacles. This ensured closer, more effective working relationships.

The above extract outlines the extent to which Kim felt her identity as a woman was of relevance to her organizational experiences. However, throughout both of Kim's

interviews she refers to *nursing* identity and the way in which she struggled to make sense of her individual (and nursing's collective) lack of self-esteem and value. Whilst not explicitly implicating gender, within her narrative Kim makes implicit reference to gender. This issue is discussed in more detail in section 6.3.

6.2.2 Gender as relevant: prompted responses

Following my prompts, those who did identify gender as relevant gave a variety of responses. For example, Viv also commented that she was keen to know how many women were on the board and was disappointed to find they were in the minority.

> **V**: But I was cross with myself because I was making the barriers there you know, I was noticing that there weren't any females when it shouldn't have even been relevant to me. I should have just …. (trailing off).
>
> **A**: But why do you think it was relevant?
>
> **V**: Because I feel very strongly that women's voices aren't heard as much as they should be. And that with the powerful, forceful GPs anyway being all male, it was perhaps going to be bit more of a battle for us to be heard (Phase 1: Interview 1).

Viv's annoyance with herself for noticing the number of men and women on the board is interesting given that she readily acknowledges the barriers women can face. Viv later commented that, 'the male voices are heard a lot more than the female voices without a doubt'. The general manager of the LHG whom I subsequently interviewed (Pam) supported this view. In order to address this issue she would prime female board members with certain questions for them to ask during the board meeting. She saw this as a useful way of raising their profile and increasing their confidence. At Viv's second interview she felt the situation had improved, as the board was now *female* dominated: 'I'm not too worried about it at the moment, mainly because there are more women on the board now. And those that are on the board are more vociferous. One in particular is excellent'.

Sam was another who expressed an interest in the number of women on the board. When I introduced the subject of gender, she commented: 'The first thing I did was to count the number of women, I don't know why' (Phase 1: Interview 1). In response to my question, Sam denied that being a woman on the board might present

particular obstacles or that female members of the board struggled in any way to make themselves heard or to assert themselves. She speculated as to why the number of women on the board nonetheless mattered to her:

> Whether as a single woman and very independent I thought, 'Yeah we've done it again!' ... I don't know, I don't know. I suppose just being an independent nineties kind of woman, I suppose ... that fights her own corners and, you know, because she has to ... It was just how many have we got compared to them (Phase 1: Interview 1).

The language Sam uses is interesting. Whilst denying her identity as a woman was problematic, Sam nonetheless alludes to a set of power relations between men and women, which is characterised by conflict. When I asked Sam if she was conscious of her identity as a woman she replied:

> S: No, no ... I've always been a bit of a bloke anyway (laughter)... I'm not good at making female small talk. I'd much rather stand and have a pint and talk about rugby or tell dirty jokes or whatever, so I guess I've never felt I'm a little female who's just sat there to make up the numbers. Or the token white person, the token female: I've never felt that, and I can't honestly say I've ever been made to feel that.
>
> I mean jokingly, (name) from the voluntary sector, at the last committee meeting, when they announced my new position at the end he came up and said, 'Who's going to get me my tea now?' But that's just a role I take on myself; I always stand at the tea urn and (laughing) say, 'Who's having coffee and who's having tea?' I mean that's always something I do.
>
> A: Why do you do that?
>
> S: I don't know, just something I tend to gravitate to I suppose. I'll say, 'I'm having coffee, does anyone else want one?' My upbringing I suppose. My parents always taught me to be polite, so if I'm there I always say, 'Do you want tea or coffee?' Not saying that I make a beeline for it, but if I'm there and someone else is behind me I'll say, 'What do you want?' He didn't say it disparagingly; he just said, 'Who's going to get my tea for me? You always get my tea'. I said, 'It's alright, I'll train Becky up' (the other nurse board member) (laughing). We get each other coffee, so I don't see that as a gender thing or a subservient issue at all.

Throughout Sam's account she implicitly appeals to gender as an explanatory and experiential factor - she mentions her concern with the number of women on the board and the fact that she often makes the tea for others. Yet she also denies its relevance. She makes light of her role as tea maker, seeing it more as common courtesy. However, as Pringle (1992) points out in relation to her work on secretaries:

There is a tendency to play this down as part of the job, part of the hostessing role, too trivial to make a fuss about. Yet it is of immense symbolic importance ... this is part of the question of professionalization and femininity. How far does success for secretaries, or for that matter any woman depend on the cultivation of a certain kind of femininity? (1992 p. 176).

Whilst Sam perhaps doesn't acknowledge the symbolic importance of this role, Debbie appeared to. But here too there are contradictions and confusions. When I asked her if gender was relevant to her experiences she argued at some length that it wasn't. However, her reference to tea making is significant:

I can't honestly say I've found it (gender) to be a problem – ever – you know, I'm not feminist, no way feminist...No I think there are roles that men do better and I think there are roles that women do better and I can accept that quite nicely... (long pause) I don't get up and pour the tea for them in the LHG meetings if that's what you mean. Oh no way! They all help themselves, (laughter) and if I get up for mine, I sit back down with mine.

Debbie sounded triumphant. When I asked her what stopped her from getting tea for others she denied it was a conscious decision and anything to do with wanting to resist traditional assumptions about women's role, adding, 'That's just the way it's worked out'. I was confronted with a situation where nurses implied gender was a feature of their organizational experiences, yet in the next moment denied its relevance.

The contradictory place of gender in nurses' accounts highlights an important challenge for feminism. It raises ethical and epistemological questions of how to avoid subordinating women's own understanding and how to validate feminist analysis, when women themselves do not necessarily see gender as relevant to their experiences, or share a feminist viewpoint (see also the discussion on the politics of representation outlined in chapter three, 3.6.2). The conflicting accounts of gender in the interview data is discussed further in section 6.5.

My interview with Sarah did provide the opportunity to discuss in depth the role and significance of gender in terms of nurses' organizational experiences as women. In particular, her account sheds light on the contradictory and complex interplay of gender and power in the construction and reproduction of subjectivity. This was

Sarah's response when I introduced the topic of gender. Extracts of this interview have also been included in chapter three in the discussion on ethics:

> **S:** You are down to being quite outnumbered, you know, and on all the sub-groups I am the only female. Yes, so that can also, you know … I end up pouring the coffee … I think 'Why am I doing this?' you know? I always get there first, that's the problem, I get there first because I go through the meeting and I have to pour the coffee and I think, 'You mad fool' (laughter). I will stop that; I'm not going to do that (**A:** Okay, next time).

> It's a hard habit to break, you know … I am just thinking about all the daft things I do, you know, like taking the clingfilm off the sandwiches - but then again Dr Wilson will give me the plate (**A:** He'll give you the plate?) to do this and I didn't think – it's only now that I've suddenly thought, 'What am I doing!' (laughter) So I won't do that – I'll give him the plate at the next meeting and he can (trailing off – both laughing).

> I feel comfortable that I'm actually *doing* something for the other members because I don't actually get to speak to them, so it's sort of a way, 'I'll make you a coffee – you must like me,' do you know what I mean?

> **A:** Yes, I do; so what's that about?

> **S:** That they don't know me either, I suppose. That I'm quite a nice person, you know and, er, try and take the time to speak to me … I suppose if there were other female members, it would be much easier, but when you're the *only* female member and like you are a mum, and this is what you do … You do, you just click in and also it gives you something to do when it's awkward, you know, if there is silence you're doing something… and it opens like, 'Do you have sugar? Yes fine', you know, 'How are you?' It does that kind of thing.

> But again it's this two fold thing - I know I shouldn't do it, but I'm comfortable doing it. … I didn't think about it before until this interview, you know, that I've got to stop being this submissive female (Phase 1: Interview 1).

In making coffee and assisting Dr Wilson, Sarah acknowledges that she conforms to and reproduces a role stereotypically ascribed to women. She speculates that her caring experiences as a mother and the only female present compel her to adopt this role. Sarah also suggests that 'doing something' alleviates what can be awkward pauses and silences. In addition, she locates her behaviour in terms of its facilitative function within the group – opening up the conversation and allowing time for people to chat amongst themselves and to get to know each other.

As suggested in chapter five, nurses saw this as important and frequently took it upon themselves to facilitate group process in this way. This is another illustration of how women concern themselves with 'making community' – attending to the welfare of others, making people feel at ease, creating the right atmosphere (Daniels 1987).

That Sarah finds comfort in this role is significant. Sarah suggests in the first paragraph that she would find it difficult to help herself to coffee and ignore the needs of others. But, as indicated in relation to Sam's experiences, this is perhaps more than a question of good manners. Sarah's role as hostess (and surrogate mother) provides her with a strategy for gaining approval and power. The strategy she uses is gendered – serving and servicing the needs of others – something she finds reassuring and comfortable. As Graham (1983) argues, caring represents a fundamental way in which gender identities are lived out:

> ... the experience of caring is the medium through which women are accepted into and feel they belong in the social world. It is the medium through which they gain admittance into both the private world of the home and the public world of the labour market (p. 30).

This argument is compelling, particularly in light of the tension Sarah experiences in wanting to both embrace and reject her gendered identity. As a woman and nurse, conforming to the ideals of womanhood improves her chances of being accepted as an organizational member. Her actions can also be understood as remedial work (Gherardi 1994) as outlined in chapter two. She takes on a role which is expressive of her femininity and maternalism and in doing so, she repairs the symbolic order of gender which is disrupted by her presence. However, the strategy she uses to gain acceptance risks undermining her credibility. She reconfirms her identity as a 'submissive female'.

But being a submissive female has its rewards. The complex interplay of pleasure and power, often at an unconscious level, is important to acknowledge if some of the contradictions and difficulties faced by women within organizations are to be appreciated (see for example Muff 1982a, Hollway 1983, Pringle 1989, Benjamin 1990, Gherardi 1994 and Wicks 1998).

The work of Benjamin (1990) is useful in such an analysis. Both Pringle (1989) and Wicks (1998) draw on her work in their analyses of the boss-secretary relationship and the doctor/nurse relationship respectively. In *The Bonds of Love: Psychoanalysis, Feminism and the Problems of Domination* (1990) Benjamin uses Hegel's master/slave dialectic to explore the universal need for recognition and the

competing drive for autonomy and the part this process plays in achieving a sense of self. Drawing on object relations theory Benjamin argues that rather than achieving mutual recognition between selves, masculine and feminine identities are mapped onto subject/object positions. For men, recognition is achieved through asserting independence and subjectivity. For women, a sense of self comes from maintaining dependence and connectedness. According to Benjamin, these identities are rehearsed through rituals and fantasies of erotic domination and submission.

Using *The Story of 'O'* (Reage 1965) - a pornographic novel exploring sado-masochism - as a case study, Benjamin suggests that 'desire for submission represents a peculiar transposition of the desire for recognition' (1990 p. 56). Recognition then can be gained:

> ... through an other who is powerful enough to bestow this recognition...this other has the power for which the self longs, and *through his recognition* she gains it, though vicariously (p. 56, my emphasis).

If recognition for women in part hinges on their submission as 'object' to man's 'subject', compliance to gendered (heterosexual) norms of behaviour takes on an added imperative. As Sarah comments, 'It's this two fold thing - I know I shouldn't do it, but I'm comfortable doing it'. It perhaps also indicates why conforming to gender ideals, in Sarah's words, is a 'hard habit to break'. Challenging such gendered norms of behaviour and defying their positioning as object requires women to give up the pleasure and rewards of recognition.

A number of authors have discussed similar issues in the context of the doctor/nurse relationship (see for example, Keddy *et al*. 1986 and Kerr 1982). These authors draw attention to the rewards for nurses in submitting to the role of doctor's handmaiden.

> This relationship has denied the nurse a separate identity, for the role requires fusion and relinquishing of the individual self. Fusion is maintained in the doctor-nurse relationship as long as nurses do not engage in independent and autonomous thinking and behaviour... Nurses in turn are treated with paternalistic benevolence and feel a boost in their own sense of importance because of the 'acceptance' received from the powerful physician... (Kerr 1982 p. 304).

Should nurses defy their position as object and assert their autonomy, conflict arises, 'for separation means losing identification with the overvalued part of the system. Nurses who do this risk being devalued, which makes the choice difficult' (*ibid.*) This is perhaps the dilemma facing Sarah.

A feminist reading of Sarah's account illustrates the way in which everyday organizational rituals and relations structure and reproduce individuals and organizations in gender terms (West and Zimmerman 1991, Acker 1992, Gherardi 1994). It sheds light on the way in which gender is deeply implicated in the daily interactions between individuals at a conscious and unconscious level. As Gherardi (1994) argues in her discussion of gendered organizational cultures:

> ... gender is not just located at the level of interactional and institutional behaviour (the gender we do) but at the level of deep and trans-psychic symbolic structures (the gender we think) (p. 595).

This issue is discussed further in the following chapter in which I explore the doctor/nurse relationship in more detail.

Kate also acknowledged the role of gender in her experiences as a board nurse. She felt the board was male dominated and, significantly, she highlights the relationship between her identity as a woman and her identity as a nurse:

> It feels male in its domination, it feels male. And I feel that not only are you kind of having to contribute as a female - as a nurse - but as a female nurse. Yeah, I think it (gender) makes a difference...I think you are going to battle to be heard as a nurse, but I think you are going to battle as well to be heard as a woman (Phase 1: Interview 1).

Kate theorises both identities as devalued and as such, being a female nurse represents a particular dilemma in the context of a masculine organizational culture, in which female nurses face a double burden of representation as Other.

Kate's experiences are interesting when compared to Linda's, her nurse colleague on the board. Linda readily acknowledged that gender was an issue in so far as the board was male dominated and that there was 'a lot of research which shows that females tend to be subordinated at these types of meetings'. However, Linda denied that

being a woman had had a negative impact on her experiences, although as she commented, this did not mean the male dominance of the board was an irrelevance:

> I imagine from an observer's point of view they might well pick up – just because I've read this stuff, you know, I know that these things happen. You're not sitting in the meeting thinking, 'Oh', you know, 'has he sidelined me because I am female?' You're trying to concentrate trying to get your point across (Phase 1: Interview 1).

Kate's account suggests gender is much more on the surface for her – it's palpable in a way that appears not to be the case for Linda. Linda's comment that *observers* may well identify gender at work is telling. Whilst attending board meetings I observed behaviour that I interpreted as gendered. This included my observations of Linda and the way in which she related to and interacted with her colleagues, in particular, the (gendered) strategies she used precisely to get her point across (see section 6.4).

Kate also highlighted another important consequence of being a woman on the board:

> The one sub-group I'm on, the meetings are all organised from 12.30 to 2.30, which would fit in very nicely with all my other commitments. That was changed to 6.30 to 8.30 in the evening. And when I rang up and said that was quite difficult for me - 'Yeah, well that's when they all want it'. 'Cause I'm the only woman on that particular sub-group - 'That's when they all wanted it' - and I felt that was a male thing you know, I felt it was very much they could get out of the evening 'cause their wives are probably ... (trailing off). Whereas for me, it was quite difficult, you know. My husband was there, but it took a bit of organising, it shifted the emphasis.... It's really back to the basics, you know, who does the washing up. But I think it (gender) has got a place, and how much time can be freed up realistically if you are a woman with a child etcetera, how much can you, um, be involved there (Phase 1: Interview 1).

Kate argues that her domestic responsibilities as a woman impact on her ability to contribute and commit to LHG work in a way she imagines not experienced by male board members. The organization of this work presupposes a particular gendered division of labour within the home, but this does not appear to be acknowledged or taken into account. As previously indicated in chapter two, Acker (1991, 1992) argues that this can be seen as illustrative of the way in which gender is deeply imbedded within organizational logic.

> Hidden within the concept of a job are assumptions about separations between the public and private spheres and the gendered organizations of reproduction and production (1992 p. 257).

6.2.3 Theorising gender as a man

I was interested to hear how Charlie, as a male board nurse, experienced and made sense of his gender identity. Charlie had already identified the board as having an 'old boys feel about it', and I was keen to know how he felt he was positioned within that and whether he felt his identity as a man had influenced his relationship with the male GPs on the board.

> C: Good question … to be honest I think it has made a difference, it has probably helped in a way
>
> A: In what way?
>
> C: With some of the older GPs in particular they can get very patronising when they are talking to other nurses. I've seen it happen… I think the doctors feel more comfortable because I am a male - that's the impression I get - than they might do otherwise… and outside meetings it seems a bit easier to talk to them because I know a lot of them anyway and I think that's probably helped in some respects. But when it comes down to brass tacks, at the end of the day *I'm just a nurse* … when it comes to brass tacks of making decisions at executive or board level, I don't think it (being a man) makes a lot of difference (Phase 2: Interview 1, my emphasis).

Charlie's identity as a man holds some advantages - particularly in more social gatherings, but in terms of decision making within the board, any advantages he has as a man risk being negated by virtue of his occupational identity. As he comments, 'at the end of the day, I'm just a nurse'.

The contradictory position of gender as a determinant in the experiences of male nurses is discussed by a number of authors (Game and Pringle 1983, Porter 1991, 1992, Pringle 1996). Porter's (1992) research is particularly relevant. In his study of power relations between nurses and doctors, Porter found that male nurses' gender identity was *subordinate* to their occupational identity. He concludes that 'the inability of male nurses to utilise the advantages of their gender is the result of the ascription to nursing of a position of female subordination (p. 517).

It would appear then for Charlie at least, the intimate relationship between nursing identity and femininity means that even as a male, it is his occupational identity as a *nurse* that is privileged.

6.2.4 Gender theorised as irrelevant

As previously indicated, there were a number of nurses (7) who were very clear that gender was not a factor in terms of their organizational experience and their identity as women was not perceived as disadvantageous, as the following comments suggest:

> 'It hasn't been an issue for me'. (Maxine. Phase 1: Interview 1)

> 'I haven't noticed that being a woman has made any difference.' (Claire. Phase 1: Interview 1)

> 'I'm just a member there'. (Rose. Phase 1: Interview 1):

Ann readily acknowledged that gender had been an issue for some board nurses, but during both interviews, she denied it had been problem for her:

> No, I don't think gender was an issue on the board because - and I know this because we had a fairly even distribution of gender, and the lay representative who was a female, was very vocal and articulate. No, no I don't think that was an issue with us. I do know that it is an issue for others though, definitely where there is a lot of testosterone on the board, and perhaps just two females, whereas we didn't have that (Phase 2: Interview 2).

As others had done, Ann understood gender at a superficial level - her analysis is limited to the relative number of men and women on the board and the high profile of one of the female board members. This suggested to Ann that gender was not an issue. Interestingly, Viv, the other nurse board member and Pam, the LHG GM both felt gender was an issue on the board, as indicated earlier in this section.

Ann also discussed the arrival of a new general manager who replaced Pam. She complained that increased power had been given to GPs on the board, whilst nurses were being sidelined and replaced from positions of authority and influence; as she commented of the new GM, 'She thinks nurses should be seen and not heard, we were just non-people'. Ann alludes to her subordinate position and identity as a nurse, but she does not draw on gender to make sense of these experiences. The next section explores this issue and the relationship between occupational and gender identity in more detail.

Nurses frequently referred to their lack of status and power and I was keen to explore the extent to which nurses theorised their occupational identity in terms of gender. Whilst I understand gender and nursing identity as intimately connected, most of those I interviewed did not share this view, as Ann's comments above suggest.

6.3 Occupational identity: meaning and impact.

Issues around nursing identity emerged unprompted throughout the majority of interviews. On those occasions when it had not, I asked participants whether they felt their identity as a nurse had any impact on their experiences. As indicated in the previous section, some nurses believed being a woman was irrelevant to their organizational lives, though their identity and status as nurses was more likely to be perceived as relevant and as having a negative impact.

6.3.1 Nursing identity: issues of self-esteem and vulnerability

One of the key issues to emerge from the data is the way in which nurses made sense of and experienced their nursing identity as contradictory. As nurse board members positive elements of their identity and their role were set against feelings of low self-esteem, vulnerability and worthlessness.

Kim's thoughts and views were particularly revealing and offered an important insight into issues relating to nursing identity. Throughout both her interviews Kim reflected on the lack of value and worth she initially felt as a nurse board member and speculated as to why she should feel this way. In the following extract, Kim was discussing her initial concerns regarding her ability to contribute to the LHG:

> **K:** I also felt that what I had to say - was it going to be worth anything, you know, was I going to be knocked down for it?
>
> **A:** Why did you think that?
>
> **K:** I thought that because I thought I can't possibly contribute like the rest of these people, you know? For example, mainly people like the GPs, the finance, the public health, Directors of Social Services. You know, that sort of... you're thinking hang on, these people are 'up there'. I put them on pedestals when I first went there. *And I think as nurses we are very bad at that.* It goes back to the consultant on the ward, you think this person is God – *it takes a long time to get over that...* It's strange,

because I've never felt like that working in this practice where I am now, never conscious of that - I've never had that conflict here at all.

When I trained in 1980 you were trained not to be vocal and grow and question and you were there to do as you were told. And I think it's taken years for nursing to get over... (trailing off).

... I have the greatest respect for the people I work with here (at her practice). They're wonderful professionals, they work really well, they have my highest respect, so why was I going – and I could challenge any of the GPs here without a problem – *I'm thinking why am I going and allowing other people to make me feel so vulnerable, you know, and worthless, when people I know and respect don't make me feel like that?* It was getting over that stage (Phase 1: Interview 1, my emphasis).

Kim works hard to make sense of her contradictory feelings regarding her value and status as a nurse. Her self-esteem appears contingent upon the context within which she operates – a positive self-image is not a given. She implies that her feelings of vulnerability and worthlessness were not related to the direct actions or behaviour of other board members; rather she sees them as coming from within herself – she was in some way to blame. Becky too raised a similar point: 'As nurses we have been guilty in the past of allowing ourselves to feel as though we are subservient.' (Phase 1: Interview1).

This is not to say that there weren't occasions – as I have previously indicated – where Kim felt nursing *was* marginalised, but in this instance Kim relates these feelings more to her socialisation and training as a nurse. A number of writers have highlighted the negative impact of nurse training and socialization on nurses' self-image and subordinate position within healthcare (see for example Melia 1987, Treacy 1989, Salvage 1992, Mackay 1993). Kim's comments also support the findings from Keddy *et al's* (1986) study outlined in chapter two, in which nurses identified their training and socialisation, and in particular their relationship with their medical colleagues, as influencing their self-image and sense of self-worth. Kim's feelings of worthlessness weigh heavy; as she suggests, nurses' learnt (and internalised) feelings of inadequacy take 'a long time to get over'.

This resonates with Gherardi's (1994) argument regarding the gendering of organizations and the way in which we 'think gender'. Kim comes to the board with certain (gendered) beliefs regarding her value and worth as a nurse and these shape and inform her organizational identity and organizational relations. These beliefs are

gendered in so far as they relate to the devalued and subordinate status of nurses, as women.

Significantly, Kim appears to expend a great deal of emotional effort in convincing herself that she is a legitimate and credible board member: 'The main thing I carry with me every time I go – I've got something to offer this group and it's not all above me'. (Phase 1: Interview 1). Viv also raised a similar point: 'We are all equal on the board – I do keep reminding myself of that. I shouldn't have to keep reminding myself, it should be…(clicks fingers).' (Phase1: Interview1).

Similar sentiments were echoed by women managers in Marshall's (1984) study. Marshall argues that a number of participants felt they were 'letting others' low expectations influence their sense of competence' and once they realised this, 'They would then deliberately *un-think* these attitudes, telling themselves instead that they *were* capable' (p. 158 my emphasis). Both nurses had to work hard at overcoming their internalised feelings of inadequacy - to 'un-think' their devalued status as nurses (and women).

At her second interview, some two years later, Kim continued to explore these issues. She had grown in confidence, but regretted what she perceived as nurses' lack of self-belief, and in particular, nurses' apathy when it came to getting involved with the LHG:

> This is what I find so frustrating when a board position goes - why can't we recruit people to apply for a board position? And we have terrible trouble doing it. I mean, I rang round all the practices in our borough and said, 'Please apply, we really fought hard for this place, it's hard work but it's excellent experience, you'll love it, it gives you hunger to do other things'.

> But I think we need to find out why we can't get nurses to apply, and I don't think that comes back to time and education - I think it's something more … how do we get people – I thought, 'Oh right, when we get degree nurses they would be educated to actually believe, to be assertive, to think 'yes, we can do this!'' but it hasn't really happened as yet has it?

> … we are the biggest volume; we can really shout the loudest and get the best for our public, if only we had the belief to do it (Phase 2: Interview 2).

Kim infers that nurses' reluctance in applying for board positions perhaps relates to a negative self-image and a lack of self-belief and self-worth. These feelings may well inhibit some nurses from putting themselves forward as potential board members, and this is important given nursing's marginalised position within the policy making arena.

Other nurse participants, notably Sarah, Claire, Rose and Viv also reflected on their initial lack of confidence and self-belief, and highlighted the importance of nurses being valued and having faith in themselves. As Poole, a PCT nurse board member comments of her experiences:

> I naively expected to be asked my views ... this was not the case and very soon I learnt that I would have to butt in. Even then my lack of confidence resulted in a rather small voice that lacked weight. This is something GPs do not seem to have a problem with. They all appear confident in their views... The self-esteem and confidence of nurse members is critical if they are to be able to contribute fully to discussions (2000 p. 36).

The work of a number of contributors to an edited collection of essays: *Women's Issues in Nursing: Socialization, Sexism and Stereotyping* (Muff 1982a) is also helpful in shedding light on some of these issues. For example, Muff (1982b) explores some of the 'compassion traps' within which nurses and women find themselves operating, and highlights the implications this has for personal and occupational identity: 'Female socialisation and the nursing tradition have combined to give most nurses a legacy of selfless subservient ethics' (Muff 1982b p. 240). For Muff, this sows the seeds of discontent:

> Perpetual subservience engenders self-hate and other-hate. Women learn that to express hatred towards others however, is to lose them; therefore anger is denied and turned against self. Women learn to feel worthless, to blame themselves and to see themselves (as society sees them) as second rate (ibid.).

It could be argued that a number of processes, including the way women and nurses are socialised, various psychological adaptation and defence mechanisms, together with the devaluing of women's caring role in society, combine to ensure that nursing identity, for some, is experienced as hugely problematic and fraught with contradictions.

What strikes me about Kim's account is the way in which she experiences her identity as ultimately fragile. Despite the good relationship she has with her work colleagues, and in particular her medical colleagues, the confidence gained from this counted for very little. Once she left her secure and familiar work environment, she felt vulnerable and uncertain. It is the strength of her feelings of worthlessness that Kim struggles to understand and negotiate.

In what can be seen as a reversal of Kim's experiences, Linda felt her identity as a nurse on the board was irrelevant: 'I can't say I feel inferior in any way'. However, when she was in practice, the situation was different:

> L: There is still undoubtedly a perception amongst GPs that nurses are, you know, inferior to them professionally - I mean there is no doubt about that... But it's like this is separate, you know? I know perfectly well if I go to their practice with my (nursing) hat on I will become 'down here' you know? (indicating subordinate position) I will not be regarded as an equal professional; I have no doubt about that.
>
> A: That's fascinating, so then you go to an LHG board meeting and what happens?
>
> L: I think maybe it's partly to do with not having worked with them or knowing them as a nurse... And it's partly because they are not confident in that role either, whereas they are extremely confident with their GP hat on. But that may change in time; they are already gaining a lot of confidence... I feel it's like I'm there with a different hat on and I'm a different person really (Phase 1: Interview 1).

Linda clearly acknowledges the negative imagery associated with nursing and nurses, but in contrast to Kim, when Linda attended LHG meetings, she was not conscious of feeling inferior or inadequate as a nurse. It seems she was able to distance herself from her subordinate identity. Linda explained she was able to do this because her GP colleagues on the board had no experience of working with her as a nurse in clinical practice, and as she subsequently added, not wearing a uniform when on LHG business reduced the chances of her being identified as a nurse. Linda also highlights the relative lack of confidence of GPs on the board, which perhaps led to her viewing relations as more equitable. I think this is an important point. One of Kim's GP colleagues also felt that GPs were uncertain with regard to their role, something Kim found reassuring. Whilst this may be the case, GPs' credibility and status were not in question in the way that nurses' appears to have been. (I discuss this further in section 6. 4 of this chapter).

Listening to Linda I was struck by how her experience differed to Kim's. Whilst she recognised the devalued status and identity of nursing, the negative feelings and emotions around her identity as a nurse appeared less embedded than Kim's – she seemed able to distance herself from them in a way that Kim struggled to do. However, for both nurses it seems that their sense of self and confidence is dependant on the context within which they are operating - in particular, the nature of existing power relations.

Linda's comments with regard to her uniform are also significant and were echoed by a number of other nurses. Sarah, Rose, and Viv said they would not wear a uniform to the LHG meetings. On each occasion, I had asked them whether they were conscious of their identity as a nurse when attending LHG meetings. All the interview extracts below were from the first phase of the research.

> **Viv:** Not in the slightest bit conscious because I'm not in uniform … and our name places are made for the tables and I'm just 'Mrs blah blah', no 'Sister Brown' or whatever. Although all the GPs are 'Dr James' whatever, but that doesn't bother me in the slightest. If I was in uniform I think I would be labelled as 'Oh, there's the nurse'. I look forward perhaps to the day when I don't have to rush from work (to change). I think I would make every effort *not* to be in uniform.
>
> **Rose :** No I'm just a member there. I think it would be different if I went in uniform. I've never gone in uniform… I think if I was there (in uniform) I would stand out like a sore thumb. You know, that nurse would be there wouldn't she?
>
> **A:** Would you ever turn up to a meeting in uniform?
>
> **Sarah :** No … now again this is contradicting what I've just said (she had denied she was conscious of her identity as the only female present at some meetings) – I would *not* do it. I don't care if I was late – I would go home and change to be on an equal level. So I mean it contradicts what I've just said, but it's something I feel very strongly about. Sometimes its difficult because I don't finish until 12.30 and the meetings are at 1 pm and you have to be there at about 12.45, so I've actually only got about 15 minutes to leave here, go home, get changed and get up to the meeting. But I will always get changed. And I will always try and dress as smartly as I can. I think it gives you more confidence to do that. I definitely feel far more sort of 'yes, I am a nurse, a humble nurse' (if in uniform) so I wouldn't do that.
>
> Especially for the GPs – I don't know if it would have the opposite effect for the other members – that might actually give me *more* authority, but it's the GPs *I want to be up there with* (my emphasis).

Discussing the subject of uniforms allowed a useful entry point to explore nurses' gendered experiences, as Sarah's comments above indicate. It seems clear from these

accounts that nurses' uniform is of great symbolic importance. A nurses' uniform signifies a range of meanings, including service, care, compassion, obedience and femininity - attributes that nurses perhaps felt would detract from their credibility and status as board members. As Szasz (1982) argues, 'The nursing uniform does not promote an image of an autonomous person' (p. 400).

The decision not to wear a uniform reflects nurses' response to the prevailing organizational culture within which they perceived themselves to occupy a marginal position. Drawing on Acker's (1991, 1992) analysis of the gendering of organizational culture, this response relates to the 'internal mental work' (Acker 1992 p. 253) of individuals, as they make sense of gendered rules and relations. In 'creating the correct gendered persona' (*ibid.*) nurses are actively involved in the gendering of organization.

Interestingly, Sarah perceives the uniform to have a different impact depending on the audience. She speculates that non-GP board members might view her in a more positive light (as a caring, competent professional?) but this is not what she imagines GPs seeing; and as she indicates, they are the ones who matter.

Marshall (1984), Pringle (1989, 1992) and Sheppard (1992) highlight the importance for women in controlling their image at work. Doing so constitutes an essential strategy for gender management, as Pringle (1992) makes clear in relation to her work on secretaries:

> Clothes are an important means of empowerment. In wearing suits women are not transgressing gender, becoming 'men', but expressing a more masculine, instrumental relation to the body. To dress in this way is to feel like a man does, sexually empowered, an actor rather than an object to be looked at. Secretaries may adopt similar strategies to construct more assertive models of femininity (p. 177).

Constructing a more assertive model of femininity appears to have been what Sarah, Rose and Viv were doing when they rushed home to change out of their uniform. I observed only one nurse wearing a uniform to LHG meetings and was immediately struck by how odd this looked and how uncomfortable I felt, as my fieldnotes at the time indicate. I was observing a board meeting at LHG1:

Becky had on her uniform, which was like a schoolgirl's - a polo top and pleated short skirt. This took me aback. She looked like a little girl.

The use of strategies in managing identity is an important issue and one that I shall discuss in more detail in section 6.4

Claire also highlighted her identity as a nurse as relevant to her experiences. Both Claire and Rose, her nurse colleague on the board were referred to in board discussions as 'the nurses' – something they took exception to. Claire described how she made sense of this: 'It's almost a sort of frivolous, 'And what do the nurses think?' We are not really there to be taken seriously I suppose' (Phase 1: Interview 1).

At our first interview, it was evident Claire felt her credibility as a nurse board member was in doubt: 'I would like to think in a year's time I'd feel that I was a true and valued member of the board. I think at the moment we are still second-class citizens on the board' (Phase 1: Interview 1). When I interviewed Claire for the second time, she was more confident of her role and more certain of her value as a board member. Reflecting on the previous two years she commented:

> We are more respected as equal members on the board, rather than just being a nurse with a very low sort of esteem. Perhaps we personally had a low esteem of ourselves when we first came to the board because we were intimidated by the other GPs and that feeling has now gone (Phase 2: Interview 2).

As Kim had done, Claire makes the connection between her identity as a nurse and her feelings of low self-esteem. She too suggests her own feelings with regard to her self-image have contributed to a sense of worthlessness. These feelings are located in the context of the doctor/nurse relationship (see chapter seven for more detail). To help overcome such feelings, Claire felt that 'confidence boosting exercises' were important for all nurse board members.

I was encouraged by Claire's growing confidence, but her account of how she sought to raise the profile of nursing on the board, suggests her lack of self-esteem as a nurse remains. She highlighted the role of nurses in running nurse-led minor illness clinics - a recent move which had benefited GP practices:

They (the other board members) now realise nurses have got these skills; they can do a lot of things. And as long as we know our *limitations* we should be able to do some of the *lesser work* and they (the GPs) are there for the diagnostic work (Phase 2: Interview 2, my emphasis).

The positive image of nurses outlined in the first sentence is then immediately undermined in the next sentence. Nurses are positioned as potentially incapable and incompetent – just the attitude Claire was keen to challenge. I wondered to what extent these comments might reflect Claire's feelings of inferiority and her subordinate status as a nurse. It seems that for some, self-image as 'less than' is never far away and as Kim's account suggests, this image is internalised and manifests itself in a number of ways.

I think nurses' comments illustrate the contradictions inherent in nursing identity. Nurses feel strongly about their work and see it as valuable and important. At the same time they are aware that nursing isn't generally valued. The confusion and discomfort that this generates are evident in Kim's account as she struggles to makes sense of her feelings of inadequacy and lack of worth. These feelings perhaps relate to the dilemma facing nursing outlined by Reverby: '... the order to care in a society that refuses to value caring' (1987 p. 1).

Four of the nurse participants felt their identity as nurses was relevant in terms of their relationship with members of the board secretariat. Kate, Linda, Ann and Tina argued that the secretariat appeared to privilege the needs and work of GP board members. For Kate and Tina such attitudes reflected and perpetuated traditional power relations between medicine and nursing. For example, nurses felt they were expected to do more of the 'legwork' when it came to organising nursing meetings and events as part of their LHG role. They seldom had access to secretarial support as part of their jobs, which meant they were faced with having to do administrative work in their own time.

When I was on about creating this network group for nurses, I asked if I could have help with premises - could I have help from the secretariat? (The response was) 'No we are ever so busy.' You know, it was more or less, 'Can you get on with it on your own? A very good idea - an excellent idea - but we are ever so busy'... would that be a nurse thing again? We don't know for definite. But I wonder what that would be like if the docs decided to have a meeting (Kate. Phase 1: Interview 1).

> I put in for support for whatever I had to do on clinical governance and absolutely
> nothing was coming back. 'Oh, we'll sort something out, don't you worry about
> that'. And the consultant for public health, who is the Chair for one of the sub-
> groups asked for something and they got somebody allocated to them straight away.
> And that's because they are a consultant – I can see all that... I am a nurse and
> chuck onto that, 'female' (Tina. Phase 1: Interview 1).

Nursing identity was also highlighted as a key issue by Louise (LHG6 GM) and Karen (senior nurse, LHG2). As previously discussed in chapter four, both argued that the nursing contribution had been affected by nurses' lack of management, political and strategic thinking skills. They argued that the reason nurses lacked these skills was in part attributable to the kind of people recruited to nursing and the way in which nurses were socialised and trained. Echoing Kim's concerns regarding her nurse training, Louise commented:

> As long as you are lovely and you are kind to people you can be a nurse (laughing) -
> you know, lovely girls... We weren't looking for people who challenged the system.
> We looked for conformists, group thinkers.

Ruiz (1982) also draws attention to the relationship between gender and nursing identity and the impact of nurse training and socialisation in terms of nurses' leadership potential:

> For women and nurses whose modus operandi has been self-sacrifice, pleasing
> others and merging with the identity of others, assertiveness can be very difficult.
> Nurses who have been socialised into a passive, self-abrogating, subservient role
> follow orders, receive limited financial reimbursement for professional services and
> rarely are involved in decision making or policy making (p. 310).

Not all nurses appeared to share these views. Four of the nurses denied they were conscious of, or experienced their identity as a nurse on the board in anything but positive ways. For example, Sam commented, 'I don't feel like the doctor's handmaiden'. She appeared comfortable and at ease with her identity as a nurse. Nonetheless, at various points in the interview she expressed some uncertainty as to whether nurses would be treated as equals and taken seriously: 'There is always that slight unease ... am I going to be able to hold my own or argue as efficiently or as well as they do?' (See also chapter four, Nursing Contribution: opportunities and challenges).

Debbie too was confident of her identity as a nurse on the board. She attributed her feelings to her age (she was in her mid fifties), assertiveness training, and her particular personality. When I asked Emma, a practice nurse, whether she was aware of, or conscious of her identity as a nurse on the board, she responded:

> Very conscious really. That's what you are there for, you are there to represent nurses and nursing issues and I don't think you can move away from that. You are not there as a board member, you are there as the *nurse* board member and there to discuss the nursing issues that affect your patients (Phase 2: Interview 1).

I realised that in asking this question I had presupposed a particular view and understanding of nursing identity – that is as devalued and subordinate. I had also supposed that nurses would readily share this view. For the most part nurses *had* responded in a way that suggested they recognised nursing identity as potentially problematic for the same reasons. It appeared they knew what I was talking about, even if they felt their own experiences contradicted this view. Emma's comments though caused me to reflect on my own motivations, experiences and understanding and the part these played in shaping and determining the research.

My desire to make sense of and come to terms with my own struggles as a nurse lay behind much of my questioning. My doubts and concerns about my ability to complete the research also mirrored what some of the nurses said about their lack of confidence and feelings of worthlessness as board members. As a nurse and as a woman I shared these feelings.

An exploration and understanding of the way in which nurses experience and make sense of their identity as nurses and women is important in identifying those factors that may inhibit the nursing contribution to the LHG. Nurses own sense of self worth and value is one of these factors. As the previous quote from Poole (2000) suggests, identity issues are critical to address if nurses are to fulfil their potential as board members. In addition, the way in which nursing identity is understood and conceptualised by others is also crucial, as Tina suggests in the following extract. Tina was talking about her role as clinical governance lead and the difficulties she had in exerting influence with her colleagues on the board and within the LHG constituency:

> They do sort of understand that I'm the lead, but I'm a nurse, so therefore that knocks it out – that invalidates it. Lead doctor big, lead nurse little (Phase 2: Interview 2).

So far in this chapter, I have explored the way in which nurses made sense of and experienced their identity as nurses and as women. Building on these analyses, the following discussion explores in more detail issues relating to credibility and the strategies participants employed to manage the contradictions and tensions in their dualistic position (Fournier and Kelemen 2001) as nurses/women and competent board members.

6.4 Credibility and strategies for managing gender identity

The issue of credibility has been identified as a key concern for women in organizations, particularly those working in male dominated environments (see for example Marshall 1985, Sheppard 1989, Gheradi 1995, Fournier and Kelemen 2001). Being positioned as out of place within masculine organizational culture, women adopt a number of strategies with which to manage their gender identity. These strategies are used to negotiate their survival and membership as credible organizational members. As Sheppard (1989) makes clear in relation to the women managers she interviewed:

> They shared a perception of gender as a *managed status*: being a woman in a male dominated environment demands handling one's gender in particular ways, and this process is done with reference to one's interpretation of the prevailing power structure in the organization. Without constant vigilance regarding gender (and sexual) self-presentation these women perceive that they run the risk of not being taken seriously, not being heard and not receiving necessary information – in other words, of not being able to participate fully in the organizational system (p. 145).

Gheradi (1995) argues that these strategies represent 'remedial' or reparative work - work that is carried out by both women and men within organizations. Such work is needed to restore the 'gender order', which is fundamentally fractured with the intrusion of women into the male world of work. Conceptualised in this way it is possible to see how organizations are gendered through the ongoing interpretation, interaction and performance of organizational members (Hall 1989, Acker 1991,

1992, Fournier and Kelemen 2001). The strategies used by a number of participants can be read as remedial work and are discussed in detail below.

The issue of credibility is also raised with explicit reference to board nurses by Antrobus (1998). Referring to the historical absence of nurses in commissioning, Antrobus questions whether 'nurses will be recognised as credible strategic players contributing to the nation's health' (p. 50). As indicated in chapter two, there is evidence to suggest that prejudicial attitudes exist toward nurses taking on such roles (King's Fund College 1993, Department of Health 1994, Kaufman 2002).

Using Antrobus' question as my starting point, I decided to ask nurses directly whether they felt their board colleagues saw them as credible strategic players. This allowed me to further explore aspects of their identity as nurses and women and on occasions generated a discussion with regard to the strategies they used to compensate for what they perceived as their lack of credibility. For the most part though, the use of strategies emerged unsolicited throughout the interviews and they were seldom theorised as I interpreted them – as strategies for gender management. As Sheppard (1989) points out in relation to her research:

> The use of strategies… may not be deliberate or even conscious. A number of women respondents initially stated that gender was not a factor for them at work and that being female was not important. Subsequently they described a variety of strategies including dress, language and relationships… although they didn't particularly identify them as strategies related to being female (p. 145).

6.4.1. Being their best

For the most part, nurses felt their credibility was not 'given' in a way that it was for others, notably GP board members. As Sheppard (1992 p 158) argues, 'women talk of a self-consciousness concerning self-presentation as organizational members that they do not perceive men as sharing'. Nurses felt they had to work at being seen as credible and could not assume equality with their colleagues, a situation Smith *et al.* (2000 p. 87) highlight in their evaluation of PCGs:

While generally seeing the board as medically oriented (if not dominated) most of the nurses interviewed felt that their GP colleagues listened to and valued their opinions on the whole. However, several pointed out that they had needed to be assertive and 'prove themselves capable' by taking on specific areas of work in order to reach this position.

In having to prove themselves capable, nurses appear to acknowledge their marginal status - that at some level they are perceived as fundamentally *in*capable, *in*credible. As the following comments in response to my question regarding their credibility suggest:

Charlie: We have more status now than we used to, but we've had to push and fight for it (Phase 2: Interview 1).

Debbie: I feel that already I've won the respect of the other board members.

A: Is respect a given for anybody?

Debbie: Oh, I think the GPs start off at a different point to which we did – that's inevitable (Phase 1: Interview 1).

Tina: It's for those of us not regarded as equals who have to prove ourselves in some way (Phase 1: Interview 1).

Rose: If you had asked me this four months ago I think because of our attitude and our feelings to being there, sort of quite apprehensive about it all, I think that, I would have to say I don't think they would have seen us as a contributing part of the team, board whatever you want to call it, but because we've brought things and umm, been able to give some really relevant information to parts of the agenda, I think they think we contribute well (Phase 1: Interview 1).

Ann: I think we earned respect as nurses on the board - I think that's worth mentioning - and that has been a truly huge breakthrough (Phase 2: Interview 2).

Sarah: We hold no sort of credibility (Phase 1: Interview 1).

One of the most common strategies for dealing with their marginal status was for nurses to make sure they were as informed as possible and that whatever they said was accurate and relevant – they had to be at their best. Six out of the total 15 nurses identified this as an important strategy. Marshall (1984) highlights a similar strategy amongst women managers who 'took it for granted that they would initially be undervalued' and as such felt the need to 'do the job well' (p. 157) to avoid criticism.

Several important issues arise from the following extracts: the amount of effort and energy expended by nurses in adopting this strategy; the fact that GPs were thought not to face the same dilemma; the precariousness of nursing identity.

> **Claire**: We can be seen to have views, but whether those views are actually going to be listened to, this is where we have got to work at it because – Rose and I have both learned that we have really got to make sure of our facts. This is one thing that has come across to us, that we have got to be absolutely one hundred percent certain of our facts, so we have to do our homework properly before we bring anything up at the board meeting, whereas the GPs seem to be able to get away with a bit more, um, vague debate. We have to be one hundred percent certain and that is the difference (Phase 1: Interview 1).
>
> **Maxine**: It's okay for GPs to admit they don't know anything, but nurses have got to know everything, you don't want to make a fool of yourself (Phase 1: Interview 1).
>
> **Kim:** It took me a while to realise – if I wasn't hundred percent sure, not to say anything because it would be wasted and that would mean that perhaps in the future they would doubt other things I might have to say (Phase 2: Interview 2).
>
> **Debbie:** I try not to say anything unless it's worth listening to, because there is a tremendous danger of being aware you're not saying anything and just finding something to say. And that would be a tremendous downfall (Phase 1: Interview 1).

The above extracts demonstrate the necessity for nurses in 'getting it right'. The consequences of failure are described in dramatic terms. These comments illustrate the fragility and precariousness of nurses' and women's status and position within organizations. As Sheppard (1989) comments, the status conflict that women managers experience 'is heightened by their sense of marginality, of being always potentially or actually seen as different and on the periphery' (p.145). Nurses' credibility is something constantly under threat, and can never be assumed. Their presence, as Other, has to be carefully negotiated, a task for which they hold themselves responsible (see also Marshall 1984 and Gherardi 1994).

In emphasising how important nurses felt it was for them (and not GPs) to get their facts right, nurses allude to the differences in status and power between doctors and nurses and medicine and nursing. The difficulties nurses have in asserting a credible organizational image are particularly acute given they have to negotiate a set of relations which position them as subordinate as women *and* as nurses.

6.4.2 A balancing act

My interpretation of nurses' experiences suggests that in their attempts to create a positive credible organizational image, women tread a fine line between success and failure (see Marshall 1984, Sheppard 1989, Fournier and Kelemen 2001). As Fournier and Kelemen (2001) comment in relation to their work on women managers:

> The ambivalent effects of individual and collective strategies bear witness to the delicate balancing acts women have to perform to reconcile the tensions present in their dualistic position as 'women' and as 'competent managers' (p. 272).

The following extract outlines the way in which Kim experienced this dilemma as a nurse board member:

> How valuable they (the board) take you is how dominant and verbal you are around the table, often. And I think there is a very fine balance to that because you could be too verbal, which means, 'Oh God here she or he goes again' to, 'Oh well they haven't said anything for months now, all of a sudden where has this come from?' And again I think that's a skill that takes a long time to get. And I'm not sure I'm there yet (Kim. Phase 2: Interview 2).

Whilst Kim infers these rules apply equally to men and women, the consequences of failing to achieve the right balance impact on men and women differently, as the earlier comments from nurses suggest. Furthermore, although Kim doesn't theorise this strategy in gendered terms, gender is relevant. Being dominant and 'verbal' are 'qualities' often associated with male conversational behaviour (see for example Katila and Merilainen 1999) and Kim identifies them as important if she wants to be seen as a valuable board member. However, she has to get the right balance – as a woman and nurse, being seen to be 'too verbal' might jeopardise her credibility as a board member. But staying silent might risk Kim being viewed as having nothing important to say. It would also reinforce stereotypical views of women as passive and compliant.

That such a view is held in relation to nurses and women is perhaps evidenced by some of the comments from other nurses. For example, Becky commented, 'I do feel they (GPs) often looked shocked when we actually do make a contribution'. Ann, the clinical governance lead (CGL) for her LHG commented of her GP colleagues, 'I

don't think they could believe a nurse could take on that role - 'What can she do?' - meaning not me personally, meaning as a nurse'. Ann's 'ambiguous' position as a nurse CGL was highlighted by the senior nurse of the LHG (Karen), who felt that despite Ann's best efforts and positive contribution, prejudicial attitudes toward a nurse taking on such a role had ultimately hampered the development of her role as CGL.

Kate and Sarah highlight the dilemma faced by nurses as they balance the conflicting demands of assertiveness and deference, and struggle to get their voices heard:

> **Kate:** You want to be able to contribute and give your opinions, but what you don't want to do is become aggressive then, and defensive either, do you? You want to be able to assert yourself and be credible with that, don't you? Which hopefully I can do ... but I recognise there is a burden in doing that. I think you could naively go into it and ignore all those kind of things, but I don't think then your contribution would be valued. I think you need to reflect first and then work out what game you are playing and then step in (Phase 1: Interview 1).

> **Sarah**: I mean my other nurse rep is used to public speaking and she'll talk, and it's a dreadful thing to say, but it comes to a point where people don't want you to say anything. There's the looks if someone goes on, 'cause some of them do, and get high and mighty and start being quite confrontational, some of them, and you can see the looks which I immediately, I think, 'Ooh gosh I can't say anything because they are going to look like that at me' you know. But I have seen it happen to a few nurses. It's like, 'This is not important', you know; 'What you are saying is not relevant, just shut up', you know. It's happened a couple of times (Phase 1: Interview 1).

These extracts also identify the necessity of learning and responding to the unspoken (gendered) rules governing organizational behaviour and the difficulty and burden in doing so. For example, whilst Sarah fears rejection and disapproval if she were to challenge and speak out, the alternative - that of 'being thought of as the weak nurse who sits in the corner', is equally untenable. Sarah joked that she hoped she would rise to the challenge when the time came: 'I'll wait for that moment, and hope it's not yet!'

Significantly for Sarah, the Chair of her LHG was also one of the GP partners in the practice in which she worked, and this compounded the problem she had in speaking out and contributing to the work of the LHG.

> I would have been a lot happier had Dr Wilson not been Chairman – that is a big problem with me… He's not an easy man, um, and he likes to put you down so it's very difficult to – I can fight it here (where she worked) because it's my job and I know it. It's difficult to fight it outside the work place … and will it be brought back here? … If I start getting *opinionated* at these meetings I've got to come back here, you know, and I might have disagreed with what he said and you've still got this work to do (Phase 1: Interview 1, my emphasis).

Sarah worried that as a board member, were she to openly disagree with Dr Wilson, it might jeopardise their working relationship and her job as a practice nurse. Sarah's identity as an employee further limits her organizational authority and status on the board.

Sarah's use of language is also interesting. In the final sentence, she implies that being 'opinionated' and disagreeing with someone are the same thing. Sarah judges herself as she perhaps imagines being judged by others. This is another example of the way in which organizations are gendered through the ongoing 'internal mental work of individuals' (Acker 1992 p. 253) as they make sense of and respond to the various rules governing gender-appropriate behaviour and attitudes. As a woman and nurse on the board, these rules emphasise co-operation and compliance. As such, disagreeing with someone or offering an opinion may well be interpreted as being opinionated.

6.4.3 Other strategies

In addition to 'being their best' and not wearing a uniform to board meetings (see section 6.3.1) nurses also used a range of other strategies. The following examples are taken from my fieldnotes when observing LHG board meetings during their first six months.

Whilst observing a board meeting of LHG1, I noticed Becky would ask permission to speak. She would raise her hand to attract the Chair's attention then ask, 'Do you mind?' This interested me, as I comment in my notes at the time:

> She doesn't seem to have a problem speaking, she sounds confident, which is why it's a bit strange she keeps asking the Chair if it's okay. No one else asks. (Phase 1: Fieldnotes)

The significance of women asking permission to speak in such situations is highlighted by a number of authors (see for example Gheradi 1995, Katila and Merilainen 1999, Fournier and Kelemen 2001). Gheradi (1995) understands such behaviour in terms of the on-going remedial work undertaken by women as they negotiate their displaced presence within male defined organizational culture. Asking permission to speak, apologising for doing so and undermining the importance of what they have to say, are all strategies that women use to manage their status as outsider. As Gheradi (1995) comments:

> I suggest that women's lack of assertive style can be interpreted as a ritual that repairs the offence caused by the infringement of the symbolic order of gender when they speak (p. 141).

Katila and Merilainen (1999) draw on Gheradi's (1995) analysis to shed light on the way in which women and men actively collaborate in the gendering of organizational culture. In their study of women academics in a male dominated scientific environment the authors observed women and men discussing and contributing to seminars in very different ways; in particular they comment on the silence of women compared to the men:

> Taking over the public space and adopting the position of a competent professional in the field is hard after years of silence. Women most often start by asking permission to intrude. In other words, women indirectly request authorization, protection and benevolence. Consequently they give up their autonomy to define the discussion (p.169).

Gheradi's (1995) theory can also be usefully applied to another encounter I observed at a board meeting of LHG3. The board were discussing the Health Improvement Programme (HIP) for the LHG. Linda, one of the board nurses present that day, sought clarification on a point identified in the programme as the 'integration of primary care and secondary care nursing'. My fieldnotes at the time describe Linda's body language and the way she appeared when she spoke:

> Linda appeared nervous. Slipping one shoulder down, giggling, slightly apologetic, head on the side (Phase 1).

In identifying what appears to have been an oversight in the plan, Linda can be seen to have made a challenge and her behaviour indicates she felt uncomfortable about

this. She tries to make herself physically smaller - less threatening. In doing so she implicitly acknowledges her status as outsider - her actions reflect the precariousness of her identity as a legitimate and competent board member. Drawing on Gherardi's analysis, Linda's body language can be read as an attempt to restore the gender order, which her presence and challenge has disrupted.

Whilst perhaps useful in the short term, strategies such as those used by Linda and Becky can have negative consequences (Acker 1992, Marshall, 1984). As Marshall (1984) makes clear in her discussion on women managers' preferred management style, the very strategies women may use to ensure their survival within organizations also risk undermining their authority and voice:

> Adopting a non-competitive style as a reaction to prejudice in fact reinforces a traditional pattern of relationships in which men are dominant and women adopt more subversive approaches... a coping strategy which protects the individual can actually block longer term or more general strategies which would make women acceptable as themselves within organizations (p. 158).

Claire and Rose were unusual in that they explicitly acknowledged they used strategies to manage their ambivalent status as nurse board members. The first of these strategies is reminiscent of the doctor-nurse game previously discussed in the literature review. Highlighting the way in which they felt they had contributed to the clinical governance work of the LHG, Rose commented: 'You have to take things to GPs, it's a strategy you develop – you actually make it their idea'.

Claire also described how they made a conscious decision at each board meeting to sit in certain places in order to improve their chances of being able to contribute more effectively:

> We were gaining a better insight into how to manoeuvre our way to getting our voice heard on the board...We've got to mix ourselves through the GPs ... We sit so that we can have eye contact with each other, but not so that we are *clumped together as nurses* (Phase1: Interview 1, my emphasis).

At the time of her second interview, Claire reiterated the importance of this strategy – that as nurses, their opinion was more readily sought when they were interspersed

amongst their GP colleagues. Marshall (1984) and Sheppard (1992) identify a similar strategy used by women managers:

> Some managers explained how they minimized their contacts with other women at work to preserve their individualistic status, and avoid being seen as 'one of the girls'. Their immediate personal context had become all-important (Marshall 1984 p. 151).

This strategy seems particularly significant. It provides a stark illustration of the symbolic importance of woman as the devalued Other. Nurses' attempts to minimize contact with each other and sit amongst the GPs on the board also draws attention to the powerlessness of nurses as a group and throws into sharp contrast the perceived status and power of GPs compared to nurses. More generally, such a strategy precludes women from utilising a valuable source of support (other women).

The above accounts illustrate the remedial work (Gheradi 1995) carried out by nurses as they balance the conflicting demands and ideologies of their identity as nurses and women with their identity as competent board members. These extracts also demonstrate the way in which women and men actively reproduce gendered subjectivities and relations and with that, the gendered organizational culture of the LHG and the NHS.

What seems clear is that a great deal of effort and forethought is needed to manage credibility in a masculine organizational culture in which nurses and women are in many ways *in*credible (Hall 1992). It is to the nurses' credit that they also continued to directly challenge power relations and resist their positioning as 'out of place' (Fournier and Kelemen 2001). Kate's account of challenging the board with regard to teenage pregnancy (see previous chapter, section 5.3) is perhaps a good example.

I have argued that some of the problems nurses face are similar to those of women managers. However, it seems nurses face an added dilemma. Nurses are on the board *precisely* because they are nurses. In this context, their occupational identity, with its negative, gendered associations, is hard to escape. As such, nurses may find it all the more difficult to gain credibility.

The final section of this chapter explores in more detail one of the key themes to emerge from the data in relation to identity – that is, nurses' ambivalence toward conceptualising their organizational experiences in terms of gender, and locating these experiences in the wider social and political context within which they live and work.

6. 5 The personal is political: making the connections

During my interviews with nurses I was struck by the tendency to deny or downplay the role of gender as a significant factor in their organizational lives. I was intrigued by this and my own very different views. As Aldridge (1991) comments in relation to her research study: '…why was it that other students had … not come to see the social world in terms of gender as I had?' (p. 16).

That nurses do address the issue of gender and engage at some level with feminist politics is, I believe, crucial, as a number of authors have argued (Muff 1982a, Roberts 1983, Darbyshire 1987, Attridge and Callahan 1989, Davies 1992, Witz 1994). For Witz, 'the problem *for* nursing has been and continues to be the problem *of* gender' (1994 p. 23).

6. 5. 1 Taking personal responsibility

It seems nurses felt personally responsible for managing their marginal organizational status and for managing the emotions and conflicts associated with their devalued identity. Seldom were solutions located at the structural and social level, as Marshall (1984) comments in relation to her study of women managers:

> From their list of strategies we see how they often took on personal responsibility for managing the disturbance they represented in the work environment. They tended to handle potential prejudice by accommodation wherever possible, adjusting their own attitudes and behaviour to counter contextual pressures (p. 159).

This is also what nurses appeared to have done. The range of strategies they used, for example 'being the best', not drawing attention to themselves or being too loud or outspoken, and other unassertive behaviour, are attempts to control their image and

accommodate prejudice. They change and adapt to a culture within which they are positioned as outsiders. As Sheppard (1989) argues, it is 'femaleness' that requires management; 'maleness remains embedded in the organizational cultural context and as such is not experienced as problematic' (p. 144). Whilst challenges may be made to the prevailing masculine organizational culture and discourse, the desire for success and acceptance leads women to focus instead on their own gender identity (Sheppard 1989). The implications of this are that the organizational culture goes largely unchallenged. The use of such strategies normalises existing relations of power. Women's presence and position as Other, as outsider, remains.

Some of those (Kate, Sarah, Viv, Megan) who identified negative aspects of their identity as nurses and acknowledged the existence of oppressive power relations which devalued and marginalised them, also implied their feelings about these relations were in some way unreasonable, potentially damaging and as such, needed to be contained. For example, early on in my research I had approached Megan as a key informant. Megan was an ex-work colleague of mine and newly appointed nurse board member to an English PCG. LHGs were not yet up and running and I was keen to find out how nurses on PCGs were progressing. We were discussing how the traditional power relations between doctors and nurses impacted on her board experiences. Megan commented that she was aware of the 'baggage' of this relationship 'the whole time', but that it was necessary 'to put the baggage to one side'. The 'exorcism' she commented, was up to her. It wasn't simply a matter of using the right strategies for managing this relationship; Megan also took responsibility for working on herself to overcome the feelings of inadequacy and inferiority that this relationship engendered.

Sarah and Viv echoed these sentiments. Both acknowledged that as nurse board members they felt very constrained by the traditions of the doctor/nurse relationship. They also felt that dealing with it was ultimately their problem, as Sarah commented in relation to the GPs she worked with at her practice:

> There is still that 'You do what I say' ... I'm down here (indicating subordinate position) and it's still like that. And it's up to me to deal with it – it's my problem – but it's very difficult, you know? (Phase 1: Interview 1).

Dealing with the impact of this relationship is burdensome and emotionally wearying for nurses. From a feminist perspective taking personal responsibility in this way also denies the significance of structural factors and processes of oppression which feed into and perpetuate inequalities in power and status. In addition, the effects of women's inequality remain hidden from view, rendered invisible.

Sheppard (1989) argues that when a woman blames herself or holds herself responsible for sexism; 'in a situation of relative powerlessness, she will exert control at the only level perceived as accessible: her own behaviour' (p. 151). Rosser and Davies (1987) highlight a similar point in their study of women in administrative roles in the NHS. Despite women's complaints about unfair and discriminatory practices and treatment, such complaints 'were often qualified by self-blame...' (p. 80).

I tried to address this issue with Sarah during the interview. She had complained about the way GPs on the board insisted they were referred to as 'Doctor' - something Sarah struggled with as this reinforced both medical authority and her subordinate position as a nurse. I challenged her when she commented that her feelings of inferiority, 'are my problem – I don't think anyone else can help'.

> **A:** I suppose when I was saying I'm not sure it's just your problem I was thinking the behaviour of others can reinforce your feelings of inferiority. So for example, if Dr Wilson said, 'Oh come on Sarah, call me Joe'....
>
> **S:** Oh it would be like – I'd probably cry! (sounding very excited)

I was trying to encourage Sarah to locate her personal experiences in the wider social context in which oppressive relations of power are maintained and legitimised. I was also trying to suggest that the actions of others can significantly contribute to such relations, and that it is legitimate to expect others to take some responsibility for addressing this – even if it is unlikely they do so. This is particularly the case in a multi-disciplinary forum like an LHG, which has an explicit mandate to work collaboratively and actively engage all members of the board.

Coping with oppressive relations and practices by taking personal responsibility helps to explain the ambivalent and contradictory place of gender in nurses' accounts. But there are other possible explanations.

6.5.2 Making sense of the denial of gender

Most of the 15 nurses I interviewed, with the exception perhaps of Tina, Kate, Viv and Sarah, to varying degrees, felt gender had had a limited impact on their organizational experiences. There were times when nurses alluded to the role of gender, in particular the relationship between their gender and occupational identity, but would then contradict themselves and deny gender had any bearing on the situation.

Davies (2003) highlights a similar issue in her study of the doctor/nurse relationship. Whilst nurses denied the gender of the doctor was a factor, 'in subsequent discussion the nurse would …often provide evidence of responding to a woman doctor differently or of a woman doctor behaving differently to them' (p. 739). Nurses' ambivalence toward the role of gender is also highlighted by Porter (1992). As previously indicated, Porter found that whilst nurses acknowledged gender as a factor affecting the status of their own occupation, when it came to medicine, 'sexism was seen as an individual phenomenon of specific doctors rather than an institutional ethos' (p. 518).

Interestingly, Kate, who seemed very conscious of and able to express her experiences in terms of gender power relations also questioned the legitimacy of her understanding. She wondered whether things were really that way, or whether, 'it's just my own personal view about being a nurse and being a woman that I'm bringing to that'. It seems that when we question prevailing ideology, we doubt ourselves, we see ourselves as being irrational and unfair - we judge ourselves as others do within the context of a masculine hegemony. As I indicated in relation to my own experiences (see chapter four, 4.5):

> It is exceedingly difficult to break away from hegemonic ideas and counter them
> with other thoughts because in doing so one is made to seem eccentric, extremist,

flying in the face of reality. Feminism is represented as all these things (Cockburn 1991 p. 169).

I wondered whether it was precisely because of the marked divisions within health care, that locating gender is so difficult. Gender is *so* inscribed in work roles and divisions within the NHS that such divisions seem normal and common sensical – they become almost invisible, as Hearn and Parkin (1992) comment: 'Fixed gender distributions are often so taken for granted that they fail to be worth mentioning by the actors themselves' (1992 p. 52). As a consequence, thinking 'outside' of these existing relations of power and hierarchies seems almost impossible.

Tina speculated that nurses' lack of gender awareness was the consequence of their training and socialisation within the male, medically dominated culture of health care. She argued that any feminist views nurses hold,

> are knocked out of them as soon as they get anywhere near a hospital…They have to produce the nurses that have to survive in the environment and the environment you are kicking them out to is patriarchal - the hospitals, the GPs - and unless they recognise it - but they don't (Phase 1: Interview 1).

As previously indicated, both Kim and Sarah similarly identified their training as contributing to a way of thinking and operating which normalised and legitimised existing gender power relations.

Significantly, Tina highlighted the importance of having done an MSc in Women's Studies and it was this in part that enabled her to identify and articulate the role of gender in her experiences. It may be that the lack of engagement in general between feminism and nursing (see for example Ashley 1976, Chinn and Wheeler 1985, Vance *et al.* 1985, Reverby 1987, Bunting and Campbell 1990, Mulligan 1992) contributes to the ambivalence amongst nurses in taking part in more critical, gendered thinking.

As previously discussed, Marshall (1984) found women managers' accounts with regard to gender similarly contradictory and confusing. Women managers denied gender was relevant, yet also identified disadvantages of being female. In trying to make sense of the contradictions in these accounts, Marshall speculates that women's

awareness of their own gender identity was important to control and represented a key survival strategy:

> [I] discovered that one way of managing the potential stress of being a woman in a man's world was to control one's awareness of being female... and different from men... By thinking of themselves as people first, they minimized their own sensitivity (1984 p. 151).

In denying the impact of gender, nurses obscure oppressive practices and behaviours that marginalise and limit them – they obscure, yet participate in the gendering of organization. But the difficulties nurses have in 'seeing' gender, perhaps ultimately reflect the contradictory and complex ways in which such gendering takes place, as Acker (1989) comments: 'I think we are only at the beginning of working out what we mean in concrete terms when we say social relations and processes are gendered' (p. 77).

6.6 Chapter summary

This chapter has explored the way in which nurses constructed, experienced and made sense of their identity as women and nurses. Nurses gave a range of responses, some clearly acknowledging that being a woman had impacted on their organizational experiences. Amongst those who were less emphatic, a contradictory picture emerged, with nurses inferring that gender was a factor in their experiences, yet at the same time denying its relevance. Nursing identity was understood and to some extent experienced in negative terms with, as the data suggests, some nurses struggling to overcome intense feelings of inadequacy and worthlessness. Nurses employed a variety of strategies with which to manage their personal identity, and invested an enormous amount of time and effort in their attempts to successfully pass as competent and credible organizational members. An exploration of the ambivalent role of gender in nurses' accounts concluded the chapter.

The findings in this chapter build on and develop the literature reviewed in chapter two to highlight the cultural devaluing of nursing and the way in which nurses make sense of and negotiate their subordinate identity as nurses and women. Together with the findings discussed in chapter five, they contribute to an understanding of one of

the key challenges facing nurses as outlined in the introduction to the thesis – 'the order to care in a society that refuses to value caring' (Reverby 1987 p. 1). Nurses occupy a particularly fragile place within masculine organizational culture, yet little is known about what this dilemma means in practice for individual nurses. In exploring the issue of identity with participants, this chapter provides important insight into how nurses experience and respond to this dilemma. Reflecting on these findings, what is significant is the depth of nurses' negative feelings in relation to their occupational identity and the inhibiting effect these feelings can have on nurses' ability to contribute to decision making processes and to play a more active part in helping to shape and determine health policy.

Drawing on feminist theory (see for example Acker 1992, Gherardi 1994, Benjamin 1988) the findings also illustrate the way in which a number of complex interrelated processes are operating at a structural and individual level to reproduce and sustain oppressive power relations. For instance, in the context of a health service in which nurses occupy a subordinate and relatively powerless position, the rewards for nurses (a degree of recognition and power) in conforming to gender ideals make any challenge or resistance to such ideals, and to nurses' position as Other, profoundly problematic. In addition, in highlighting the role of pleasure in the maintenance of (heterosexual) relations of dominance and submission within the doctor/nurse relationship, these findings draw attention to the powerful drives that underpin and help to maintain this relationship.

In her analysis of doctors and nurses at work, Wicks (1998) also examines the issue of pleasure, but does so principally in terms of the pleasure nurses get from caring and nursing work. One concern in this chapter has been to draw attention to the unconscious desires and impulses (for example, the pleasure in submitting) that help shape the doctor/nurse relationship and which undermine the development of more egalitarian relations between doctors and nurses (and medicine and nursing) in general.

I continue to explore these themes in the following chapter on medical power where I further develop an understanding of the way in which nursing and gender identity is constructed and negotiated in the context of the doctor/nurse relationship.

Chapter Seven Medical power

7.1 Introduction

Medical power emerged as a central analytic theme in the data, as I have highlighted in previous chapters. In this chapter I develop this theme by exploring in some detail how medical power was experienced and understood by nurses and doctors on LHG boards. In particular, this chapter further demonstrates the ways in which medical power is reproduced at individual and organizational levels and how this reflects and contributes to the gendering of organizational culture. Building on findings in chapter six and literature reviewed in chapter two, this chapter also adds to an understanding of the meaning and impact of the doctor/nurse relationship.

Medical power was evidenced in two ways. Firstly, the way in which GPs and GP concerns fundamentally shaped and informed the work of the LHG was a clear reflection of the influence they exerted. Secondly, medical power was evidenced in the traditional doctor/nurse relationship, in which nurses occupy a subordinate position to doctors. For some, this relationship had a significant impact on their experiences as board nurses. These experiences are explored in detail in the first half of this chapter.

The subject of medical power emerged largely unprompted during the interviews with nurses, who readily identified this as a major concern of theirs. Early speculation in the nursing press regarding the power and control of GP board members, my interest in the power relations between doctors and nurses, and nurses' own concerns, meant that this issue was a key area for exploration in the interviews.

I begin in section 7.2 by looking at the doctor/nurse relationship in more detail to highlight the way in which gender is implicated in the construction and negotiation of this relationship. Section 7.3 addresses nurses' experiences and views on medical power and dominance on the boards of LHGs. This analysis is developed further in section 7.4 where I consider the views of GPs in relation to their position of power and authority. The chapter concludes with an exploration of medical professionalism

and masculinity which helps contextualise nurses' and GPs' organizational experiences in terms of gender.

7.2 Perceptions of the doctor/nurse relationship

The doctor/nurse relationship has been the topic of much debate in the nursing literature. The importance of this relationship and its continuance as a source of conflict and difficulty is illustrated by a joint publication of the *Nursing Times* and *British Medical Journal*, which was devoted to the topic of doctors and nurses working together (Salvage and Smith 2000).

That medical power and the doctor/nurse relationship is also an issue for nurses on LHG/PCG boards is highlighted by a number of authors, including Smith *et al.* (1999), Smith *et al.* (2000) and Poole (2000). For example, reflecting on her own experiences as a PCG board nurse, Poole comments on the barriers and obstacles facing nurses in her position:

> My concern at present is that there is an underlying history of barriers between nurses and doctors that cannot be demolished overnight. Until we are able to acknowledge the unspeakable hidden agendas – 'doctors feel intellectually superior to nurses', 'the medical model is the only model of health care' – then we will make little progress (2000 p. 37).

Aspects of the doctor/nurse relationship and its impact on nurses' experiences have been outlined in previous chapters of the thesis. In particular, I have drawn attention to the way in which the nursing contribution, with its emphasis on nursing knowledge and perspectives, offers an alternative discourse and can be seen as a direct challenge to medical authority and the medical model of health. The relationship has also influenced nurses' experiences in terms of their identity as nurses and women. For some, it has been a struggle to assert themselves and create an alternative, more egalitarian narrative in their relationship with their medical colleagues.

The purpose of this section is to explore in more detail the experiences of those nurses who have felt particularly troubled by the doctor/nurse relationship. As

Davies (2000b p.1022) argues, there is a 'weight of tradition' which defines this relationship, and which poses a major obstacle to establishing more egalitarian working relationships. I wish to focus on the way nurses feel about, construct, and negotiate this relationship. Doing so sheds light on the processes whereby damaging patterns of oppression and subordination are sustained, reproduced and resisted at an individual level. To reiterate Gherardi's (1994 p. 595) point:

> Gender is not just located at the level of interaction and institutional behaviour (the gender we do) but at the level of deep and trans-psychic symbolic structures (the gender we think).

It is the gender nurses 'think' in the context of the doctor/nurse relationship, which is the focus of the following section.

It may be that relations between doctors and nurses on the board are less intense than the one-to-one encounters and negotiations that take place in clinical practice. In the main, encounters and discussion between the two groups took place in large, multi-disciplinary meetings where the different views and beliefs of other stakeholders (for example, social services, lay and voluntary representatives) were also evident. This perhaps 'dilutes' the intensity of this relationship. Nevertheless, it is clear that this relationship had a marked impact on some nurses.

7.2.1   The burden of the doctor/nurse relationship: nurses' experiences

Of the 15 nurses in the sample, five spoke at some length about the impact of the doctor/nurse relationship on their experiences as board nurses.

For example, Maxine, an experienced and mature community nurse, had been talking about the medically dominated LHG agenda and how it was important to 'keep chipping away' to ensure other voices were heard. She fell silent for a few seconds then commented, 'I hate to admit this after all these years but the 'doctor/nurse' baggage is still there'(Phase 1: Interview 1). As other nurses had argued, Maxine felt her training and socialisation as a nurse had left her with a legacy of deference and a lack of self-belief, which she felt other non-GP board members did not share. She explained: 'The optometrist isn't in awe of the GPs as the nurses are'.

Mahon and Garrod (2000) make a similar point in their study of PCG chief executives, some of whom felt board members, and nurses in particular, were inhibited by the dominance of GPs. One chief executive described nurses as 'hiding their light under a bushel' (p 26).

When I asked Maxine how her feelings about the doctor/nurse relationship might impact on her role as a board member or the function of the LHG, she said: 'It stops you challenging – unless you are absolutely sure. It's hard to stick to your opinion – you think they (the GPs) *must* know.'

What I find particularly interesting about this comment, is that Maxine indicates that it is her own deep rooted feelings about who doctors and nurses are, rather than any deliberate overt discriminatory behaviour on the part of GPs, which influences her behaviour. Despite believing that the medical view expressed at the board was at times narrow and ill informed, Maxine does not challenge this - such is the legacy of the doctor/nurse relationship and the requirement of deference and subordination which has traditionally underpinned these relations. She doubts herself and her own beliefs - as she says of GPs, 'you think they must know'. Power and status are accorded to GPs even when the evidence would seem to point to their uncertainty and fallibility.

This is another illustration of the way in which certain (gendered) values and beliefs reproduce oppressive power relations between men and women, doctors and nurses and between medicine and nursing at an individual and organizational level.

Sarah also highlighted the doctor/nurse relationship as a key feature of her organizational experiences. This relationship appeared to dominate the way she felt about her role and her ability to contribute to the work of the LHG. Early on in our interview, Sarah identified the importance of this relationship to her. We had been talking about decision making procedures on the board and Sarah commented on what she saw as the formality of board procedures:

S: Our groups are still very formal – it's still 'Doctor' this ... I don't think there are any that are called by their first names. So everything still has that formality.

A: What do people call you?

S 'Sarah.'

A: Is that something you asked for?

S: Yes, I don't want to be called Sister Jones or Mrs Jones. I want to be called Sarah. But I think in meetings especially it should be informal and that's how you get to know people. *But you've still got this big gap between doctor and nurse, and that I find the biggest problem.*

A: That's really interesting, that's something that I wanted to explore, so tell me a little more about that.

S: There's one who's in charge of clinical governance. Now I feel quite happy calling him Brian. But Dr Wilson – as I still call Dr Wilson – is a *very* formal person; he's nice, but very formal and I find it, I can't quite call him 'Joe' like the other male members do.

A: Okay, so other people in the group call him Joe?

S: I'm not happy calling him Joe, I don't feel as though that barrier has been dropped around me to do that. And again it's so difficult because it's Dr Wilson here (at the surgery). But the other board members that aren't GPs, it's first name terms, it's only the GPs who seem to maintain this 'Doctor'.

(Phase 1: Interview 1, my emphasis).

Sarah refers to the 'formality' of the LHG (something I too observed) and her discomfort with this. However, the use of titles is more than formality - the use of the title 'Doctor' is of great symbolic importance. The title is associated with power, status, prestige, omnipotence, autonomy, and masculinity. Referring to GPs as 'Doctor'- especially when others are referred to by their first names - serves to reinforce their status and power and perpetuates traditional patterns of domination and subordination. Rituals and interactions such as these illustrate the way in which we 'do gender' in our organizational lives (Acker 1992, Gherardi 1994).

Sarah's relationship with Dr Wilson - her boss and the LHG chair - appears particularly problematic. It seems that other male members of the board (the majority of whom were GPs) did refer to him by his first name – although Sarah's account is contradictory in this respect. Sarah though, struggles to do likewise. Undoubtedly Dr Wilson's position as her employer, his social and organizational status as a male and

a doctor and his rather formal approach, combine to make it very difficult for her to challenge. As Davies (2000a) comments of the doctor/nurse relationship, 'inequalities in power can make it virtually impossible to speak out' (p. 35). Sarah's comments perhaps also highlight the extent to which she experiences her identity as a nurse as devalued and subordinate. Rather than any direct request on Dr Wilson's part, it seems it is her own deep rooted feelings about this relationship, in particular her feelings of inadequacy, that prevent her from referring to him by his first name. As she says, '*I can't quite call him Joe ... I'm not happy calling him Joe*'. It is the gender both Sarah and Dr Wilson do that helps to maintain the conventions of the doctor/nurse relationship and which contributes to the gendering of organizational culture.

It seems significant that there is no direct or explicit request by Dr Wilson that Sarah refer to him as 'Doctor'- in one sense it's voluntary. This is important to recognise, as Pringle's (1989) discussion on the boss-secretary relationship illustrates. In her account, Pringle (1989) provides an analysis of Benjamin's use of Hegel's master/slave dialectic to explore gendered subjectivity and patterns of domination and submission. Pringle (1989) comments that in the maintenance of relations of domination and subordination between subject and object: 'What is important is that the submission be voluntary and that the annihilation of the object be indefinitely deferred. This prolongs the moment of recognition' (p. 176).

It is possible to understand the dynamic between Dr Wilson and Sarah in this way. Together they are bound up in a ritual that confirms their identity and successfully constructs and maintains oppressive relations of power. Sarah grants Dr Wilson recognition as subject. For her part, Sarah (in theory at least) has the chance of gaining power albeit vicariously, through his patronage and association.

Toward the end of Sarah's account she mentions the barrier she has to overcome if she is to use first name terms. The significance of overcoming this barrier is illustrated by Sarah's comment that should Dr Wilson suggest she call him by his first name, she would 'probably cry'. Her position as object to his subject would be fundamentally disrupted.

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The way in which the use of titles is legitimised and normalised as part of the LHG activity and ritual does nothing to encourage Sarah to break free from or push the boundaries of her thinking. This is significant for as Kim suggests in the following extract, having organizational support for the use of first name terms and the informality this engenders was key to helping her loosen her own gender thinking. Kim had been discussing how she initially felt inadequate compared to other board members, particularly GPs. The legacy of the doctor/nurse relationship was something she had struggled to overcome.

> And I think what made it, when we became more of an informal group, when we had a coffee and a sandwich together - like I'll go in today, it'll be 'Hi Kim all right?' you know, and I'll shout back 'Hi John, yeah fine – how's things been?' I think once we got past that barrier of being called first names - I think that's what changed it for me. Hang on, these people are the same as me! Yes, they've got loads to contribute from their areas, but no more than I have from my area. I actually went home one night and I thought if I'm not going to get over - if I'm not going to get over that step, it's a waste of time me going (Phase 1: Interview 1).

The 'step' Kim refers to can be interpreted as the process she must go through to rethink gender – to deconstruct and dismantle her feelings of inadequacy and resist her positioning as the Other.

Interestingly, on Kim's board (LHG3) there had been a discussion about the use of titles, with GPs initially wanting to be called 'Doctor', apparently on the basis that 'if the press were in, it looks professional'. However, the remainder of the board objected and felt if GPs were to be referred to by their title and surnames, then everyone should be. The board took a vote and the non-GP members, who outnumbered the GPs, won.

LHG2 and LHG6 were the only LHGs where I observed GPs referred to as 'Doctor'. However, Smith *et al.* (2000) also identify this as an issue in their interim evaluation of PCGs:

> In one PCG, one of the barriers to effective nurse involvement in board discussions was cited as being 'double standards' in how members were addressed, this being seen as a perpetuation of some of the hierarchies in nursing and medicine: *'GPs are addressed as 'Dr...' whilst nurses are called by their first names. The traditional doctor/nurse relationship is continued at the board'* (social services nominee) (p. 71).

Viv was another who struggled to deal with her feelings with regard to the doctor/nurse relationship. These feelings came to the fore when she first joined the board, as the following extract taken from our first interview indicates. Viv had mentioned that board members were 'equal partners'. I then asked her whether she *felt* equal:

> (Shaking her head and laughing) No, but that's my own problem I think, Yes I really, mmm, it's a self-worth type thing. I'm not getting deep and psychological with you now. It's a bit of a struggle I think probably because I want them to realise, I want them - the rest of the group to realise – i.e. no, I want the *GPs* to realise, because the other members of the group don't give me a problem at all. I want them to know that I am their equal and perhaps I'm having a bit of a struggle with that at the moment... I think perhaps my attitude is coloured by the fact that in the GP practice that I used to work in I *was* taken for granted and used as a 'dogsbody' and adopted that role of the subservient, um, female. I'm probably still taking that with me because I do feel quite bitter about it (Phase 1: Interview 1).

As she talks, Viv is trying to make sense of her feelings. She realises that in terms of equality, it is her relationship with GPs that is so crucial. It's as if she wants to force them to acknowledge her equality – to recognise her as another subject. As previously indicated, a number of writers argue that self-esteem for nurses depends on the approval and recognition of those more powerful than them, most notably doctors (Kerr 1982, Roberts 1983, Keddy *et al.*1986, Attridge and Callahan 1989). Attridge and Callahan (1989) comment of nurses in their study: '... where colleagues did indicate approval for their behaviour, this opinion did not seem to count if more powerful physicians or supervisors did not share this opinion' (p. 55).

At our second interview two years later, I returned to the subject and asked Viv what had changed – how did she now feel about her relations with her GP colleagues?

> **V**: More equal, not as equal.
>
> **A:** And how has that happened?
>
> **V**: My increasing self-confidence I would say? (sounding as if she is asking me – almost not sure) My assurity (*sic*) that I was there to do something and however I felt, I must not feel like that - have you ever spoken to yourself like that? ... By doing that, you do actually feel a lot better and so it is easier to do it next time without having to talk to yourself (Phase 2: Interview 2).

Just as Kim did, Viv works hard to rid herself of the negative feelings and emotions she experiences in response to the doctor/nurse relationship. The work of a number of feminist writers (see for example Benjamin 1988, Pringle 1989b and Wicks 1998) suggests that nurses are grappling with conflicting emotions and desires in terms of this relationship and face a huge task in breaking free from the thinking that binds them to it. For Kim and Viv this work takes place in silence, yet must continue within the context of an organizational culture in which medical power is reinforced and legitimised by virtue of the structure, procedures and orientation of the LHG and the beliefs and attitudes of some of its members.

7.2.2 Alternative discourses on the doctor/nurse relationship

There were other experiences and interpretations of the doctor/nurse relationship. Somewhat removed from the rituals of the relationship by virtue of her role as general manager, Louise noted that the traditional power relations between doctors and nurses were reproduced and played out on the board:

> I certainly see it because I think, again the gender thing, my experience is predominantly male GPs, predominantly female nurses, then you get the play off of genders on the board. 'We know best' and nurses are allowed to comment. And sometimes they gang up together against the other professions, 'because we know each other the best don't we?'
>
> And then the doctors try to get the nurses on side 'cause if they've got the nurses on side no one else will be horrible to them because the nurses are always the goodies in this. And I think what the nurses haven't quite learnt to do is to challenge enough (Phase 2: Interview 1).

I think this account illustrates the complexities and subtleties of the doctor/nurse relationship. What particularly interests me is Louise's observation that doctors and nurses form an unspoken alliance – ganging up against others, 'because we know each other best...' This dynamic felt very familiar to me – it rang true. The motivations for doctors in forming such an alliance – as Louise suggests – are that they get to be associated with the 'goodies'. This is a useful strategy in meeting (new) challenges to their dominance and in consolidating their power.

Drawing on Benjamin's (1984) interpretation of the master/slave dialectic it is possible to see the benefits for nurses too. Being so closely allied to doctors, nurses get to merge with the powerful subject, and in so doing, they achieve some recognition. As suggested in chapter six, this may account for why nurses find it hard to challenge medical authority. Whilst they may lack the experience and confidence to challenge, were they to do so they risk losing the power such an alliance affords.

Louise also argued that the doctor/nurse relationship was characterised by paternalism and a patronising attitude on the part of doctors:

> People tend to certainly initially go into traditional ways of thinking about groups, so the nurse is female and young and so therefore a GP would put her in the same bracket, 'there there pet', and smile nicely, 'isn't she kind?'. If the GPs have been male and predominantly older they have been paternal towards the nurses who tend to be younger (Phase 1: Interview 1).

Becky supported the view that GPs could be paternalistic. She argued that her GP colleagues on the board had been quite protective toward her: 'I think initially they felt they better look after the nurse, because this might be a difficult environment'. However, for Becky, such paternalism wasn't necessarily experienced or understood as negative. It seems her relationship with the GP Chair, whom she knew well from clinical practice, had been a positive and beneficial one. Becky felt she had received a great deal of support from him. He had reassured her that she did have an important contribution to make and not to be afraid to make it. As she commented, 'I haven't found that they've (the GPs) put us down at all, quite the contrary really' (Phase 1: Interview 1). It is worth speculating whether this relationship might be undermined were Becky to break out of the father/daughter relationship and refuse to be 'daddy's little girl' (Lovell 1982 p. 210).

Early on in the research I approached two key informants – a senior nurse on a PCG (Kay) and an LHG general manager, who was also a nurse (Rita). Both felt the traditions of the doctor/nurse relationship had been imported into the PCG/LHG. In particular, they felt that nurses were positioned in a support role to GPs. For example, Rita complained that nurses had been asked to 'go off and do clinical

governance stuff' when it was not their job to do so – rather it was the secretariat's role.

Debbie made a similar point. She also highlighted what she saw as oppressive power relations between doctors and nurses, commenting on the way in which nurses in general occupied support roles with diminished authority and control. For Debbie the issue was doctors' 'ownership' of patients, which she felt conferred on them power and status - particularly in relation to nurses. This, she argued, was the root cause of inequalities in power between doctors and nurses:

> Ultimately they are the GP's patients. And I caseload them. I cannot prescribe for them, I cannot even immunise one of them without the GP giving me a prescription. Ultimately they are *his* responsibility. You see what I am saying? And until we change that we are not going to change this pecking order in the LHG. 'They're my patients, you just look after them for me'.

> That's where the power lies. My health visiting number is given to me because I am Dr Bryant's HV. It's a GP attachment. Everything we do is because we are attached to a GP. District Nursing is the same. They have a code – a GP attachment number. And those patients are registered with him. See what I am saying? We have no sort of ownership out there unless it's part of that general practice.

> If I was a practitioner in my own right and people could register with me for a service, for instance if I was a baby management expert and people were having problems with their children, they could register with me no matter who their GP was and I offered them a service within the community, then I would have that level of power within that specific sphere. But we have so many skills that we use in so many ways, to meet the needs of so many people, who are owned by the GP. That's the rub (Phase 1: Interview 1).

Debbie expresses deep resentment at her lack of autonomy and control as a practitioner – unable to draw on her full range of skills and expertise without prior authorisation from doctors. Her relationship to patients is in part determined and sanctioned by doctors. She indicates that medical dominance and power within the LHG is based on GPs' ownership of patients. This view was shared by Will, the GP Chair of LHG3, who commented, 'The power and control is still with doctors insofar as a lot of the clinical responsibility will come back to the doctor'. For Debbie, until the issue of medical ownership is fundamentally challenged, others, including nurses, will remain subordinate to doctors.

Wicks (1998) makes a similar point in her study of nurses and doctors at work. Discussing one nurses' expertise in wound management, Wicks suggests that whilst the nurse could be asked to undertake a variety of jobs,

> ...the fact remained that she 'owned' none of them. Whilst she took charge of the wounds, the patients themselves remained under the ownership of the doctor. Ultimately the successful outcome of the healed wound was submerged into the overall success of the total procedure (1998 p. 156).

Wicks (1998) contends that this situation diminishes and renders invisible nursing knowledge and skill and illustrates the way in which organizational practices reflect and perpetuate structural inequalities and power relations.

The issue of medical ownership and doctors being legally responsible for patients has been highlighted by a number of others (see for example, Gamarnikow 1978, Stacey 1992, Wiles and Robison 1994) and is discussed in more detail later in this chapter. It is worth noting that Debbie did challenge medical power and authority as a board member. As indicated in chapter four, she continually pushed for a better understanding of the contribution and impact nurses and other members of the primary care team make to patient care and the importance of considering this when planning, developing and evaluating services. In this sense she actively questioned medical ownership and clinical autonomy.

I was struck by how passionately Debbie felt about medical power. It clearly saddened and frustrated her. I was interested when in response to my question, she stated that gender was not an issue in terms of the doctor/nurse relationship:

> I don't think it is a factor because the community nurses, health visitors and midwives that are men – they fare no better, so I don't think so. No, I think it's still this ownership of patients, the ownership of the power, I'm convinced that's what it is: 'this is my health visitor, this is my district nurse'... If it has influenced it, I don't think it's a major contributor to the problem of power. No way. I think it's a small part of it (Phase 1: Interview 1).

Because male nurses 'fare no better' in their relationship with GPs, Debbie sees this as evidence that gender is not a factor in the doctor/nurse relationship. However, as previously argued, as an occupation nursing is heavily gendered female. As Porter

(1992) makes clear, 'the inability of male nurses to utilise the advantages of their gender is the result of the ascription to nursing of a position of female subordination' (p. 517).

7.2.3 A GP's perspective on the doctor/nurse relationship

My main focus in interviewing GPs (five in total) had been to explore their perceptions of the nursing contribution to LHGs and to shed light on the way GPs experienced, made sense of and justified medical power and control of the LHG.

As I have illustrated above, the doctor/nurse relationship is one way in which this power and control is expressed and maintained. I found it very difficult to broach the subject of this relationship with GPs, and certainly none of them raised it. I had asked all the GPs about medical power and nurse's concerns regarding medical dominance on the LHG, but only on one occasion did I feel able to discuss the doctor/nurse relationship directly. This was when I judged the participant would be reasonably open to discussing it. I regret not being more pro-active in my questioning with others. My reasons for not doing so perhaps relate to my uncertainty as to how to broach the subject sensitively and how to 'push' doctors' thinking on this issue – something I anticipated having to do.

I asked Will (GP Chair of LHG3) his thoughts on the nursing contribution and he commented that nurses had made a useful contribution:

> Clearly they are learning more than the GPs, certainly they are slightly quieter than some of the GPs, but then lots of the issues have been more GP based and they are learning (Phase 1: Interview 1).

I questioned Will further regarding nurses' 'quietness'. My questioning was engineered to open up the topic of the doctor/nurse relationship and the impact this might have had in inhibiting nurses from contributing more fully. Will admitted that 'at times, the board gets led by the doctors too much', but he argued that, 'we're all encouraged to speak up for ourselves'. I said I wondered how easy it was for nurses to speak up for themselves. In response, Will speculated that the practice nurse (PN) on the board might feel intimated having her boss (one of the GPs) as a co-board

member (something Kate denied at interview). He also suggested that the geographical isolation of the practice at which she worked limited her networking with other PNs, which in turn resulted in a lack of confidence and certainty regarding her contribution. (How could she represent the views and concerns of nurses if she wasn't sufficiently familiar with that they were?)

At this point I introduced the topic of the doctor/nurse relationship:

> **A:** I suppose I was thinking – coming from a district nurse background myself, the issue of the doctor/nurse relationship – the baggage of that relationship, you know, the power, and I just wondered how much of that is transferred to the LHG setting?
>
> **W:** At the moment a lot, because they [nurses] haven't had the budget to debate so actually the only budgets we are debating are the ones that affect their (PNs) salary and the GMS budget.
>
> **A:** I suppose it's coming back to this quietness and whether that's an inhibiting factor, you know; you are sitting there and yes, you've got other reps, but you've also got six GPs. I think for me that would be an issue, or I would be very conscious of that. (**W:** yeah) I don't know, I just wondered whether that had ever occurred to you?
>
> **W:** I think those barriers are being broken down, nationally, er, I think team working is becoming much more apparent in primary care, rather than 'you are my slave, do this because I told you to'.
>
> **A:** Yeah, but I think that kind of weighs quite heavy still. I think even if things are changing I think the baggage of that is still felt (**W:** yeah); that's how I would feel about it.
>
> **W:** But within that is the realism that there is actually not a lot of point in the nurse suggesting something if all the doctors go, 'No we can't'. Because it won't happen anyway; but if they suggest and market the idea of 'why don't we do this' and get us on their side....

Will recognises the power relationship between doctors and nurses, but at first sees this in terms of the dominance of GP issues and concerns on the board. After further prompts from me, Will acknowledges the oppressive interpersonal dynamics of the relationship, although the discussion is short lived.

This extract raises several issues. Firstly, I did not express myself very clearly. I was lost for the right words and phrases to capture the significance and meaning of the doctor/nurse relationship and what it appeared to represent for some nurses (and for

me). I was also trying (but failed!) to avoid asking leading questions - the vagueness of my questions perhaps reflects this intention.

What also strikes me about this encounter is my unpreparedness for Will's apparent disengagement from the topic. I had assumed that GPs in general would be more conscious of the power relations between doctors and nurses and what this might mean for those involved in the relationship. As one half of the equation, it seemed odd that they were not. In contrast, mention of the 'doctor/nurse relationship' elicited an immediate response from nurses for whom this relationship was saturated with negative meaning and connotation. They characterised the relationship as based on oppressive and damaging patterns of subordination and dominance. Nurses acknowledged that for some, the 'baggage' of this relationship could be experienced as hugely problematic, even if they denied it had a negative impact on them personally (or that gender was a feature of this relationship).

I think this demonstrates the difficulty those in positions of power and authority may have in critically reflecting on their power and the impact it might have on the lives and experiences of others (Hartsock 1990). Tina's observation that the oppressors 'don't have to know the oppressed very well 'cause they don't need to', is apt. Lorde's (1984) comments regarding the relationship between the oppressed and the oppressor are also pertinent:

> ...it is members of oppressed, objectified groups who are expected to stretch out and bridge the gap between the actualities of our lives and the consciousness of our oppressor... The oppressors maintain their position and evade responsibility for their own actions (p 162).

Whitehead (2001) illustrates this with particular reference to gender in his research on men in education management. He concluded each interview asking the following question: 'Do you think your experiences in education as a manager have in any way been affected by you being a man?' He comments:

> Unlike the women I spoke to, this question appeared to floor these men. On occasions it was as if I had spoken in an incomprehensible language. The majority had no sense of what the question meant or was referring to. They appeared never to have reflected on themselves, as men, indeed, never felt the need to reflect on

themselves as men. Their manhood, maleness, masculinity was a given, a universal 'fact'. It was as if all else revolved around this, with them as the centre (p. 77).

Whitehead (2001p. 79) concludes that whilst men remain the 'invisible gendered subject' (their gender identity taken for granted and unproblematised) there would seem little hope of transforming the organizational culture, which is rooted in and recreates a masculinist vision.

In my interviews with GPs, there were occasions when I broached the subject of medical power and GPs too seemed lost for words, unable to appreciate the significance of their status and identity as (male) doctors (see remainder of this chapter). But when I interviewed nurses and asked them about the impact and role of gender in their organizational lives, I was sometimes met with a similar response. They too appeared never to have reflected on themselves as women. Whitehead (2001 p. 79) comments, 'I very much doubt that many men are able to readily grasp the 'gendered reality' which surrounds them and, indeed, significantly informs them'. However, as I have argued, women are not necessarily any more capable of this than men. To assume otherwise risks overlooking the complex processes and practices which combine to obscure the role of gender in women's organizational lives and the efforts needed to raise gender awareness in both men and women.

Thus far in this chapter and the previous chapter I have highlighted the way in which the doctor/nurse relationship was seen by some nurses as having a negative impact on their organizational experiences as board members. Particular attention has been given to the way in which nurses construct, negotiate and enact this relationship and in so doing confirm and resist gender relations of power and inequalities between doctors and nurses, and medicine and nursing. In light of the literature on the doctor/nurse relationship outlined in chapter two, which proposed a shift to a more egalitarian relationship, the data presented here would seem to suggest that for some this relationship remains highly problematic and is certainly not experienced as a relationship of equals. In the following sections (7.3, 7.4), I shall continue to explore the dynamics of medical power by focusing on the way in which medical dominance of the board was experienced more widely in the context of the role and function of the LHG.

7.3 Medical power in relation to the role and function of LHGs: the views and experiences of nurses.

As previously discussed, the dominance of GPs was a key concern for nurses. Nurses consistently highlighted the way in which the LHG agenda reflected general practice issues and the needs and concerns of GPs (e.g. GMS issues and finances, prescribing, IT, GP manpower, premises development). In the early months of LHGs, this focus was to some extent inevitable. In part, this was because the LHG had to address some of the problems resulting from the demise of fundholding, including the levelling of services between different practices (Banks-Smith *et al.* 2001). However, nurses expressed concern that these issues dominated to the exclusion of much else and set the tone for how the board would proceed.

In addition, nurses were critical of what they perceived as the narrowness and introspection of GPs in terms of their approach to and understanding of health and of primary care development. These two issues were seen by nurses to pose a significant obstacle to the development of sensitive, patient-centred services.

During both phases of fieldwork there was some evidence that things were beginning to slowly change. GPs were seen as more willing to acknowledge and respond to the skills and contribution of other board members. Even so, amongst those who identified this shift in GP thinking (five nurses and one GP), all agreed that GP dominance and introspection were still very much in evidence.

Similar concerns have been identified by a number of studies evaluating the progress of PCGs and LHGs (see for example, Smith *et al.* 2000, Regen *et al.* 1999, 2001, Wilkin *et al.* 1999, Audit Commission 2000, Mahon and Garrod 2000 and Linck *et al.* 2001) and LHCCs in Scotland (Hopton and Hill 2001). Perhaps the strongest arguments come from the team at the Health Services Management Centre, University of Birmingham, who have consistently highlighted the medical dominance of PCG boards in their series of reports (see Smith *et al.* 2000, and Regen *et al.* 1999, 2001). The final report, published in 2001, some three years after the

inception of PCGs, indicated that changes had taken place, but sounded a note of caution:

> Clearly there have been some improvements regarding the inappropriate dominance of GPs within PCG boards over the last year. However, given the government's vision of a multi-disciplinary approach to service provision and commissioning (Department of Health 1997), the fact that the majority of PCGs within the study were still reporting high levels of GP dominance suggests that there is considerable room for further progress to be made (2001 p. 77).

7.3.1 A medically dominated agenda

The inappropriate dominance of GPs was a key concern for Charlie. When I asked him to describe the main challenges he faced as a board nurse, he commented:

> As far as the challenges are concerned I have to be quite honest when I say that the biggest challenge I find are the GPs. Not mainly in the positive way. I find the agendas brought to the board and to the executive are very doctor-led – very medically-led agendas and that does seem to influence the scope or direction of the LHG, at all levels … You might have ten things on the agenda to do with medics, then one or two community-led projects, then if you are lucky you might have one nurse-led topic. What I'm concerned about is where do these agendas come from? How is the agenda decided? I'm definitely going to look into this (Phase 2: Interview 1).

My observational data of LHG meetings and review of documentation produced by the LHG (e.g. HIPs and primary care development plans) support Charlie's argument. They reflected a bias in favour of general practice issues and a traditional approach to public health (based on a disease oriented medical model). There was little evidence of or primacy given to community-led and nursing initiatives, local population needs assessment, or alternative, more radical approaches to patient care and service delivery.

Similar concerns regarding medically dominated agenda and the marginalisation of nursing are also raised by Allen (2001) in her study of hospital nursing practice:

> The nurse managers at Woodlands expressed the opinion that it was extremely difficult for them to get nursing issues discussed at Trust management meetings. The Director of Nursing described how she often had to resort to tacking nursing concerns into other items on the agenda, which were afforded higher priority (p. 164).

What is also interesting in his account is Charlie's question, 'Where do the agendas come from?' This was also a question that occurred to me listening to nurses' accounts. However, on the occasions that I asked this question of nurses, none of them were able to answer with any degree of certainty. It was as if this was something they had not previously considered. Most began by saying they didn't know, and then speculated that it could be the executive. Whilst nurses lamented the medically-led agenda in broad terms, and challenged the boards' over reliance on a medical model of health, Charlie was the only one, without my prompting, to question how the agenda was set and to see this as something that could be explicitly and directly challenged.

This concerned me because I felt it important that nurses understood how such decisions were made and how they could contribute to and influence the LHG agenda. As Louise (GM of LHG 6) had argued nurses needed to be more pro-active in their involvement. Yet, nurses' lack of confidence in this respect may well have been compounded by their uncertainty regarding their position as board members. As I shall argue, some nurses felt like 'outsiders' and felt they had minimal ownership of board process and decision making.

These concerns stayed with me throughout my data analysis. In particular, a comment by Pam, the general manager of LHG5, proved significant in my thinking. Pam was critical of the way in which the board was medically dominated and argued that nurses, as well as others, needed to 'reclaim the primary care agenda' (Phase 2: Interview 1). She was disappointed that this was not happening.

Nurses generally pushed for a more inclusive and broad approach to needs assessment and service delivery, but few were challenging the agenda in the fundamental way Pam's comment suggests. It occurred to me that were I sitting on the board of the LHG, I would not know how to 'reclaim' the primary care agenda (or indeed that I could). It hadn't occurred to me that it was up for grabs in the way Pam implied. I struggled to think what the new primary care agenda would look like. This is not to overlook the many new and innovative nurse-led initiatives taking place in primary care, such as NHS walk in centres and Personal Medical Service (PMS) pilots which are challenging traditional ways of working (Walsh *et al.* 2003).

It is to suggest that perhaps nurses and others struggle to reclaim the agenda because of the shift in thinking that this requires – that is to 'un-think' GPs as the natural, legitimate leaders of primary care – to think beyond hegemonic ideology. As Roberts (1983), citing Torres (1981) points out: 'Consistent with the theory of oppression, nurses have been led to believe that it is right or natural for medicine to maintain control of the entire health care enterprise' (p. 29).

A similar issue is raised by Williams (2000) in her study of medicine and nursing and by Wiles and Robison (1994) in their account of team working in primary care. Wiles and Robison highlight the way in which a move to more democratic decision making processes was hampered, in part, by nurses' perception of GPs as the leaders in primary care:

> The fact that the majority viewed the GP as the leader in practice and the arrangements for access to GPs which involved the nursing professionals fitting around GPs, indicate that traditional views of the GP as the central figure taking the lead role still hold strong (p. 328).

Indeed, two nurses saw it as wholly appropriate that medical issues did dominate the LHG agenda because, they argued, the LHGs were about general practice. Emma, an experienced practice nurse commented, 'When it comes down to it, it's about how GP services are run... there has been a lot of 'Oh it's all about GPs' but that is what it's all about'. This assumption needs to be challenged, as Pam suggests.

7.3.2 Nurses (and others) as outsiders

The position of non-GP board members as outsiders on the board was a key feature of nurses' early experiences as LHG board members. Nurses commented on how the board appeared to be 'owned' by GPs:

> **Rose:** 'You looked at everybody in the first three months and just the GPs were buzzing... they were all so vocal, we felt as if they'd all met up beforehand' (Phase1: Interview1).

> **Sarah:** I can't describe it in words; there is definitely a different attitude towards the GPs and other members... I think they feel we are just an 'add-on' – this is their group (Phase1: Interview1).

Charlie: GPs see things as GPs and as about GPs; it's as if they are saying, 'you can come along if you want to' (Phase 2: Interview1).

Claire: We were new people in the arena and felt barred by it because GPs had this close working relationship at the time (Phase1: Interview1).

As some of these comments indicate, previous involvement as part of local commissioning groups gave GPs an advantage, which made it difficult for others to feel some ownership of and responsibility for the board. Nick, one the GPs I interviewed appeared to support this view. He acknowledged that at first it was an 'us and them scenario'. In addition, as Rose speculated, it became clear that GPs in at least four of the LHGs in my sample had met prior to board meetings to lobby and network amongst themselves and to decide who should take on key posts.

GPs apparent sense of ownership and confidence was evident in my early fieldwork. My observational and interview data highlighted the contrasting attitudes and feelings, motivations and frustrations of nurses and GPs as they embarked on their career as board members. These differences seemed to reflect the differential power and status of each group.

In the main, nurses' reasons for joining the board appeared altruistic and reflected a concern to use their nursing knowledge and expertise to inform decisions and improve the health care of the local community (see also Smith *et al.* 2000). Most nurses expressed a degree of uncertainty and anxiety with regard to their ability and role and it was this that preoccupied them in the early days. GPs on the other hand, appeared confident and at ease with the task before them. For the most part, they saw themselves representing the particular interests and concerns of GPs and general practice (see also Smith *et al.* 2000). Their reasons for involvement in the LHG related more to the potential threat posed by the LHG to their professional control and autonomy and most importantly, to their businesses - a point I shall return to.

7.3.3 Medical introspection

One of the main complaints by nurses related to what was perceived as introspection and insularity on the part of GPs. This was evident not just in terms of the medically-

led agenda, but in other ways too. For example, Pam – the GM of LHG5 saw the prevailing attitude of many GPs as the biggest challenge to the success of the LHG: 'GPs think and respond like GPs, as one, with GP interests at heart... GP thinking is the biggest problem.' (Phase 2: Interview1). These sentiments were echoed by participants in a study of PCG chief executives, as the following comment by one of the chief executives suggests: 'GPs always talk about their perception of things. They are not talking about how it is for real in the PCGs, they are talking about how it is for them' (Mahon and Garrod 2000 p. 26).

The 'GP thinking' to which Pam referred, privileged GP autonomy and independence, which were strongly defended. As previously outlined in the literature review, these features are typically associated with masculine ideals and codes of behaviour and are deeply embedded in the culture and organization of the medical profession, as Davies (2000 p. 35) argues:

> Traditionally the medical profession created doctors who were self-reliant and independent. It stressed expertise, autonomy and responsibility more than interdependence, deliberation and dialogue.

This point has been made by a number of writers who highlight a lack of collaborative practice and team working amongst doctors and other professionals (see for example Cant and Killoran 1993, Wiles and Robison 1994, Hunter 1994 and Parkin 1999).

Karen, the senior nurse on LHG2, supported Pam's view:

> I totally agree with that. That is one of the biggest problem areas that we actually have. And it's not just frustrating for the nurse board members; the other disciplines on the management team find this extremely difficult. I think there is a prediction to what GPs will say and I think whatever LHG you sit on, is probably exactly the same issue. I think what's interesting about GPs is that individually their views sometimes differ from the collective, but in terms of - when it comes to the crunch, they will sound with the collective and will then retrospectively contact people and say, 'Actually, I wasn't too sure, but didn't feel quite comfortable saying that' (Phase 2: Interview1).

It seems clear from Pam and Karen's comments that 'GP thinking' was experienced as deeply frustrating and disabling by non-GP board members. However, as Karen's comments also suggest, there were those *within* the medical profession who held

differing views to their medical colleagues, but nonetheless felt compelled to conform and 'sound with the collective'.

This raises some interesting issues in relation to medical power; in particular, I think it illustrates the complexities and contradictions in sustaining medical dominance. For example, it suggests an oppressive medical culture, which impacts on those both inside, as well as outside the profession. GPs on the board were expected to project a united front, and to support each other, regardless of their own personal views. They appeared reluctant to challenge their colleagues. Unity and conformity within medicine are important professional strategies. These strategies are discussed in more detail in section 7.5.

Karen's observations also undermine the view of medical power as monolithic and immutable. This opens up the possibility of seeing medical power and control as more contested - more fragile, as Wicks (1998 p. 122) suggests: 'It is vital to see it (medical power) as riven with internal conflicts and contradictions with an authority that has to be constantly worked at to be maintained'.

Such a view offers hope for resistance and change, although there may be a cost to those who challenge, as well as to the organization as a whole. For example, Karen highlighted the disillusionment of various GPs who had resigned because of having to battle with their medical colleagues on the board and within the LHG constituency. Significantly, she also identifies the role of gender in opening up a more critical and challenging dialogue amongst GP board members:

> Some of them have… felt *exhausted* by this peer pressure and have felt they cannot really do what they'd hoped to do, because the pressure of the profession that is pulling them in an opposite direction.
>
> And as the number of female GPs has increased - half are now female - so have the levels of what they will say and vocalise - the women GPs. I think the gender bias has influenced GPs because there was only one female GP, and the rest were male GPs and that individual I feel, felt it was difficult because she did have some different views but felt quite isolated. Now the gender balance is shifting and different GPs have come on board, they are much more vocal and saying, 'Well actually I don't agree with this'. And they are beginning to subtly disagree with other colleagues in terms of GPs and have some very interesting debates. Now, that in itself then means that a lot of board business is taken up talking about GP issues.

And so it shifts then the time available to talk about other issues and that has the potential to be problematic as time goes on (Phase 2: Interview 1).

It seems that the growing number of female GPs provided an important source of mutual support. In addition, the presence of more women on the board may have been influential in other ways. For example, as suggested above, unity and conformity reflect elements of medical professionalism, and as Davies (1995) argues they also reflect masculine ideals (see section 7.5). The increase in the numbers of women, who appear willing to reject those ideals, is therefore significant.

7.3.4   Medical power and the role of the secretariat

There were other interpretations of medical dominance which highlighted the way in which existing hierarchical power relations were transferred and reproduced on the LHG. For example, Kate speculated that the behaviour and attitude of other board members, including the secretariat, perpetuated patterns of dominance and subordination evident in primary care. She argued that board members tended to 'look towards the GPs' and that this was particularly the case with members of the secretariat. Kate drew on her own experiences as a practice nurse working within general practice to make sense of this. She argued that the secretariat 'submitted to doctors the way receptionists do':

> I think GPs have been indulged for so long. I mean, to give them some credit, their behaviour in that environment is just carried on forward from how they are being able to kind of function in their work environment, because to some extent they are kind of indulged, aren't they?

> I think again it would be interesting to look at the concept of the secretariat within that, you know. I've heard comments like, 'I get on great with the Chairman' you know, from the secretariat so, you know, 'He's great' and I get a sense of - I know perhaps I'm being very general but, you know, like the receptionist/secretariat/GP relationship. You know I get a sense of that.

> ... I think the gender issue is incredibly interesting, I just find it very interesting... Like you said the subtleties of it and I find that role of the secretariat and the women within that, I find that interesting – I think that's the crux of some of this business with relationships with male GPs ... If they begin to take on that role it'll be fascinating to see how that pans out. Because it will make any females' (role) around that job perhaps slightly more difficult in an unintentional way (Phase1: Interview 1).

Kate highlights the way in which she sees medical dominance and authority, as expressed within general practice, being reproduced at LHG level. GPs continue to be 'indulged'. She points to the gendered nature of the relationship between receptionists and doctors, with women positioned in a subordinate and supporting role. Here there are parallels with Pringle's (1989, 1992) work on the boss-secretary relationship in which secretaries undertake a range of supportive and servicing tasks and functions for their bosses.

Kate seems to imply that comments made by members of the secretariat indicate a wish to claim a privileged relationship with GPs. This suggests a model, similar to the one between doctors and nurses previously discussed, where intimacy with and submission to the powerful subject allows for recognition and power. The master/slave relationship is also highlighted by Pringle (1989) as one of the ways in which the boss-secretary relationship is played out.

Interestingly, Kate concludes by speculating that for women outside of that relationship (nurses on LHG boards perhaps), life may be difficult in terms of creating an alternative discourse and way of being which resists and undermines that particular power relationship – one where GPs are not indulged, but are challenged. Kate's account illustrates the way in which daily interactions between organizational members serve to reproduce relations of dominance and subordination (Sheppard 1989, Acker 1992) and in particular, the way in which medical power is sustained at an individual and organizational level.

Having focused on the experiences of nurses, I now want to turn to those of GPs to shed further light on the way in which medical power is understood, negotiated and reproduced.

7. 4 Medical power in relation to the role and function of LHGs: the views and experiences of GPs.

The extent to which GPs dominated the board was a recurring theme in my interviews with nurses. Many nurses were particularly concerned with what was seen

as GPs' undue influence as independent contractors. I was keen to ascertain GPs' views on the issue, and doing so proved illuminating and challenged some of my preconceptions about medical power and dominance.

My first GP interview (five in total) was with Richard – the Chair of LHG4. I asked him for his thoughts on the claim that LHGs were medically dominated. His response reflected the views of other GPs:

> **R:** Well they are! (laughter) I mean we are the only people who bring our own money to the table. We bring our salary to the table.
>
> **A:** Okay, what do mean by that?
>
> **R:** I mean in terms of a GP's income, obviously the practice is a small business, so our income is the profit of the practice and we're actually making decisions about our profitability at LHG board level, by what sort of reimbursements come into the practice and all the technical side of running the practice... 'cause the GMS budget which is the budget concerned with the running of the practices is devolved down to the LHG. The other professionals, the pharmacist, the dentist are not doing that, um, and obviously the lay, voluntary and nursing members are not doing that. So we are really bringing our life and soul to the LHG board. I mean what the LHG board does fundamentally alters our practices and actually will also affect our profitability as practices as well. So, you know, 'we are bringing our all, they're not' would be most doctors' views and I think that you've got to be honest about that. It doesn't mean that for one moment we should dominate it in terms of decision making, but we have a much bigger vested interest in this process than the other professionals... the nurses and doctors who are from primary care have a much bigger vested interest in making it (the LHG) successful. What the LHG decides will determine how practice nurses practice and their working life (Phase 1: Interview1).

These comments raise several issues. Up until this point (10 months into the research), I had not fully appreciated the motivations and concerns of GPs. I had not realised the extent to which they saw the work of the LHG impacting on their livelihood. It came as something of a surprise to me. In this respect I think my experiences were similar to those of some of the board nurses, particularly those employed by the NHS Trust. Tina, Ann, Becky and Charlie expressed amazement at how 'money-oriented' GPs appeared and how this impacted on the work of the LHG. As Ann commented, 'Everything has a price tag on it - they could make or break a bid purely by that' (Phase 2: Interview1). Similar sentiments were echoed by social services representatives (SSR) of PCG/T boards in Coleman and Rummery's (2003) study: 'SSRs found some aspects of working with GPs on the Boards particularly

difficult, notably their insistence, as independent contractors, on sorting out reimbursement for their involvement' (p 278).

Richard appears to justify medical dominance on the basis of the needs of GPs as business people, but cautions against GPs dominating decision making. However, it seems unlikely that others will be able to contribute to decision making on an equal footing, partly because, as was widely acknowledged, discussions centred on the business needs and concerns of GP practices.

In addition, whilst practice nurses may well have been affected more by the decisions made at the LHG than their Trust colleagues, this did not appear to be an obvious concern of theirs. They were aware of the impact of LHG decisions on their work, but for the most part they were as eager as other nurses to broaden the debate from general practice to the wider health and social care agenda. Richard's comments also imply that he sees the success of the LHG in rather narrow business terms. For nurses, success appeared to be judged more in terms of advances and improvements in patient care and services and in 'making a difference', a view supported by Smith *et al.* (1999).

This illustrates what I came to see as a fundamental tension in the function and role of the LHG. On the one hand, the decisions the LHG makes may significantly affect the profitability of GPs businesses, and on the other hand, the LHG is charged with improving and developing primary care for the benefit of patients. To what extent then is the success of one achieved at the expense of the other? A number of those I interviewed - Louise, Karen and Will - felt very strongly about this. They believed these two elements of LHG work were incompatible and had limited the extent to which the board had been able to engage with the broader agenda and function of the LHG. It had hampered board progress. As Louise argued, 'You've got those two dynamics of professional self-interest and bias jarring with the greater good and the wider public health' (Phase 2: Interview 1). Will elaborated the dilemma facing his GP colleagues:

> The vast majority of the general public do not understand we are self-employed businessmen and the vast majority of GPs I believe are quite serious businessmen, and there is always an ethical clash on where do you draw the line, between personal

financial gain and reduced patient services. Because providing more services costs you more money and why should your wife and your kids be deprived because you happen to want to improve the availability of services to your patients? (Phase 1: Interview1).

At the time of the interview I was surprised by the cynicism and candidness of his comments. Similar issues regarding the impact of GPs' status as independent contractors are highlighted by a number of other studies (see for example Audit Commission 1999, Mahon and Garrod 2000, Regen *et al.* 2001). As one Health Authority manager of a PCG in Regen *et al's* study commented:

> Its been a challenge to get GPs to look broadly at the HIMP process... as a sub-contractor (especially ex-fundholders) they are inward looking to run their practice and therefore do not naturally look to the greater good (2001 p. 29).

Louise and Will argued that plans for successor LHGs, the Local Health Boards (LHBs) would address some of these concerns and limit medical dominance. At the time these plans involved an increase in lay representation and a reduction in GP board members – perhaps to two[3]. A similar view was expressed by participants in Regen *et al's* (2001) research who felt that 'this imbalance would only be addressed with the transition to PCT status and establishment of lay dominated PCT boards' (p. 77).

Louise also argued that the process by which GPs were originally selected for the board (nomination then election by their peers) reinforced the view that GPs were there principally to represent their colleagues and their business interests. Nurses, by contrast, were selected (nominated then interviewed) on the basis of whether their skills and experiences matched those required. A uniform approach to selection, whereby all members were interviewed and assessed as to their suitability, would, Louise argued, go some way to shifting the current preoccupation of the LHG with the business needs and concerns of GPs. For Claire, such a move would also ensure a more 'equal playing field' amongst board members - an issue raised by Smith *et al.* (1999) who point out, 'GPs were not expected to conform to any list of competencies before their election to the PCG Board' (p. 55).

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[3] Of the 17 non-officer members, LHBs have up to 3 GPs, 4 lay/voluntary members and a Chair who is publicly appointed and normally a lay person.

The optimism expressed by Will and Louise regarding the future of LHBs was not shared by Karen. Karen argued that government plans for the restructuring of primary care, including LHGs, had overlooked an opportunity to challenge medical authority and control:

> I think fundamentally this problem will continue to be one that will challenge the new LHB, even though potentially there's going to be two GPs on the board, because of the independent status issue. And I think the primary care strategy [4]... maybe has lost a golden opportunity to rethink that in a more radical way. It's still talking about independent status ... and on the edges of that, salaried GPs, but very much on the very edges – 'if you would like; if it wouldn't be too much bother to you'. Whereas I think if they'd been a little more radical thinking, traumatic as it would have been for everyone ... I think at the end of the day in terms of how it would influence patient care, it would be a worthy exercise to have gone through. But at this point in time that doesn't seem to be on the agenda. They are still very soft on the GPs, mindful of GP sensibilities (Phase 2: Interview 1).

Several participants agreed that the role of government had been crucial in establishing and endorsing medical authority and control of LHGs. For example, Louise argued that the structure of LHGs was:

> ... probably some deal worked out three years ago, which was a compromise, so you didn't quite get 'son of GP fund-holder', but we got 'grandson of GP fund-holder' because we have got a bit more of an extended family around the table now, but we have to somehow keep the GP community with us, so give them the overall dominance of the board in terms of numbers. And we also gave them the right to the chairmanship in a way no other members had access to at that time (Phase 2: Interview 1).

This view was supported by Will, who commented:

> I think the number of GPs were put there to make it politically acceptable to the profession - 'We are getting rid of fundholding, but yes, you can be on this to influence things' (Phase 1: Interview 1).

The role and influence of the medical profession in shaping PCG configuration and structure is also highlighted by Smith et al. (1999). Drawing on data from the National Tracker study of PCGs (Wilkin et al. 1999), they argue that as plans were being formulated, the medical profession lobbied and pushed hard for increased involvement and representation on PCG boards. Knowing the co-operation of GPs to be vital to the success of the reforms, the government acquiesced to their demands.

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[4] The National Assembly for Wales (2001) *Improving Health in Wales: The Future of Primary Care: a consultation document.*

This situation contrasted to that of the nursing profession, who, they argue, 'did not expect much so they did not get much' (Smith *et al.* 1999 p. 55). They continue:

> GPs and nurses reacted differently to the proposals. This may be partly explained by the existence of organised, self-interested professional networks that enable GPs to mobilise quickly. The fundamental structural differences in power between GPs and nurses ensured that GPs would have more influence in the debate. GPs had absolute confidence in their 'right' to be at the forefront of PCG development... The hierarchical nature of the health services ensured that at the critical moment of policy inception nurses were far less confident of their ability to influence PCG direction (ibid.).

In Wales, a battle was also being fought by senior nurses at the Welsh Assembly, who found themselves struggling to secure a place for two nurse representatives on LHG boards. One senior nurse within the Assembly with whom I spoke, contrasted their struggle with that of GPs. She commented that those responsible for the planning of the policy 'still think all nurses do is wipe bottoms - you have no idea what a battle it has been for us'. GPs on the other hand, she argued, 'hadn't had to do a thing ... the principle aim for the civil servants seems to have been to placate the fundholding GPs – to make sure they are happy'. Hard lobbying of stakeholder groups, and canvassing the support of nursing unions and nursing leaders across Wales had been instrumental in ensuring two places on the board were eventually awarded to nurses.

The final part of this chapter returns to the issue of medical professionalism discussed in section 7.3.3. In particular, I build on this discussion to explore the meaning and significance of medical professionalism in terms of gender.

7.5 Medical professionalism and GP dominance of LHGs

Many of the frustrations for nurses including GP self-interest and introspection can be understood in terms of the particular professional project embarked upon by doctors. Stacey's (1992) account of the General Medical Council (GMC) of which she was a lay member, provides a particularly useful analysis. In reflecting on the challenges facing the GMC, Stacey highlights what she sees as outmoded and damaging forms of professionalism. Of the GMC, Stacey argues:

My view is that they are deluded by certain tenets about professionalism which were useful in the mid-nineteenth century but which now are no more than collective illusions which misguide rather than guide the profession (p. 227).

Such a model of professionalism is characterised by collective self-interest, unity and exclusiveness. The latter is reflected in the primacy of the one-to-one doctor-patient relationship and the doctrine of clinical autonomy. This doctrine reflects the view that:

...only she or he who is in charge of the case may make decisions about it, that no one else is capable of offering judgement, and that only peers may comment on its rectitude should it be questioned (Stacey 1992 p. 228).

For Stacey (1992) it is this exclusiveness, which 'isolates the profession and leads to in-turningness and seeming arrogance' (p. 223).

It is important to acknowledge this model of professionalism is also gendered. It is gendered in so far as the particular professional project embarked upon by the medical profession in the mid-nineteenth century represents a gendered strategy of patriarchal control and exclusion (Witz 1992). But it is also gendered in so far as some of the key elements of that professionalism - self-interest, conformity, control, mastery, expertise, independence and autonomy - can be seen to reflect masculine values (Davies 1995).

It can be argued that it is these tenets of professionalism that nurses come up against on the board and which contribute to the gendering of the organization. For example, as nurses and others commented, there was a reluctance on the part of some GPs to work collaboratively and acknowledge the value and contribution of non-GPs. There was an over reliance on medical knowledge and expertise in defining problems and seeking solutions to health care issues. GPs were criticised for their collective insularity and 'inward lookingness' to the needs and concerns of their profession. In addition, the suitability of GPs as potential board members was decided by their peers – it appeared taken for granted that in such matters, they were the best judges.

My interview with Nick perhaps illustrates some of these points. Nick's interview was dominated by his misgivings about the LHG. In particular, he regretted the demise of fundholding and the way in which the creation of LHGs had undermined

the power and autonomy GPs had previously enjoyed as fundholders. He did not appear to value the potential for new, more collaborative ways of working that the LHG offered. As he commented, 'It's been forced on us to get non-GPs involved'. Nick came across as resentful and bitter about the situation he and his colleagues were in:

> They (non-GP board members) still don't appreciate the mechanisms involved in general practice and how things run. I mean even supposedly knowledgeable, say nurses or whatever, don't necessarily appreciate how general practice runs, even primary care, let alone secondary care.

> Okay involve these people, social services and all that sort of thing, but how much discussion and debate should they be having about health services' money or care, when they – okay, involve them, but it's still not, say, dental money that's going to be compromised. At the end of the day ... they have got all the power and none of the financial commitment, whereas GPs it's both (Phase 1: Interview 1).

Nick was clearly frustrated by what he saw as the illegitimate influence of non-GPs and the potential impact this might have on his livelihood as an independent contractor. His comments also resonate with aspects of medical professionalism outlined above. He appears inward looking to the workings of general practice and his comments suggest he sees this as the principal concern for the LHG. He conflates 'general practice' with 'health services' and he implies that GPs are the legitimate 'experts' in this field. The experiential knowledge, understanding and contribution of others in relation to general practice (and health care generally) goes unacknowledged. As Davies (1995) comments in her analysis of the gendering of profession, 'It is important to recognise that professions represent themselves as autonomous only by ignoring or misrepresenting the work of others' (p. 60).

Nick's comments would appear to confirm fears of prejudicial and negative medical attitudes to the involvement of others in the commissioning and policy decision making process (King's Fund College 1993, Department of Health 1994, Kaufman 2002).

Listening to the accounts of nurses and doctors, it became clear that their experiences and perceptions of medical power were different. Doctors, for example, felt insecure and disempowered, resenting what they saw as the illegitimate influence of others in

the running of general practice and in the erosion of their power base as independent contractors and budget holders. Nurses highlighted what they saw as the destructive power and control of GPs, which limited the potential of the LHG. GPs did not appear to have spent much time thinking about how their relative power and status might have impacted on others or the working of the board, yet this was a major preoccupation of all the nurses and the general managers with whom I spoke.

The way in which participants experienced and made sense of medical power and its effects was characterised by the competing realities and conflicting concerns of doctors and nurses and to some extent, medicine and nursing. As Sibbald (2000) comments in her discussion on the interface between nursing and medicine within primary care, 'The focus for debate within each profession is surely centred on points of vulnerability' (p. 17).

It is worth saying that a number of nurses, including Tina, Becky and Ann did recognise the challenges and difficulties facing GPs. Becky acknowledged that LHGs were medically dominated, but added that she felt GPs 'were as intimidated and vulnerable as anybody else, strangely enough' (Phase 1: Interview 1). This comment is significant because it provides an important entry point to understanding the way in which doctors in particular experience and make sense of medical power and control. The work of Watkins (1987), also cited by Stacey (1992) and Davies (1995) is especially helpful in providing such an analysis and in shedding light on the differing perceptions and experiences of medical power.

Watkins (1987), himself a doctor, highlights the enormous power of the medical profession, but argues that the profession does not *see* itself as powerful:

> It feels embattled. It actually feels itself to be powerless, pushed around by hostile and powerful forces against which it must maintain relentless hostility in order to have some slight influence on events... This perception is reinforced every time some other group attacks some aspect of the medical profession's use of that power; far from seeing itself as having created that opposition, the profession sees its old enemies at work trying to roll back some toe-hold of influence that the profession has gained in its bitter struggle against a hostile world (p.18).

For Watkins, it is the profession's refusal to share power with others that creates the hostility and opposition that the profession fears. The 'paranoid delusion' (p.19) of the medical profession is explained in terms of its historical struggle to gain recognition and status. However, the profession fails to realise that the battle is not only won, but that it is now itself an oppressor. Watkins (1987) continues, 'The main weapon in the medical profession's battle against the hostile world has always been its absolute unity' (p.19); as Davies (1995) reminds us, unity, conformity and control can be seen to reflect cultural codes of masculinity.

This analysis is useful in understanding the attitudes and concerns of the GPs with whom I spoke and in understanding the different perceptions and experiences of medical power as expressed by nurses and doctors. The sense of being under siege was very much evident listening to the accounts of GPs – the question would appear to be to what extent this feeling was justified.

7.5.1 LHGs as a challenge to medical authority?

The creation of LHGs signalled a reduction in the influence and power of individual fundholding GPs, and as Williams *et al.* (1993) observe, GPs have generally enjoyed a great degree of professional autonomy - many having entered general practice for this reason. Sibbald (2000) identifies a number of challenges facing GPs with the introduction of PCGs and LHGs. Whilst recognising they may appear to consolidate medical authority in general, she argues that these new primary care organizations in fact pose a number of threats to medical ethos and power. Sibbald (2000) comments that:

> ... as independent contractors, general practitioners have no tradition of working together within larger organizational structures and have strongly resisted attempts by previous governments to exercise greater control over the quality and content of their services (p. 25).

LHGs challenge GPs on both these issues. For example, GPs will be held increasingly accountable for the care and services they provide - clinical governance is a key function of the LHG and GPs, along with other professionals, will need to demonstrate that they are providing clinically effective and responsive care. LHGs

are required to oversee and coordinate clinical governance and quality frameworks within general practice, and as Sibbald (2000) suggests, this fundamentally challenges the clinical autonomy and freedom so valued by GPs.

The response of GPs can then perhaps be viewed not as 'paranoid delusion,' but as justifiable or at least understandable. However, Regen *et al's* (2001 p. 77) comment regarding the '*inappropriate* dominance' of GPs provides an important counterpoint to this view. The collective response of GPs to the threat posed by LHGs appeared overwhelming and comprehensive – they continued to dominate the agenda and the 'air space', at the same time generally defending the rights and privileges of their colleagues as independent contractors.

The findings from a study by Locock *et al.* (2004) undertaken as part of the wider research by the HSMC in Birmingham (see Regen *et al.* 1999, 2001 and Smith *et al.* 2000) is also relevant. The authors interviewed 16 GPs to explore their experiences in PCG/Ts, and in particular whether those not involved at board level felt PCG/Ts had undermined their control of decisions and clinical practice. The authors suggest that despite GP concerns regarding the increasing influence of PCG/Ts, GP autonomy and control had not been fundamentally affected. The authors conclude:

> It would seem then at present the erosion of clinical freedom is more an anticipated threat than a reality... What can be concluded is that neither PCTs nor Government have yet made much of an impression on individual clinical autonomy (p. 34).

General practitioners' response to the potential threat posed by LHGs also needs to be seen in the context of arguments put forward by Hunter (1994) in his discussion on the managerial challenge to medicine. Hunter (1994) begins by outlining the increasing emphasis on managerialism as evidenced in a series of NHS reforms. He argues that managerialism reflects the drive for increasing cost effectiveness and accountability on the part of clinicians, and a shift from 'producer-led' services, which favour professionals, to a user-led service.

Whilst some have claimed such a shift in thinking represents a major challenge to the medical profession, Hunter (1994) questions the view that increasing managerialism within the NHS has significantly eroded medical dominance and autonomy. He

suggests instead that doctors, by taking on management roles themselves, are able to respond successfully to these challenges to ensure medical power and status are not fundamentally undermined:

> Involving doctors more centrally and pivotally in the management function could institutionalise and entrench the very forces that are likely to prevent any attempt to move from a medical model of disease to a broader, societal conception of health and illness ... Doctors as managers, then, becomes a perfectly legitimate stratagem for ensuring that no fundamental challenge is mounted to their prevailing view of the world (p. 18).

Hunter's comments resonate with the experiences and concerns of some of those I interviewed. There are parallels in his argument between the position of doctors as managers and doctors as board members. As previously outlined, the GP board members were in a strong position to shape and define the LHG agenda to reflect their concerns and views. Indeed, a key concern of nurses (and others) related to the prevalence of a biomedical model of health and the limitations this posed for a broader, more radical approach to the public health agenda. Hunter (1994) concludes:

> ... it is not denied that the position of doctors has changed and that they now have to justify and account for their actions in ways unthinkable a decade or so ago, or that the biomedical model is not under challenge as a result of a revival of the public health movement. But these forces have yet to play themselves out and it is by no means certain that doctors will have to surrender their position even if required to be more explicit about it or share it with others in the health policy arena or both. They could seek to maintain it (p. 19).

This situation mirrors that of LHGs. It could be argued that seeking to maintain power and control in the face of numerous challenges is precisely what GP board members have done. Nick perhaps alluded to the political skills of doctors in successfully responding to government policy and initiatives when he commented that, 'We've always known how to, not work the system, but how to work with the system' (Phase 1: Interview 1). In addition, as Hunter (1994) argues, the power of GPs is assured whilst medicine enjoys a high social status. There did not appear to be any evidence that this view of doctors was being essentially challenged or undermined on the LHGs; indeed, as I have argued, the status and power accorded to doctors was, in a number of ways, actively reproduced on the board.

7. 6 Chapter Summary

This chapter has explored the way in which medical power was experienced and constructed within the LHG. Drawing on feminist literature, I have sought to highlight the role of gender in the maintenance and reproduction of medical power on the board. Interview data suggests that for some nurses the doctor/nurse relationship was a significant factor in their lives as LHG board nurses. Drawing particularly on Gherardi's (1994) work, attention has been given to the way in which the doctor/nurse relationship is constructed, negotiated and resisted at an individual level - specifically the way in which nurses 'think gender' in the context of this relationship. Nurses' experiences and medical power have also been located in the context of a model of medical professionalism that reflects the values and qualities culturally assigned to masculinity.

I have also highlighted the wider political and structural factors which serve to legitimise and perpetuate medical dominance of LHGs. These include the legacy of fundholding, GPs' position as independent contractors and the significant social and cultural status and authority of doctors, which has allowed them to gain unrivalled political influence over NHS reforms.

Interviewing GPs allowed for a better understanding of how medical power and dominance was justified and reproduced. This reinforces the point made by Reay (1996), that is, the importance of taking seriously the accounts of those in privileged positions to expose the 'denial of dis/advantage' and to expose 'what the limited vision of centrality hides' (p. 69). My overriding impression from the interviews with GPs was of individuals largely ignorant of the power they exercised, yet feeling disempowered and desperate to regain and reaffirm 'lost' power and influence (see also Game and Pringle 1983).

Medical power has undoubtedly undermined nurses' ability to challenge board working and to contribute to and shape LHG policy. The findings in this chapter further illustrate the critical role of gender in nurses' organizational experiences and as such can be usefully applied to the NHS in general. They offer important insight

into the various processes, rituals and interactions that construct medical power and dominance within health care and which help to maintain and reproduce oppressive gender power relations. Such relations continue to silence and subordinate nurses and to limit their ability to take a more pro-active part in shaping a health service in which they are central.

Chapter Eight   Conclusion

8.1 Introduction

In this final chapter I draw together the main themes of the study and discuss them in relation to the original aims of the research and the literature presented in chapter two. The implications of my findings for nursing and wider health policy agenda are identified. I also summarise the contribution to feminist analysis which this thesis makes. The chapter concludes with a reflection on some of the theoretical tensions I have experienced in doing the research.

The aim of this research was to explore the role of gender in nurses' organizational experiences. In particular the research focused on the experiences of nurses on LHG boards and the way in which gender can be seen to shape and impact upon nurses' organizational lives as board members. Drawing on feminist theory, I have argued that gender impacts upon nurses' organizational lives in a number of important ways.

Nurses' experiences as board members and their ability to contribute to and influence the work of the LHG have been circumscribed by their devalued and subordinate identity as nurses and women. I have suggested that nurses occupy a particularly fragile position within organizations in which the dominant values, images and ways of being reflect a masculine vision. Some of the difficulties nurses have experienced in contributing to and influencing the work of the LHG can be seen in this context. I have also highlighted the way in which day-to-day interactions, rituals and practices construct and reproduce organizations and individuals in gender terms and perpetuate oppressive power relations. In the following section I explore these issues in more detail.

This thesis raises a number of other wider issues relating to nursing identity, the value of caring work, women's position within organizations, and the relationship between gender and nursing (see section 8.5.3). In addition, this study is of particular importance given that it took place during a critical period of health policy implementation. Some of these policies, such as the establishment of new healthcare

organizations, signalled an increased decision making role for nurses. Drawing on gendered organizational theory, this study provides valuable insight into the experiences of nurses and some of the opportunities and obstacles they faced in this new role.

8.2 Gender and the nursing contribution to LHGs

Exploring the nursing contribution to LHGs was central to my inquiry into the role of gender in nurses' organizational experiences. I wanted to explore how nurses were able to contribute as board members and the extent to which they felt able to influence decision making processes. Given nursing's historical marginalisation from policy making and debate within the NHS (Strong and Robinson 1990, Robinson 1992, Davies 1995, Gough 1997) the appointment of nurses to the boards of LHGs was widely recognised as a significant step. Various studies had highlighted the key role nurses could play in the policy making arena and in particular, the valuable contribution nurses could make to the commissioning process (Goodwin 1992, King's Fund College 1993, Department of Health 1994, Antrobus and Brown 1997, Kaufman 2002). The skills and qualities that nurses were seen to possess in terms of identifying health needs, their ability to negotiate and work across professional and organizational boundaries, and their focus on quality issues were highly relevant to the role and function of LHGs in this study.

I have argued that the nursing contribution was gendered in a number of ways. One of the key findings related to the nature of the nursing contribution. Nurses felt their contribution reflected a holistic, humanistic, patient-centred model of health. They also expressed a concern with relational work and organizational process. I have suggested that nurses' understanding and knowledge and the qualities and skills they brought to the board were informed by the intimacy of their caring experiences and relationships – as nurses and as women. Their contribution was consistently positioned in opposition to the prevailing medical model of health as characterised by a concern with objectivity, outcomes, rationality, and intervention and treatment which was seen to underpin much LHG activity.

This view of the nursing contribution supports and builds on work previously outlined in the literature review and in chapters four and five which highlight the differing gendered ideologies expressed within nursing and medicine (see for example, Hagell 1989, Smith 1992, Witz 1994, Antrobus 1997, and Wicks 1998). Both Wicks (1998) and Smith (1992) discuss nursing in terms of its challenge to medical dominance within healthcare, as the following extract from Smith (1992) suggests: 'Nurses are seeking their own knowledge base and work methods based on alternative paradigms of healing, holism and emotional care in order to free themselves from medical dominance' (p. 197).

However, drawing on gendered organizational theory and in particular the work of Davies (1995), I have argued that attempts to assert a different rationality and way of being have had limited success, because attempts to do so take place within an organizational culture in which precisely these paradigms are relegated and marginalised – defined as they are in opposition to masculinity.

What this might mean for individual nurses is also important to consider. For the most part nurses spoke positively of their experiences in terms of the new challenges and opportunities that being a board member has afforded – for some the experience has been a rewarding and immensely exhilarating one. However, within nurses' accounts implicit and explicit reference is also made to conflict, to a battle being fought. Nurses spoke of feeling weary and, toward the end of the period of fieldwork, disillusioned.

This finding resonates with Marshall's (1995) work in which she highlights how women managers felt a sense of achievement, but 'also became bruised and tired' (p. 318) through their attempts to adapt to and negotiate their organizational presence as outsiders. Davies (1995) makes a similar point. She argues that because masculinity fears and denies emotionality, dependency and intimacy and that because nursing is closely associated with these things, nurses 'will often feel bruised and confused' (p. 187) when they enter the policy making arena.

It is interesting to consider my findings in light of Bolton's (2005) work. In her study of gynaecology nurses, Bolton draws attention to the way in which nurses viewed

their identity and their caring experiences as women as central to their role and to the creation of a unique work culture. Significantly, Bolton argues that whilst nurses fail to 'resist the ideological image of the patriarchal feminine they do resist its subordinate position in a differentiated social order' (p. 183). These nurses were able to create 'an open, caring culture whilst being assertive … with those who threaten to cause disruption to their world' (ibid.). Significantly, the nurses also drew upon their distinctive (gendered) knowledge and skills to challenge the medical model of health, and as a result were able to bring about important changes to organizational policy and practice in the care of women. Operating in a different context, it seems that at the time LHG board nurses did not have the same opportunities to resist and shape the organizational culture in which they worked.

I have also argued that the difficulties some nurses had in contributing to the work of the LHG can be understood in terms of the challenge nurses face in articulating the value of nursing and nurses' day-to-day caring concerns and translating this to the strategic function of the LHG. The masculine discourse of strategy and the linguistic and bureaucratic rules and procedures governing board working exacerbated nurses' sense of alienation and marginalisation. The work of Antrobus (1997, 1999) and Antrobus and Brown (1997) have been influential in my thinking on this issue. This thesis perhaps provides additional insight into how nurses experience this challenge, what it looks like in practice and, drawing on feminist theory, how we can add to our understanding of the difficulties nurses encountered.

Women's absence from the means of knowledge production and the silencing and invisibility of nursing as skilled work has compounded the difficulty in articulating the value of nursing. The cultural devaluing of the feminine and the absence of language to adequately describe women's experiences has particular implications for nurses, for whom gender and occupational identity are intimately linked. In many ways, exploring and understanding this relationship and highlighting the implications it holds for nursing and nurses (and women), has been at the heart of this study.

Drawing on findings from the national Tracker study of PCGs, Dowswell *et al.* (2002) concur with my view that whilst nurses felt enthusiastic about their role and have shown great commitment and belief in the value of their contribution, they

perceived that their own influence as board members was limited. However, the authors also highlight the way in which budgetary limitations and the wider political imperatives and national policy goals constrain the decision making of *all* board members. This is important to acknowledge - indeed this was something that the GPs with whom I spoke were keen to point out, expressing frustration at what they perceived as the undue and excessive influence of the Health Authority, and in particular the Welsh Assembly Government (WAG) on LHG activity (for a similar finding in relation to PCG/Ts in England see Locock *et al*. 2004). This does not alter the general view that nurses were far less influential than their GP colleagues and that the medical model of health and GP concerns continued to dominate board activity (Wilkin *et al*. 1999, Regen *et al*. 2001).

The importance of addressing the dominance of the medical model of health is highlighted by a recent report (Kendall and Lissauer 2003) on the health care workforce, as one of the key challenges facing policy makers and practitioners in assuring genuinely patient-centred care.

8.3 Identity

Issues relating to identity and self are a common theme in the literature exploring women's organizational experiences and were of particular relevance to this study. I wanted to explore the way in which nurses made sense of their identity as women and as nurses, and the extent to which their gendered and occupational identity impacted on their organizational experiences. My interest in these issues came from reading research by Marshall (1984, 1995) and Sheppard (1989, 1992) whose work has been important in helping me understand nurses' experiences.

As with participants in Marshall's (1984) and Sheppard's (1989, 1992) research, nurses' accounts with regard to the impact of their gender identity were frequently contradictory with just over half identifying gender as impacting on their organizational experiences. Whilst some of those I interviewed denied being a woman was a factor for them on the board, within their accounts implicit reference is made to behaviour and attitudes which suggested that at some level, nurses were

aware of their identity as women and that being a woman was experienced as disadvantageous.

I was also keen to ascertain how nurses made sense of their occupational identity and the extent to which they felt this impacted on their organizational experiences. In effect this allowed me another 'entry point' to explore the role of gender in nurses' organizational experiences.

Participants readily acknowledged their identity as nurses as problematic. For some, positive views with regard to their work and worth as nurses were set against acute feelings of inferiority and low self-esteem – feelings often attributed to the cultural devaluing of nursing and nurses' socialisation. The majority of nurses also felt they lacked credibility as board members and that they were perceived as relatively unimportant and 'second-class'. A great deal of effort was required to un-think damaging and limiting images of self which some nurses had internalised.

The confusion and sadness that nurses appeared to experience in negotiating and making sense of conflicting identities and images felt to me particularly poignant and burdensome. I saw this as significant. In many ways these accounts shed light on the way in which nurses experience and make sense of the dilemma identified by Reverby (1987 p. 1) and outlined in the literature review, that is, 'the order to care in a society that refuses to value caring'.

I have argued that in order to manage and negotiate their devalued identity as nurses and women (their place as outsider, as Other) and in an attempt to assert a more credible organizational image, nurses adopted a number of strategies. This finding supports much of the feminist literature on women's organizational experiences (see for example, Marshall 1984, 1995, Sheppard 1989, 1992, Gherardi 1994, 1995, Katila and Merilainen 1999 and Fournier and Kelemen 2001). However, nurses' use of strategies is problematic. It is 'femaleness' (Sheppard 1989 p.144) which requires management, but given the close cultural links between femininity and nursing, nurses face an especially onerous task in managing their identity and being seen as credible organizational members.

For the most part these strategies were recounted in a straightforward way, as if nothing exceptional or notable was happening. Yet as Acker (1991, 1992) suggests, gender management is hugely significant for it illustrates the way in which daily interactions and the 'internal mental work of individuals' (1992 p 253) reflects and reinforces the gendering of individuals and relations and with that, organizational culture. The need for strategies also highlights the extent of the cultural devaluing of the feminine – nurses' reluctance to wear their uniforms to board meetings is a powerful illustration of this.

Exploring the issue of identity has also allowed for a better understanding of the barriers and obstacles that inhibit the nursing contribution. These barriers are not only 'external', such as lack of time, resources, or the medically dominated agenda, but also relate to 'gender thinking' and nurses' internalised image of themselves as 'less than', as inferior; as Poole (2000) argues, 'The self-esteem and confidence of nurse members is critical if they are to be able to contribute fully to discussions'(p. 36).

I have also explored the ambivalence some nurses felt in identifying gender as an important factor in their organizational lives. Whilst nurses are urged to engage more fully with the issue of gender and feminist politics (Muff 1982a, Roberts 1983, Chinn and Wheeler 1985, Attridge and Callahan 1989, Darbyshire 1987, Witz 1994), little research appears to have been done which explores this issue directly with nurses themselves. Porter (1992) is a notable exception; however, my finding that many nurses appeared ambivalent about the role of gender is in contrast to Porter's conclusion that nurses were conscious of gender as a significant factor affecting their status. My data suggests that nurses' sense making with regard to the role of gender may reflect a far more contradictory and complex picture.

8.4 Medical power

Medical power was a key feature of nurses' organizational experiences. I have discussed this issue in the context of the doctor/nurse relationship and the dominance of GPs and GP issues in shaping and determining LHG activity. Of particular interest

is the way in which issues relating to identity once more emerge as significant. Drawing on the work of Gheradi (1994, 1995), I have focused on the way in which gender thinking and nurses' internalised negative sense of self (as subordinate, inferior), actively contribute to the maintenance of oppressive power relations between doctors and nurses. As indicated, a substantial amount of emotional energy and effort is needed to overcome and resist such thinking – a task especially burdensome in an organization which endorses medical authority and dominance.

Focusing on the ways in which nurses feel about and construct the doctor/nurse relationship is of central importance in understanding the way in which organizations, in this case LHGs, are gendered at both the individual and organizational level.

This study shares much in common with Wicks' (1998) work and her concern to explore the dynamic between structure and agency, and in particular her focus on the way in which nurses are 'active agents' (p. 174) in the construction of the doctor/nurse relationship. Where this study goes further is in exploring the impact of self-image and nurses' sense of self (as Other) as factors influencing the reproduction of oppressive power relations between doctors and nurses.

Whilst I can support the basic premise of writers who question the *necessarily* oppressive and hierarchical nature of the doctor/nurse relationship and point to ways in which this relationship is being undermined (Hughes 1988, Porter 1991, 1992, Svensson 1996, Wicks 1998), it is nonetheless important to acknowledge those experiences of nurses (for example, the internalised feelings of inferiority and lack) which suggest the relationship continues to exert a powerful influence in terms of nurses' daily working lives. For some, their feelings about this relationship have had a critical impact in terms of their ability to contribute to and influence LHG activity.

The other important aspect of medical power I highlighted was GP dominance of board meetings and the board agenda, and the prevailing medical model of health. My findings are supported by a number of other studies looking at PCGs/LHGs (Smith *et al.* 2000, Regen *et al.* 1999, 2001, Wilkin *et al.* 1999, Audit Commission 2000, Linck *et al.* 2001 and Dowswell 2002), though within this literature medical

dominance is not explored in detail. In light of a gendered analysis, this study adds some insight into how we might better understand medical dominance in the context of LHGs.

Nurses frequently referred to medical dominance in terms of GPs' insularity, the privileging of medical knowledge and expertise, GPs' lack of collaborative working and their conformity and professional unity - features also evident within the accounts of GP participants. Drawing on the work of Stacey (1992) and Watkins (1987) I have argued that these features are associated with medical professionalism. This particular model of professionalism, Davies (1995) suggests, can be seen as gendered, reflecting cultural norms and values associated with masculinity. As such the difficulties nurses face illustrate the way in which gender is deeply implicated in nurses' organizational experiences and in the construction and reproduction of organizations according to a masculine vision.

8.5 Implications

A number of important implications arise from this study. These are discussed in relation to nursing and health policy, and the personal and professional development of nurses. This section also addresses the implications and contribution of this thesis in terms of gender analysis.

8.5.1 Implications for nursing and health policy

Changes to health care services across the UK and Europe indicate that primary care is at the centre of current health policy reform (Exworthy 2001, Williams and Heyerdahl 2004). This offers new opportunities and roles for nurses. For example, the Department of Health (1999) made it clear that the modernised NHS depended on the effective participation of nurses in key decision making and leadership positions (such as PCGs/PCTs) - a view shared by the National Assembly for Wales (1999). In their strategic framework for nursing, midwifery and health visiting (*Realising the Potential*), the National Assembly called for nurses to 'have a voice in the following arenas/contexts: commissioning, purchasing, policy making at all levels, influencing

the strategic agenda' (p 34). However, this study suggests that having an effective voice in these areas is circumscribed by nursing's and nurses' continuing subordinate and devalued position within health care.

Putting Patients First (Welsh Office 1998) identified partnership working, collaboration, a patient-centred focus and a broad approach to health and social care as fundamental to the function and success of LHGs. These features were readily identified by nurses (and to some extent by others) as reflecting nursing concerns. However, nurses' relative lack of influence as board members, and a lack of organizational support for the relational work necessary for effective partnership working, may well have undermined the shift in policy practice that the White Paper signalled. Furthermore, nurses' lack of influence has undermined government rhetoric regarding nurse involvement in LHGs.

Nursing's contribution to commissioning has been widely identified as a unique and valuable one (Goodwin 1992, King's Fund College 1993, Department of Health 1994, Antrobus and Brown 1997, Kaufman 2002), but amongst the LHGs within my sample this potential had not fully materialised - indeed, few board nurses felt they had any direct involvement in commissioning decisions or planning. Commissioning appears to have been led by LHG and HA managers rather than clinicians (see also Regen *et al.* 2001). This has perhaps further diminished the potential of LHGs to work in new and different ways that might better meet the needs of the local population.

The findings from this study also highlight the enormous task facing these new organizations in overcoming hierarchical power relations to ensure that collaboration, partnership and team working become more than just government rhetoric.

This study suggests that despite their efforts, nurses struggled to influence and contribute fully to the policy decision making within the LHG. Whilst it may well be that nursing concerns 'are at the very least being voiced and considered in discussions' (Dowswell *et al.* 2002 p. 41) this counts for little, if, as Dowswell *et al.* also conclude in their study of PCGs, nurses have limited influence in decision

making processes. As Regen *et al.* (1999) comment of nurses in their study, 'involvement in itself does not necessarily result in influence or real decision making power' (p. 57). Addressing the marginal position of nursing within the policy making arena is not simply a matter of increasing the number of nurses in this area, but reflects a more complex situation. Account needs to be taken of the way in which gender is central to their struggles.

In light of this argument it is important to consider the experiences of nurses currently involved in LHBs, the successor organizations to LHGs. To my knowledge, little information or research exists with regard to the experiences of nurses working in and represented on LHBs (or PCTs). The appointment of nurse directors to LHBs was in part recognition of the need for more senior, experienced nurses who could respond to the expanding role of LHBs as they took on more complex and demanding work. The experiences of these nurse directors and their ability to shape and influence the work of the LHB is an important area for further enquiry, particularly as they come equipped with the political and strategic thinking skills seen by many as so vital to nursing's success in this area. The experiences of LHB nurse board members would also be worthy of further study, particularly in light of changes to the make up of the board (so that now for example, LHB chairs are generally lay people, GP numbers are reduced to three, and local government and lay membership is doubled).

The arguments outlined in this thesis have implications beyond LHGs, raising questions about the wider impact of gender upon nurses' organizational lives as they attempt to influence health care and decision making at the clinical, managerial and strategic level.

Nurses and nursing's exclusion and marginalisation from the policy making arena remains an issue for supporters of nursing. The RCN and others continue to lobby hard for nurse representation on the boards of all health bodies. At the time of writing, the *Nursing Standard* is concluding a major, year-long publicity campaign – 'Nursing the Future' - which is aimed at enhancing the image and reputation of nursing in the UK. The RCN has published its *Definition of Nursing* (2003). In part,

these efforts can be seen as a reflection of, and a response to nursing's continued marginalisation from decision making and influence within the NHS.

8.5.2 Implications for the personal and professional development of nurses.

Nurses, GPs and GMs all highlighted the need to equip nurses with the right set of skills and experiences to enable them to function more effectively at board level. Within the literature nurses taking on such roles are similarly urged to develop the requisite leadership, political and strategic thinking skills (Antrobus and Brown 1997, Antrobus and Kitson 1999, Dawes and Dobson 2001, Kaufman 2002, Kitson 2004). For example, Dawes and Dobson (2001) list a number of skills including finance skills, presentation skills, assertiveness training, commissioning and political and strategic thinking, as key areas for training. Similar skill requirements were also identified by the all-Wales LHG nurses' forum in November 2000.

A carefully designed programme of personal and professional development would have helped nurses enormously. In particular, something akin to the RCN's clinical leadership programme (Cunningham and Kitson 2000) would have helped nurses think through strategies for dealing with the workload demands and pressures they faced as board nurses and to develop their confidence in challenging and questioning board process and activity. Programmes such as these provide much needed time and space for critical reflection in a supportive and facilitative environment and importantly have been shown to have a positive effect on nurses' self-esteem and confidence (RCN 2002).

The RCN currently runs a primary care leadership programme aimed at developing practitioners' strategic and commissioning skills (Antrobus et al. 1999, Hayes 2003). Whilst it covers a wide range of topics - all highly relevant to the work of board nurses - the focus appears to be on skills acquisition rather than personal development. Based on my understanding of the problems facing nurses, I would argue for a programme that gives more priority to issues relating to personal identity, self-esteem and assertiveness.

That so little appears to have been done in terms of providing a structured, needs-led programme of support and training for LHG board nurses is a major concern. Given the symbolic importance of nurses' appointment to the boards, the provision of adequate training and support needed to be a higher priority. Some of the obstacles facing nurses taking on these new roles, and their development needs were anticipated at the time (see for example Wheatley and Sweeting 1999, Department of Health 1999).

> A special focus is needed to support and develop nursing, midwifery and health visiting leadership in Primary Care Groups and Trusts to secure an effective contribution to planning and commissioning services (Department of Health 1999 p. 54).

Support for LHG board nurses was identified as an action point in *Realising the Potential* (The National Assembly for Wales 1999), but participants in this study felt the support offered through the all Wales LHG nurse forums - which the Assembly co-ordinated - was largely inadequate.

Toward the end of the second phase of fieldwork LHG nurses appear to have taken matters into their own hands. Plans were being developed to establish an all-Wales LHG nurse network. This would provide a point of contact and support for nurses as well as raising the nursing profile and increase nurses' ability to lobby and gain political influence. Tina in particular felt this was a long overdue move, and compared nurses' lack of collective support and influence with that of GPs, who benefited from the support of the Local Medical Committee (LMC).

It should be noted that additional training and support for *all* board members had been called for (Smith *et al.* 2000, Wilkin *et al* 2001, the Audit Commission 2000, 2002, Linck *et al.* and Regen *et al.* 2001). My view, given the arguments put forward in this study which highlight the particular dilemmas facing nurses, is that specific support and training for nurses was justified. Its absence has contributed to some of the difficulties nurses have encountered and, as a consequence, has ultimately weakened and compromised the overall working of the LHG.

Whilst I have argued that more training, support and development would have helped nurses, it is important to avoid seeing the problems as based on the shortcomings of individual nurses (see also Davies 1995, 2004). One of the key arguments of this study is for the need to understand the difficulties nurses experienced with reference to the cultural devaluing of nursing and the gendering of organizations.

Attridge and Callahan (1989) argue that 'consciousness raising' (p.60) is vital for the empowerment of nurses. They call for a better understanding amongst nurses of nursing history and the societal reasons for their powerlessness:

> It enables them to perceive what may have been defined as individual failure ... in the light of societal and structural explanations. Rather than accept responsibility for events beyond their control, they may derive energy and motivation to redress their situation (p 63).

Attridge and Callahan (1989) suggest that nursing education has a pivotal role to play in this process and in preparing nurses for the problems and dilemmas they will face in the workplace. Nursing education that explicitly engages with feminism seems critical, though attempts to raise awareness amongst nurses with regard to the role and impact of gender are not straightforward, as I have indicated. The troubled relationship between nursing and feminism remains (Chinn and Wheeler 1985, Vance *et al.*1985, Bunting and Campbell 1990, Mulligan 1992). That said, efforts have been made to incorporate feminist theory into nurse education, for example in the works of Keddy (1995) and Doran and Cameron (1998). Drawing on their experiences as nurse educators in the US and Australia respectively, these authors argue that whilst there was some initial resistance and ambivalence toward feminist scholarship amongst students, as the teaching progressed many nurses experienced a profound shift in their thinking. The following quote from one of Keddy's (1995) students highlights this:

> I can't get enough of reading about how oppressed I have been all these years. For once my life is starting to make sense. Why haven't I heard more about feminist analysis and research before this? What is wrong with nursing that it has taken so long? (p. 693).

8.5.3 Summary of the contribution to gender analysis

This thesis adds to a feminist understanding of women's organizational lives and experiences. Drawing on the experiences of nurses in particular, the thesis builds on and develops existing literature on gender and organization. It also contributes to the literature on gender and nursing.

The feminist literature on women in management provides a useful framework with which to interpret nurses' experiences. In the main this literature has focused on the *discontinuity* between women's organizational identity and gender identity. My analysis of nurses' experiences however, also draws attention to the importance of considering the implications for women for whom occupational and gender identity is intimately connected. The *continuity* between nursing identity and gender identity for instance, has important implications for gender analyses which highlight the masculinity of organizational culture.

As indicated in the literature review, a number of writers have called for greater recognition and understanding of the role of gender in shaping nursing and the experiences of nurses. Drawing on gendered organizational theory to make sense of nurses' experiences, this thesis adds to the literature on gender and nursing. Whilst there are some examples (Davies 1995, Brooks and MacDonald 2000, Cross and Bagiholle 2002, Davies 2003, Bolton 2005) there is still relatively little work which explores nursing and nurses' experiences in the context of masculine organizational culture.

The use of gendered organizational theory in this thesis contributes to the literature on gender and nursing by adding to an understanding of the subordination and devaluing of nursing and nurses. Exploring how nurses (and doctors) 'think and do' gender for example, highlights the way in which oppressive power relations between doctors and nurses are constructed and maintained. In locating nurses' experiences in the context of masculine organizational culture, the thesis also adds to a feminist understanding of caring. It draws attention to the continuing subordination of women's caring work and the wider implications of this for those who care,

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including the implications for nurses' ability to influence health policy, particularly at a strategic level.

Finally, as indicated in section 8.3, in exploring the way in which nurses themselves make sense of gender, and in identifying and interpreting the ambivalent role of gender in nurses' accounts, this thesis contributes to feminist analyses which call for nurses to engage more fully with the relationship between gender and nursing.

8.6 Where does a gendered analysis take us?

Given the relevance of her work to this study, it is worth considering the arguments Davies (1995) puts forward for how nursing and nurses can overcome some of the dilemmas and issues facing the profession. Davies points out that gendered identities and relations are not fixed, but actively reproduced – as she comments, 'a gendered world must constantly be re-created' (1995 p. 184). This opens up the possibility for change and transformation, a point also made by Due Billing and Alvesson (2000): 'Value systems are cultural constructions and therefore it is possible to change 'perceptions' so that something, which was previously regarded as negative, can be re-valued and regarded as positive' (p. 153).

Davies argues that hope lies partly in attempts by nurses and others to better understand and articulate the value of nursing and the work of caring (see also Attridge and Callahan 1989 and Smith 1992). The task before us is one of '... putting nursing into words – the kind of words that will enable nurses to give voice to the work that they do, give them dignity and allow them to take their proper place at the policy making table' (Davies 1995 p. 184).

Hand in hand with this is the need for nurses to reject the masculine tenets of 'old professionalism' and work alongside others (patients and other health workers) in building a 'new professionalism' - one which more adequately acknowledges and values the complex interplay of emotionality, connectedness and intimacy, and formal and experiential knowledge in the provision of professional care.

Findings from this study would certainly support such a strategy. The difficulty nurses sometimes experienced in articulating the value of their work and nurses' support for values and ideals which challenge a masculine model of professionalism indicate that Davies' suggestions would do much to foster a growing confidence amongst nurses and within nursing.

Significantly, this study also illustrates the everyday challenges facing nurses as they grapple with these issues. Whilst I subscribe to the idea of gender identity and relations as fluid and open to negotiation and resistance, in emphasising the potential this offers for change there is a danger that the personal cost to women and the onerous task they face in dismantling and resisting oppressive power relations may be overlooked.

The work that nurses and nursing needs to do if they are to 'confront the current domination of health care by masculinist ideology' (Pearson 1991, p. 298) is to some extent dependent on the emergence of a more explicit and consistent dialogue between nursing and feminist ideas at all levels. Nursing education and training (in its broadest sense) is central to this process; however as I have indicated, it is uncertain as to whether such a move would have widespread support within the profession. In addition, it is not clear how much scope there will be for nurses, as part of their training, to engage in such debate within a curriculum already under pressure and which is becoming increasingly 'competency' based (see *Fitness for Practice*, UKCC 2001).

Help in revaluing care work may also come from other sources. For example, a recent BBC Radio Four programme *The Other Medicine* (5th October 2004), featured a discussion about the therapeutic benefits of alternative medicine, in particular homeopathy. Work was in progress which looked at separating out the specific benefit of the treatment and the 'non-specific effect of talking and being listened to' (http/www.bbc.co.uk/radio4/science/other_medicine_transcript1.shtml).

Several GPs, all complementary and alternative medicine (CAM) practitioners, highlighted the therapeutic benefits of taking a holistic approach, and of 'deep communication' - actively listening to people's stories in a supportive and safe

environment. The 'process' of the encounter appeared key to the efficacy of the treatment or, put another way, the way patients were *cared* for was central. These arguments resonate with the ongoing work within nursing to develop a greater understanding and knowledge of its therapeutic value (Pearson 1991).

What was particularly significant about this discussion was that these were GPs and medical scientists talking passionately about the importance of caring, and struggling, as others have done, to better understand and highlight its centrality in the healing process. Further, as one of the GPs commented, such work 'will ask questions about the way we practice medicine'. Listening to this debate though, my optimism was tempered with disappointment. In trying to conceptualise the complexities of caring, there was no mention of the debates and insights within *nursing* which might have shed light on this issue – the experiences and labour of women, so important in understanding caring, were rendered invisible.

Ultimately, prioritising gender in relation to nurses' experiences means that attention needs to be given to the wider role and position of women in society. For whilst it is important for nurses to understand and articulate the value of caring and 'to put nursing into words', it is not clear how this would lead to the revaluing of nursing without a fundamental shift in the status and value of women. We are brought back to the central relationship between nursing and femininity and the cultural devaluing of woman as Other. The future for nursing also lies in work which continues to explore and acknowledge this relationship.

For example, Wicks (1998) argues that we need to do more than revalue the skills of care - we need to transcend the care/cure binary. Extrapolating from Chodorow's arguments regarding shared parenting and its potential to undermine a masculinity which fears and denies women, Wicks (1998) offers the radical suggestion that doctors should nurse:

> If she [Chodorow] is right about the need for men to become mothers through changing patterns of child care as a precondition for the possibility of the emergence of new types of feminine and masculine identity, then this same argument applies to the feminine identity of nurses and the masculine identity of doctors and the division

of labour between them ... the solution lies in the fundamental restructuring of the workforce. In particular, I propose that doctors be nurses (p 180).

The point I wish to make here is that the way forward for nurses and nursing must lie with work which continues to highlight and challenge women's oppression and subordination. As Reverby comments: 'The dilemma of nursing is too tied into the broader problems of gender, race and class in our society to be solved by the political or professional efforts of one occupational group' (1990 p. 145).

8.7 Some tensions

At times nurses spoke of their influence and contribution in positive and optimistic terms. My own view is less positive. In part this relates to the differing interpretation of experience between researcher and participant. I have contextualised nurses' experiences with reference to feminism – an ideology the majority of nurses did not share. As indicated, this issue highlights an important challenge for feminist analysis - how to reconcile differing interpretations between researcher and participant whilst still valuing women's own sense making.

Thinking about nurses' views I wondered how I could be more certain of the extent to which nurses had influenced and contributed, which might allow me to share some of their optimism. This might require a study focusing on fewer LHGs (or LHBs) where I could immerse myself more fully and find ways to 'trace' the nursing influence and contribution more thoroughly. However, my feminist beliefs and understanding would still be brought to bear - women's position as Other would (probably) remain central to my own sense making.

At the beginning of the literature review, I also argued against over-determining women's position as Other. But being alert to this has been difficult and at times I have felt in danger of reinstating the binary thinking I have tried to problematise. Commenting on Davies' (1995) work, Crompton *et al.* (1999) highlight similar concerns:

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The definition of 'feminine' as 'not masculine' (and vice versa) makes the possibility of the transformation of the relationship between the sexes problematic – the 'devalued Other', by definition, cannot be superseded but will be reproduced anew (p. 183).

It is however, the concept of woman as the 'devalued Other' that I have found so helpful in trying to explain women's experiences - including my own and those of others. My instinct has been to appeal to analyses that recognise the power of structure and women's subordinate position within patriarchy; yet at the same time, I have argued that gender identities and relations are fluid and reproduced in a myriad of ways, all of which are open to challenge and resistance.

Wicks (1998) addresses a similar issue in her work and argues that in conceptualising the interconnectedness between structure and agency, she has avoided analysing nursing '... from a perspective which views the sexual division of labour as structurally determined and so impossible to change unless the structures of class and gender are (somehow) removed' (p 176). I have found this issue more problematic to resolve, as the following extract from my reflexive notes suggests:

> There must be some way of valuing caring ... it must be possible to resist the denial and repression of femininity – masculinity cannot be so fixed, immutable, yet it feels that way... if it is culturally, psychically, historically and discursively produced then it should be possible to reframe, undermine and reconstruct what it means to be male and to overturn the Othering of women. Why is this so hard though and why are definitions of masculinity (as privileged, dominant and valued) so persistent? (October 03).

The tension expressed here resonates with the wider debates between feminism and post-modernism and post-structuralism (see for example, Nicholson 1990, Barrett and Phillips 1992 and Ramazanoglu 1993). How do we acknowledge gender identity and power relations as constructed, unstable and contingent, whilst also acknowledging the embodied and lived experiences of women, many of whom continue to face overwhelming powerlessness and oppression? As Cockburn (1991) argues in her discussion on masculinity:

> While it is helpful that we can see gender and its relations as changing over time and differing in different classes and cultures, there is a danger that the idea of 'multiple masculinities' at the level of culture is allowed to deflect attention from the consistency in men's domination of women at systematic and organizational levels,

from the continuation of material, structured inequalities and power imbalances between the sexes (1991 p. 225).

This study has focused on the role of gender in nurses' experiences and as such has underplayed the role of other factors (e.g. race, sexuality, class, age and disability) - a point also made by Davies (1995) of her work. That feminist research acknowledges the complex interplay of such factors in shaping women's lives has long been seen as important (Maynard and Purvis 1994). As Acker (1998) suggests: 'I think in our fascination with gender we often fail to adequately attend to the ongoing presence of class and racial aspects of organizing processes' (p.196).

To some degree a more detailed exploration of these aspects was limited. This is partly because of the particular characteristics of the research sample (for example, all nurse participants were white, shared similar professional backgrounds, and were aged between 35-55), but also perhaps because of my own identity as a white, middle class woman. My focus on gender arose principally from my own experiences as a woman and nurse and from the experiences of nursing colleagues. In this respect, 'the story I was researching was my own' (Reger 2001 p. 611). Nonetheless, the omission of a more thoroughgoing analysis that takes sufficient account of race and class - factors also deeply embedded in the structuring of health care - can be seen as a limitation.

The appointment of nurses to the boards of LHGs marked a critical point in nursing history and was viewed as a long overdue response to nursing's 'invisibility' and exclusion from the policy making arena. Despite the importance of these new roles for nurses, the experiences of LHG nurse board members (and those on the boards of other new primary care organizations) have received relatively little critical analysis. Through exploring the day-to-day lives of LHG board nurses this thesis indicates that gender is key to understanding the organizational experiences of nurses. In particular I have argued that nurses' experiences need to be contextualised with reference to the gendering of organizational culture and the cultural devaluing of woman as Other. Such an understanding is vital if some of the obstacles and dilemmas nurses face in their attempts to influence health care and contribute to policy and decision making are to be addressed.

Bibliography

Acker, J., Barry, K. and Esseveld, J. (1991) 'Objectivity and Truth: Problems in doing feminist research', in M. Fonow, J. Cook (eds.) *Beyond Methodology: Feminist scholarship as lived research*. Bloomington, Indiana University Press.

Acker, J. (1991) 'Hierarchies, jobs, bodies: a theory of gendered organizations', in J. Lorber and S. A. Farrell (eds.) *The Social Construction of Gender*. London, Sage.

Acker, J. (1992) 'Gendering Organizational Theory', in A. Mills and P. Tancred (eds.) *Gendering Organizational Analysis*. London, Sage.

Acker, J. (1998) 'The Future of 'Gender and Organizations': Connections and Boundaries'. *Gender, Work and Organization*, **5**, (4), 195-206.

Acker, S. and Piper, D. W. (1984) *Is Higher Education Fair to Women?* Guildford, SRHE and NFER-Nelson.

Addison, R. B. (1992) 'Grounded hermeneutic research', in W. L. Millar and B.F. Crabtree (eds.) *Doing Qualitative Research*. Newbury Park, CA. Sage.

Akid, M. (2001) 'The nurse who shattered the glass ceiling'. *Nursing Times*, **97**, (23), 13, June 7

Alasuutari, P. (1995) *Researching Culture: Qualitative method and cultural studies*. London, Sage.

Aldridge, J. (1991) 'Research accounts, method in sociology and 'social reality': Some reflections on the production of a thesis', in J. Aldridge, V. Griffiths, A. Williams (eds.) *Rethinking: Feminist research processes reconsidered*. Manchester, Department of Sociology, University of Manchester.

Allen, D. (1997) 'The nursing-medical boundary: a negotiated order?' *Sociology of Health and Illness*, **19**, (4), 498-520.

Allen, D. (2001) *The Changing Shape of Nursing Practice*. London, Routledge.

Anonymous (Spring 1999) *Overview of LHG board role*. Workshop organised by Gwent Health Authority on the development of LHGs, held at the Parkway Hotel, Cwmbran.

Antrobus, S. (1997) 'An analysis of nursing in context: the effects of current health policy'. *Journal of Advanced Nursing*, **25**, (3), 447-453.

Antrobus, S. (1998) 'Board and Lodgings'. *Nursing Times*, **94**, (50), 50-52, December 16

Antrobus, S., Pickard, D., Reed, A. and Sutton, E. (1999) 'Strategy for success'. *Primary Health Care*, **9**, (1), 10-14.

Antrobus, S. (2000) 'Nurse as strategist, operating between policy and practice', in P. Gough and N. Walshe (eds.) *Nurses and Nursing: Influencing policy.* Abingdon, Radcliffe.

Antrobus, S. and Brown, S. (1997) 'The impact of the commissioning agenda upon nursing practice: a proactive approach to influencing health policy'. *Journal of Advanced Nursing,* **25,** (2), 309-315.

Antrobus, S. and Kitson, A. (1999) 'Nursing Leadership: influencing and shaping health policy and nursing practice'. *Journal of Advanced Nursing,* **29,** (3), 746 - 753.

Ashley, J. (1976) *Hospitals, Paternalism and the Role of the Nurse.* New York, Teachers College Press.

Attridge, C. and Callahan, M. (1989) 'Women in women's work: Nurses, stress and power', in L. Hardy and A. J. Randell (eds.) *Recent Advances in Nursing: Issues in women's health.* Edinburgh, Churchill Livingstone.

Audit Commission (2000) *Local Health Groups in Wales: The first year.* London, HMSO.

Audit Commission (2002) *Local Health Group Development Reviews.* London, HMSO.

Banks-Smith, J., Dowswell, T., Gillam, S. and Shipman, C. (2001) 'Primary Care Groups and Trusts'. *Nursing Times,* **97,** (45), 30–32, November 8.

Barrett, M., and Phillips, A. (eds.) (1992) *Destabilizing Theory: Contemporary feminist debates.* Cambridge, Polity Press.

Beauvoir, S. D. (1949) *The Second Sex.* London, Picador, 1988.

Benjamin, J. (1988) *The Bonds of Love: Psychoanalysis, feminism, and the problem of domination.* New York, Pantheon Books.

Benner, P. and Wrubel, J. (1989) *The Primacy of Caring: Stress and coping in health and illness.* New York, Addison-Wesley.

Bergen, A. (1999) 'An analysis of caring', in I. Norman and S. Cowley (eds.) *The Changing Nature of Nursing in a Managerial Age.* Oxford, Blackwell Science.

Billingham, K. and Glasby, L. (1998) 'Stainless Zeal'. *Nursing Times,* **94,** (50) 52-53 December 16/23/30

Bogdewic, S. (1992) 'Participant Observation', in B. Crabtree and W. Millar (eds.) *Doing Qualitative Research.* Newbury Park, CA. Sage.

Bologh, R. W. (1990) *Love or Greatness: Max Weber and masculine thinking - a feminist enquiry.* London, Unwin Hayman.

Bolton, S. (2005) 'Women's work, dirty work: The gynaecology nurse as 'Other''. *Gender, Work and Organization,* **12,** (2), 169-186.

Boughn, S. and Wang, H. (1994) 'Introducing a feminist perspective to nursing curricula: A quantative study'. *Journal of Nursing Education,* **33,** (3), 112-117.

Brewer, J. D. (2000) *Ethnography.* Buckingham, Open University Press.

British Sociological Association (2003) *Statement of Ethical Practice*. Durham, British Sociological Association.

Brooks, I. and Macdonald, S. (2000) ''Doing Life': Gender relations in a night nursing sub-culture'. *Gender, Work and Organization,* **7,** (4), 221-229.

Brown, C. and Jones, L. (2004) 'The Gender Structure of the Nursing Hierarchy: The Role of Human Capital'. *Gender, Work and Organization,* **11,** (1), 1-25.

Bunting, S. and Campbell, J. (1990) 'Feminism and Nursing: Historical perspectives'. *Advances in Nursing Science,* **12,** (4), 11-24.

Burgess, R. G. (1984) *In the Field: An introduction to field research.* London, Allen and Unwin.

Calas, M. and Smircich, L. (1999.) 'From 'the woman's point of view': Feminist approaches to organization studies', in S. R. Clegg, C. Hardy and W.R. Nord (eds.) *Handbook of Organization Studies.* London, Sage.

Cant, S. and Killoran, A. (1993) 'Team Tactics: a study of nurse collaboration in general practice'. *Health Education Journal,* **52,** (4), 302-208

Carpenter, M. (1977) 'Managerialism and the division of labour in nursing', in M. Stacey and M. Reid (eds.) *Health and the Division of Labour.* London, Croom Helm.

Cassell, J. (1988) 'The Relationship of observer to observed when studying up', in R.G.Burgess (ed.) *Studies in Qualitative Methodology.* London, JAI Press

Chase, S. (1996) 'Personal vulnerability and interpretative authority in narrative research', in R. Josselson (ed.) *Ethics and Process in the Narrative Study of Lives.* Thousand Oaks, CA. Sage.

Chinn, P. and Wheeler, C. (1985) 'Feminism and Nursing: can nursing afford to remain aloof from the women's movement?' *Nursing Outlook,* **33,** (2), 74-77.

Chodorow, N. (1978) *The Reproduction of Mothering,* Berkeley, CA. University of California Press.

Cockburn, C. (1991) *In the Way of Women: Men's resistance to sex equality in organizations.* Basingstoke, Macmillan.

Coffey, A. and Atkinson, P. (1996) *Making Sense of Qualitative Data: Complementary research strategies.* Thousand Oaks, CA. Sage.

Coleman, A. and Rummery, K. (2003) 'Social services representation in Primary Care Groups and Trusts'. *Journal of Interprofessional Care,* **17,** (3), 273-280.

Colliere, M. F. (1986) 'Invisible care and invisible women as health-care providers'. *International Journal of Nursing Studies,* **23,** (2), 95-112.

Collins, P. H. (1990) *Black Feminist Thought: Knowledge, consciousness, and the politics of empowerment.* Boston [Mass.], Unwin Hyman.

Collinson, D. and Collinson, M. (1989) 'Sexuality in the Workplace: The Domination of Men's Sexuality', in D. Sheppard, J. Hearn, P. Tancred-Sheriff and G. Burrell (eds.) *The Sexuality of Organization.* London, Sage.

Corcoran-Nantes, Y. and Roberts, K. (1995) ''We've Got One of Those': The Peripheral Status of Women in Male Dominated Industries'. *Gender, Work and Organisation.* **2,** (1), 21-33.

Cortazzi, M. (2001) 'Narrative Analysis in Ethnography', in P. Atkinson, A. Coffey, S. Delamont, J. Lofland and L. Lofland (eds.) *Handbook of Ethnography.* London, Sage.

Cotterill, P. (1992) 'Interviewing Women'. *Women's Studies International Forum,* **15,** (5/6), 593-606.

Crompton, R. E. (1999) *Restructuring Gender Relations and Employment: The decline of the male breadwinner.* Oxford, Oxford University Press.

Cross, S. and Bagiholle, B. (2002) 'Girls' jobs for the Boys? Men, Masculinity and Non-Traditional Occupations'. *Gender, Work and Organization,* **9,** (2), 204-226.

Cunningham, G., Kitson, A. (2000) 'An evaluation of the RCN Clinical Leadership Development Programme: Part 1'. *Nursing Standard,* **15,** (12), 34-37, December 6.

Daniels, A. K. (1987) 'Invisible work'. *Social Problems,* **34,** (5), 403-415.

Darbyshire, P. (1987) 'The Burden of history'. *Nursing Times,* **83,** (4), 32-34, January 28.

Davies, C. (1992) 'Gender, history and management style in nursing: towards a theoretical synthesis', in M. Savage and A. Witz (eds.) *Gender and Bureaucracy.* Oxford, Blackwell.

Davies, C. (1995) *Gender and the Professional Predicament in Nursing.* Buckingham, Open University Press.

Davies, C. (1996) 'The sociology of professions and the profession of gender'. *Sociology,* **30,** (4), 661-678.

Davies, C. (2000a) 'Vive La Difference: that's what will make collaboration work'. *Nursing Times*, **96,** (15), 35, April 13.

Davies, C. (2000b) 'Getting health professionals to work together'. *British Medical Journal*, **320,** 1021-1022.

Davies, C. (2004) 'Political leadership and the politics of nursing'. *Journal of Nursing Management*, **12,** 235-241.

Davies, C. and Rosser, J. (1986) *Processes of Discrimination: A Study of Women Working in the NHS*. London, Department of Health and Social Security.

Davies, C. and Rothschild, J. (1994) 'Organizations Through the Lens of Gender: Introduction to the Special Issue'. *Human Relations,* **47,** (6), 583-590.

Davies, K. (2003) 'The body and doing gender: the relations between doctors and nurses in hospital work'. *Sociology of Health and Illness,* **25,** (7), 720-742.

Dawes, D. (2002) 'Primary Care Trusts - two years on'. *Primary Health Care,* **12,** (3), 22-24.

Dawes, D. and Dobson, K. (2001) *Nurses on Board: An analysis of nurse leadership in 1st and 2nd wave Primary Care Trusts*. The Leadership Centre, NHS Modernisation Agency, London, HMSO.

Denzin, N. K. and Lincoln, Y. S. (1998) *Strategies of Qualitative Inquiry.* Thousand Oaks, CA. Sage.

Department of Health and Social Security (1983) *NHS Management Inquiry* (The Griffiths Report). London, DHSS.

Department of Health (1994) *Building a Stronger Team: The Nursing Contribution to Purchasing*. Leeds, NHS Executive.

Department of Health (1997) *The New NHS: Modern, Dependable*. London, The Stationary Office.

Department of Health (1999) *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and health care.* London, Department of Health.

Diers, D. (1978) 'Different kind of energy: Nurse-power'. *Nursing Outlook*, January, 51-55.

Doran, F. and Cameron, C. (1998) 'Hearing nurses' voices through reflection in women's studies'. *Nurse Education Today,* **18,** 64-71.

Dowswell, T., Wilkin, D. and Banks-Smith, J. (2002) 'Nurses and English primary care groups: their experiences and perceived influence on policy development'. *Journal of Advanced Nursing*, **37**, (1), 35-42.

Due Billing, Y. and Alvesson, M. (2000) 'Questioning the Notion of Feminine Leadership: A critical perspective on the gender labelling of leadership'. *Gender, Work and Organisation*, **7**, (3), 144-157.

Ely, M., Anzul, M., Friedman, T., Garner, D., and McCormack Steinmetz, A. (1991) *Doing Qualitative Research: Circles within circles*. London, Falmer Press.

England Ministry of Health. (1966) *Report of the committee on senior nursing staff structure. (The Salmon report)*. London, Ministry of Health and the Scottish Home and Health Department

Exworthy, M. (2001) 'Primary Care in the UK: understanding the dynamics of devolution'. *Health and Social Care in the Community* **9** (5) 266-278

Feire, P. (1971) *Pedagogy of the Oppressed*. New York, Herder and Herder.

Field, R. and West, M. (1995) 'Teamwork in primary health care 2: Perspectives from practices'. *Journal of Interprofessional Care*, **9**, (2), 123-130.

Fielding, N. (1993) 'Qualitative Interviewing', in N. Gilbert (ed.) *Researching Social Life*. London, Sage.

Finch, J. (1984) ''It's Great to Have Someone to Talk to': Ethics and Politics of Interviewing Women', in C. Bell and H. Roberts (eds.) *Social Researching: Politics, problems, practice*. London, Routledge and Kegan Paul.

Finlayson, L. R. and Nazroo, J. Y. (1998) *Gender Inequalities in Nursing Careers*. London, Policy Studies Institute.

Fisher-Smith, J. (1999) 'Marginalization in PCGs'. *British Journal of Community Nursing*, **4**, (3), 148.

Fletcher, D. (2002) ''In the Company of Men': A Reflexive Tale of Cultural Organizing in a Small Organization'. *Gender, Work and Organization*, **9**, (4), 398-419.

Fletcher, J. K. (1999) *Disappearing Acts: Gender, power and relational practice at work*. Cambridge MA, MIT Press.

Fonow, M. and Cook, J. (eds.) (1991) *Beyond Methodology: Feminist scholarship as lived research*. Bloomington, Indiana University Press.

Fonow, M. and Cook, J. (1991) 'Back to the Future: A Look at the Second Wave of Feminist Epistemology and Methodology', in M. Fonow and J. Cook (eds.) *Beyond Methodology: Feminist scholarship as lived research*. Bloomington, Indiana University Press.

Foucault, M. (1980) *Power/Knowledge: Selected interviews and other writings*. New York, Pantheon.

Fournier, V. and Kelemen, M. (2001) 'The Crafting of Community: recoupling discourses of management and womanhood'. *Gender, Work and Organisation,* **8**, (3), 267-290.

Gabe, J., Kelleher, D. and Williams, G. (1994) *Challenging Medicine*. London, Routledge.

Gamarnikow, E. (1978) 'Sexual division of labour: the case of nursing', in A. Kuhn and A. M. Wolpe (eds.) *Feminism and Materialism*. London, Routledge and Kegan Paul.

Gamarnikow, E. (1991) 'Nurse or Woman: gender and professionalism in reformed nursing', in P. Holden and J. Littlewood (eds.) *Anthropology and Nursing*. London, Routledge.

Game, A. and Pringle, R. (1983) *Gender at Work*. Sydney, George Allen and Unwin.

Gherardi (1994) 'The gender we think, the gender we do in our everyday organizational lives'. *Human Relations* (special issue), **47**, (6), 591- 610.

Gherardi, S. (1995) *Gender, Symbolism and Organizational cultures*. London, Sage.

Gherardi, S. (1996) 'Gendered Organizational Cultures: narratives of women travellers in a male world'. *Gender, Work and Organization*, **3**, (4), 187-201.

Gherardi, S. and Poggio, B. (2004) 'Call for Papers: Gender as social practice: doing, saying and performing gender relations'. *Gender, Work and Organization*, **11**, (2), 227.

Gillam, S. (1999) 'Primary care: Trust in the future'. *Nursing Times*, **95** (13), 57-9. March 31

Gilligan, C. (1982) *In a Different Voice: Psychological theory and women's development*. London, Harvard University Press.

Glucksmann, M. (1994) 'The Work of knowledge and the knowledge of women's work', in J. Purvis and M. Maynard (eds.) *Researching Women's Lives from a Feminist Perspective*. London, Taylor and Francis.

Goffman, E. (1959) *The Presentation of Self in Everyday Life*. New York, Doubleday.

Goodwin, S. (1992) 'Nurses and Purchasing'. *Senior Nurse,* **12**, (6), 7-11.

Gough, P. (1997) 'Time to grasp the nettle'. *Nursing Times,* **93**, (12) 26-27, March 19

Graham, H. (1983) 'Caring: a labour of love', in J. Finch and D. Groves (eds.) *A Labour of Love: Women, work and caring*. London, Routledge and Kegan Paul.

Grimshaw, J. (1986) *Feminist Philosophers: Women's perspectives on philosophical traditions,* Hemel Hempstead, Harvester Wheatsheaf.

Gutek, B. A. (1989) 'Sexuality in the Workplace: Key issues in social research and organizational practice', in D. Sheppard, J. Hearn, P. Tancred-Sheriff, and G. Burrell. (eds.) *The Sexuality of Organization.* London, Sage.

Hagell, E. (1989) 'Nursing Knowledge: women's knowledge? A sociological perspective'. *Journal of Advanced Nursing,* **14,** (3), 226-233.

Hall, M. (1989) 'Private Experiences in the Public Domain: Lesbians in organizations', in D. Sheppard, J. Hearn, P. Tancred-Sheriff, and G. Burrell. (eds.) *The Sexuality of Organization.* London, Sage.

Hammersley, M. (1992) 'On Feminist Methodology'. *Sociology,* **26,** (2), 187-206.

Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in practice.* London, Routledge.

Hardy, L. (1986) 'Career Politics: the case of career histories of selected leading female and male nurses in England and Scotland', in R. White (eds.) *Political Issues in Nursing: Past, present and future.* London, Wiley and Sons.

Hartsock, N. (1990) 'Foucault on Power: A theory for women', in L. Nicholson (ed.) *Feminism /Postmodernism.* New York, Routledge.

Harvey, S. (1994) 'Put the gem in stratagem'. *Nursing Management,* **1,** (4), 24-25.

Hayes, L. (2003) 'A primary care leadership programme'. *Primary Health Care,* **12,** (10), 22-25.

Hearn, J., Sheppard, D., Tancred-Sheriff, P. and Burrell, G. (eds.) (1989) *The Sexuality of Organization,* London, Sage.

Hearn, J. and Parkin, W. (1992) 'Gender and Organizations: A selective review and a critique of a neglected area', in A. Mills and A. P. Tancred (eds.) *Gendering Organizational Analysis.* Newbury Park, CA. Sage.

Holland, J. and Ramazanoglu, C. (1994) 'Coming to Conclusions: Power and interpretation in researching young women's sexuality', in J. Purvis and M. Maynard (eds.) *Researching Women's Lives from a Feminist Perspective.* London, Taylor and Francis.

Hollway, W. (1983) 'Heterosexual Sex: power and desire for the Other', in S. Cartledge and J. Ryan (eds.) *Sex and Love: New thoughts on old contradictions.* London, The Women's Press.

Holstein, J. and Gubrium, J. (1997) 'Active Interviewing', in D. Silverman. (ed.) *Qualitative Research: Theory, method and practice.* London, Sage.

hooks, b. (1991) *Yearning: Race, gender and cultural politics*. London, Turnaround.

Hopton, J. and Hill, M. (2001) 'Connecting Communities with the NHS.' Report of the LHCC Best Practice Group. Scottish Executive

Hornsby-Smith, M. (1993) 'Gaining Access', in N. Gilbert (ed.) *Researching Social Life*. London, Sage.

Hudson Jones, A. E. (1988) *Images of Nurses: Perspectives from history, art and literature*. Philadelphia, University of Pennsylvania Press.

Hughes, A. (1996) *The Handmaiden's Tale: Gender and the organizational experiences of nurses*. Unpublished MSc. Dissertation, School for Policy Studies, Bristol University.

Hughes, D. (1988) 'When nurse knows best: some aspects of nurse/doctor interaction in a casualty department'. *Sociology of Health and Illness*, **10**, (1), 1-22.

Hughes, L. (1990) 'Professionalizing domesticity: A synthesis of selected nursing historiography'. *Advances in Nursing Science*, **12**, (4), 25-31.

Hunt, M. (1991) 'Qualitative Research', in D.F.S. Cormack (ed.) *The Research Process in Nursing*. Oxford, Blackwell Scientific Publication.

Hunter, D. (1994) 'From tribalism to corporatism: the managerial challenge to medical dominance', in J. Gabe, D. Kelleher, and G. Williams (eds.) *Challenging Medicine*. London, Routledge.

Irigaray, L. (1985) *Speculum of the Other Woman*. Trans. G. C. Gill. Ithaca, New York, Cornell University Press.

Irigaray, L. (1993) *Je, Tu, Nous: Toward a culture of difference*. London, Routledge.

Isaacs, D. and Poole, M. (1996) 'Being a Man and Becoming a Nurse: three men's stories'. *Journal of Gender Studies*, **5**, (1), 39-47, March.

James, N. (1989) 'Emotional labour: skill and work in the social regulation of feelings'. *Sociological Review*, **37**, 15-42.

James, N. (1991) 'Care, work and carework: A synthesis?' in A. Gray, R. Elkan and J. Robinson (eds.) *Policy Issues in Nursing*. Buckingham, Open University Press.

James, N. (1992) 'Care = organisation + physical labour + emotional labour'. *Sociology of Health and Illness*, **14**, (4), 488-509.

James, S. M. and Busia, A.P. (1993) *Theorizing Black Feminisms: The visionary pragmatism of Black women*. London, Routledge.

Janesick, V. (1998) 'The dance of qualitative research design', in Y. Lincoln and N. Denzin (eds.) *Strategies of Qualitative Inquiry*. Thousand Oaks, CA. Sage.

Jones, R. (2004) 'Strength through compassion'. (Letters). *Nursing Standard,* **18,** (30), 30 April 7.

Katila, S. and Merilainen, S. (1999) 'A Serious Researcher or Just Another Nice Girl?: Doing Gender in a Male-Dominated Scientific Community'. *Gender, Work and Organization,* **6,** (3), 163-173.

Kaufman, G. (2002) 'Investigating the nursing contribution to commissioning in primary health-care'. *Journal of Nursing Management,* **10,** (2), 83-94.

Keddy, B., Jones Gillis, M., Jacobs, P., Burton, H. and Rogers, M. (1986) 'The doctor-nurse relationship: an historical perspective'. *Journal of Advanced Nursing,* **11,** (6), 745-753.

Keddy, B. (1995) 'Feminist teaching and the older nurse: the journey from resistance through anger to hope'. *Journal of Advanced Nursing,* **21,** (4), 690-694.

Kelly, L. (1988) *Surviving Sexual Violence.* Cambridge, Polity.

Kelly, L., Burton, B. and Regan, L. (1994) 'Researching women's lives or studying women's oppression', in J. Purvis and M. Maynard (eds.) *Researching Women's Lives from a Feminist Perspective.* London, Taylor and Francis.

Kendall, L. and Lissauer, R. (2003) *The Future Health Worker.* London, IPPR.

Kerfoot, D. (1999) 'The Organisation of Intimacy: managerialism, masculinity and the masculine subject', in S. Whitehead and R. Moodley (eds.) *Transforming Managers: Gendering change in the public sector.* London, Taylor and Francis.

Kerfoot, D. and Knights, D. (1996) 'The Best is Yet to Come?: The quest for embodiment in managerial work', in D. Collinson and J. Hearn (eds.) *Men as Managers, Managers as Men: Critical perspectives on men, masculinity and managements.* London, Sage.

Kerr, N. (1982) 'The narcissistic fit between medicine and nursing', in J. E. Muff (ed.) *Socialization, Sexism and Stereotyping.* Illinois, Waveland Press Inc.

King's Fund College (1993) *The Professional Nursing Contribution to Purchasing.* London, King's Fund.

Kitson, A. (2004) 'The whole person'. *Nursing Standard,* **19,** (12), 14-15, December 1.

Knights, D. and Morgan, G. (1991) 'Corporate strategy, organizations and subjectivity: a critique'. *Organization Studies,* **12,** (2), 251-273.

Kuzel, A. (1992) 'Sampling in Qualitative Inquiry', in W. Millar and B. Crabtree (eds.) *Doing Qualitative Research.* Newbury Park, CA. Sage.

295

Lane, N. (2000) 'The Low Status of Female Part-Time NHS Nurses: A bed-pan ceiling'. *Gender, Work and Organization,* **7,** (4), 269-281.

Latimer, J. (1996) 'Book Review: Gender and the Professional Predicament of Nursing'. *Sociological Review,* **44,** (2), 316-319.

Linck, P., Parry-Jones, B., Elliston, P., Miles, L. and Robinson, C. (2001) *The Inter-Agency Working Capabilities of Local Health Groups.* Centre for Social Policy Research and Development, University of Wales, Bangor.

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic Inquiry.* Beverly Hills, CA. Sage

Lipley, N. (1999) 'Movers and Shakers'. *Nursing Standard,* **13,** (39), 20-22, June 16.

Locock, L., Regen, E. and Goodwin, N. (2004) 'Managing or managed? Experience of general practitioners in English Primary Care Groups and Trusts'. *Health Services Management Research,* **17,** 24-35.

Lofland, J. and Lofland, L. (1984) *Analyzing Social Settings: A guide to qualitative observation and analysis.* Belmont, CA. Wadsworth Pub. Co.

Lorber, J. and Farrell, S. A. (1991) *The Social Construction of Gender.* Newbury Park, CA. Sage, in cooperation with Sociologists for Women in Society.

Lorde, A. (1984) *Sister Outsider: Essays and speeches.* New York, Crossing Press.

Lovell, M. (1982) 'Daddy's little girl: the lethal effects of paternalism in nursing', in J. Muff (ed.) *Socialization, Sexism and Stereotyping.* Illinois, Waveland Press Inc.

Maben, J. (2003) *The Fate of Ideals and Values: Experiences of newly qualified nurses.* Unpublished PhD thesis, School of Nursing and Midwifery, University of Southampton.

Mackay, L. (1992) 'Working and co-operating in hospital practice'. *Journal of Interprofessional Care,* **6,** (2), 127-131.

Mackay, L. (1993) *Conflicts in Care: Medicine and Nursing,* London, Chapman and Hall.

Mahon, A., and Garrod, D. (2000) 'Fighting chance'. *Health Services Journal,* 26-27, April 20.

Mallik, M. (1992) 'The role of the nurse on the consultant's ward round'. *Nursing Times,* **88,** (5), 49-52.

Manias, E. and Street, A. (2001) 'Nurse-doctor interactions during critical care ward rounds'. *Journal of Clinical Nursing,* **10,** 442-450.

Marshall, J. (1984) *Women Managers: Travellers in a male world.* Chichester, Wiley.

Marshall, J. (1995) *Women Managers Moving On: Exploring career and life choices.* London, Routledge.

Martin, B. (1992) 'Feminism, criticism and Foucault', in H. Crowley and S. Himmelweit (eds.) *Knowing Women.* Cambridge, Polity Press.

Mason, J. (1996) *Qualitative Researching.* London, Sage.

Mauthner, N. and Doucet, A. (1998) 'Reflections on a voice-centred relational method: analysing maternal and domestic voices', in J. Ribbens and R. Edwards (eds.) *Feminist Dilemmas in Qualitative Research.* London, Sage.

Maynard, M. (1994) 'Methods, Practice and Epistemology: The debate about feminism and research', in M. Maynard and J. Purvis (eds.) *Researching Women's Lives from a Feminist Perspective.* London, Taylor and Francis.

Maynard, M. and Purvis, J. (1994) *Researching Women's Lives from a Feminist Perspective.* London, Taylor and Francis.

Mayor, S. (1998) 'Primary Care Groups - friend or foe?' *Practice Nurse,* **15** (10) 578-81.

Mays, N. and Pope, C. (1995a) 'Rigour and Qualitative Research'. *British Medical Journal,* **311,** 109-112.

Mays, N. and Pope, C. (1995b) 'Observational methods in health care settings'. *British Medical Journal,* **311,** 182-184.

McDowell, L. and Pringle, R. (1992) 'Introduction: Women as 'Other''. in L. McDowell and R. Pringle (eds.) *Defining Women : Social institutions and gender divisions.* Cambridge, Polity in association with the Open University.

McKenna, H., Keeney, S. and Bradley, M. (2004) 'Nurse leadership within primary care: the perceptions of community nurses, GPs, policy makers and members of the public'. *Journal of Nursing Management,* **12,** (1), 69-76.

Meerabeau, L. (2005) 'The invisible (inaudible) woman: nursing in the English academy'. *Gender, Work and Organization,* **12,** (2), 124-146.

Melia, K. M. (1987) *Learning and Working: The occupational socialization of nurses.* London, Tavistock.

Melosh, B. (1982) *The Physician's Hand: Work culture and conflict in American nursing.* Philadelphia, Temple University Press.

Melosh, B. (1988) ''A Special Relationship': Nurses and patients in twentieth-century short stories', in A. Hudson Jones (ed.) *Images of Nurses: Perspectives from history, art and literature.* Philadelphia, University of Pennsylvania.

Metcalfe, B. and Linstead, A. (2003) 'Gendering Teamwork: re-writing the feminine'. *Gender, Work and Organization*, **10**, (1), 94 - 119.

Miles, M. and Huberman, M. (1993) *Qualitative Data Analysis: A sourcebook of new methods* (2nd ed.). Newbury Park, CA. Sage.

Mills, A. (2002) 'Studying the gendering of organizational culture over time: concerns, issues and strategies'. *Gender, Work and Organization*, **9**, (3), 286-307.

Mills, A. (1992) 'Organization, gender and culture', in A. Mills and P. Tancred (eds.) *Gendering Organizational Analysis*. London, Sage.

Mills, A and Tancred, P. (1992) *Gendering Organizational Analysis*. London, Sage.

Morgan, M. (1999)'Speaking Out'. *Nursing Times*, **95**, (26), 43, June 30.

Muff, J. (ed.) (1982a) *Socialization, Sexism, and Stereotyping*. Illinois, Waveland Press Inc.

Muff, J. (1982b) 'Altruism, socialism, and Nightingalism: the compassion traps', in J. Muff (ed.) *Socialization, Sexism, and Stereotyping*. Illinois, Waveland Press Inc.

Muff, J. (1982c) 'Handmaiden, battle-axe, whore: An exploration into fantasies, myths and stereotypes about nurses', in J. Muff (ed.) *Socialization, Sexism, and Stereotyping*. Illinois, Waveland Press Inc.

Muff, J. (1988) 'Of Images and Ideals: A look at socialization and sexism in nursing', in A. Hudson Jones (ed.) *Images of Nurses: Perspectives from history, art and literature*. Philadelphia, University of Pennsylvania Press.

Mulligan, J. (1992) 'Nursing and Feminism: caring and curing', in C. Kramarae and D. Spender (eds.) *The Knowledge Explosion: Generations of feminist scholarship*. New York, Teachers College Press.

Murphy, E. and Dingwall, R. (2001) 'The Ethics of Ethnography', in P. Atkinson, Coffey, A., Delamont, S., Lofland, J. and Lofland, L. (eds.) *Handbook of Ethnography*. London, Sage.

National Assembly for Wales (1999) *Realising the Potential: A strategic framework for nursing, midwifery and health visiting in Wales into the 21st century*. Cardiff, National Assembly for Wales.

National Assembly for Wales. (2001) *Improving Health in Wales: A plan for the NHS with its partners*. Cardiff, National Assembly for Wales.

National Assembly for Wales (2001) *Improving Health in Wales: The future of primary care - A consultation document*. Cardiff, National Assembly for Wales.

Neil, R. and Watts, R. (eds.) (1991) *Caring and Nursing: Explorations in feminist perspectives.* New York, National League for Nursing.

Nicholson, L. (ed) (1990) *Feminism and Postmodernism.* New York, Routledge.

Norman, I. J. and Cowley, S. (1999) *The Changing Nature of Nursing in a Managerial Age.* Oxford, Blackwell Science.

Oakley, A. (1981) 'Interviewing women: a contradiction in terms', in H. Roberts (ed.) *Doing Feminist Research.* London, Routledge and Kegan Paul.

O'Brien, M. (1993) 'Social research and sociology', in N. Gilbert (ed.) *Researching Social Life.* London, Sage.

O'Dowd, A. (2000) 'Excluded: that's how nurses feel about primary care groups'. *Nursing Times,* **96,** (13), 32-33, March 30.

Opie, A. (1992) 'Qualitative research, appropriation of the 'Other' and empowerment'. *Feminist Review,* **40,** 52-69, Spring.

Ortner, S. (1976) 'Is female to male as nature is to culture?' in M. Z. Rosaldo and L. Lamphere (eds.) *Woman, Culture, and Society.* Reprinted. ed. Stanford, CA. Stanford University Press.

Parkin, P. (1999) 'Managing change in the community 2: partnership in PCGs'. *British Journal of Community Nursing,* **4,** (4), 188-195.

Patton, M. (1987) *How to use Qualitative Methods in Evaluation.* Newbury Park, CA. Sage.

Pearson, A. (1991) 'Taking up the challenge: the future for therapeutic nursing', in R. Mc Mahon and A. Pearson (eds.) *Nursing as Therapy.* London, Chapman and Hall.

Philpin, S. (2004) *An Interpretation of Ritual and Symbolism in an Intensive Therapy Unit.* Unpublished PhD thesis, School of Health Science, University of Wales Swansea.

Poole, J. (2000) 'Thirst to be Equals'. *Nursing Times,* **96,** (1), 36-37, January 6.

Pope, C. and Mays, N. (1995) 'Researching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research'. *British Medical Journal,* **311,** 42-45, July 1.

Porter, S. (1991) 'A participant observation study of power relations between nurses and doctors in a general hospital'. *Journal of Advanced Nursing,* **16,** (6), 728-735.

Porter, S. (1992) 'Women in a women's job: the gendered experience of nurses'. *Sociology of Health and Illness,* **14,** (4), 510-527.

Porter, S. (1995) *Nursing's Relationship with Medicine: A critical realist ethnography*, Aldershot, Avebury.

Pringle, R. (1983) 'Sex and power in hospitals: the division of labour in the 'health' industry', in A. Pringle and R. Game (eds.) *Gender at Work*. Sydney, Australia, Allen and Unwin.

Pringle, R. (1989a) *Secretaries talk: Sexuality, power and work*, London, Verso.

Pringle, R. (1989b) 'Bureaucracy, rationality and sexuality: the case of secretaries', in D. Sheppard, J. Hearn, P. Tancred-Sheriff and G. Burrell. (eds.) *The Sexuality of Organization*. London, Sage.

Pringle, R. (1992) 'What is a Secretary?', in L. McDowell and R. Pringle (eds.) *Defining Women: Social institutions and gender divisions*. Cambridge, Polity in association with The Open University.

Pringle, R. (1996) 'Nursing a Grievance: women doctors and nurses'. *Journal of Gender Studies*, **5**, (2), 157 - 168.

Rafferty, A. (1992) 'Nursing policy and the nationalization of nursing: the representation of 'crisis' and the 'crisis' of representation', in A. Gray, R. Elkan and. J. Robinson (eds.) *Policy Issues in Nursing*. Buckingham, Open University Press.

Ramazanoglu, C. (1992) 'On Feminist Methodology: male reason versus female empowerment'. *Sociology*, **26**, (2), 207-212.

Ramazanoglu, C. (ed.) (1993) *Up Against Foucault: Explorations of some tensions between Foucault and feminism*. London, Routledge.

Reage, P. (1965) *Story of O*. New York, Grove Press

RCN (1999) *The New Local Health Groups: The knowledge and skills nurses need to make them a real success*. London, RCN.

RCN (2002) *Summary Evaluation Report for Phase 2 of the RCN Clinical Leadership Programme*. London, RCN.

RCN (2003) *Defining Nursing*. London, RCN.

Reay, D. (1996) 'Insider perspectives or stealing words out of women's mouths: interpretation in the research process'. *Feminist Review*, **53**, 57 – 74, Summer.

Regen, E., Smith, J., Goodwin, N., McLeod, H. and Shapiro, J. (2001) *Passing on the Baton: Final report of a national evaluation of primary care groups and trusts*. Birmingham, Health Services Management Centre, University of Birmingham.

Regen, E., Smith, J. and Shapiro, J. (1999) *First off the Starting Block: Lessons from GP commissioning pilots for PCGs*. Birmingham, Health Services Management Centre, University of Birmingham.

Reger, J. (2001) 'Emotions, objectivity and voice: an analysis of a 'failed' participant observation'. *Women's Studies International Forum,* **24,** (5), 605-616.

Reverby, S. (1987) *Ordered to Care: The dilemma of American nursing 1850-1945.* Cambridge, Cambridge University Press.

Reverby, S. (1990) 'The duty or right to care? Nursing and womanhood in historical perspective', in E. Abel and M. Nelson (eds.) *Circles of Care: Work and identity in women's lives.* New York, State University of New York.

Rich, A. (1979) *On Lies, Secrets and Silence: Selected prose 1966-1978.* London, Virago.

Roberts, H. (1981) *Doing Feminist Research.* London, Routledge and Kegan Paul

Roberts, S. (1983) 'Oppressed group behaviour: implications for nursing'. *Advances in Nursing Science,* **5,** (4), 21-30.

Robinson, J. (1989) 'Nursing in the future: a cause for concern', in M. Jolley and P. Allen (eds.) *Current Issues in Nursing.* London, Chapman and Hall.

Robinson, J. (1992) Introduction: Beginning the study of nursing policy, in A. Gray, R. Elkan and J. Robinson (eds.) *Policy Issues in Nursing.* Buckingham, Open University Press.

Robinson, J. (1997) 'Power, politics and policy analysis in nursing', in A. Perry (ed.) *Nursing: A knowledge base for practice.* London, Arnold.

Rose, K. and Webb, C. (1998) 'Analyzing data: maintaining rigor in a qualitative study'. *Qualitative Health Research,* **8,** (4), 556-562.

Rosser, J. and Davies, C. (1987) ''What would we do without her?': invisible women in NHS administration', in A. Spence and D. Podmore (eds.) *In a Man's World: Essays on women in male dominated professions.* London, Tavistock.

Ross-Smith, A. and Kornberger, M. (2004) 'Gendered Rationality? A genealogical exploration of the philosophical and sociological conceptions of rationality, masculinity and organization'. *Gender, Work and Organization,* **11,** (3), 280-305.

Rowden, R. (1999) 'Arena: here's to 1,000 brave innovators'. *Nursing Times,* **95,** (11), 22, March17.

Rowe, A. (1999) 'Spectre at the feast'. *Nursing Times,* **95,** (2), 28-29, January 13.

Rowe, J. (1998) 'Primary Opportunity'. *Health Visitor,* **71,** (2), 49, February.

Ruiz, M. (1982) 'Lack of ego differentiation: its effect on nursing leadership', in J. Muff (ed.) *Socialization, Sexism and Stereotyping.* Illinois, Waveland Press Inc.

Saks, K. (1990) 'Does it pay to care?', in E.K. Abel and M.K. Nelson (eds.) *Circles of Care: Work and identity in women's lives.* New York, State University of New York.

Salvage, J. (1985) *The Politics of Nursing.* London, William Heinemann Medical Books.

Salvage, J. (1992) 'The New Nursing: empowering patients or empowering nurses?', in A. Gray, R. Elkan and J. Robinson (eds.) *Policy Issues in Nursing.* Buckingham, Open University Press.

Salvage, J. and Smith, R. (2000) 'Doctors and nurses: doing it differently'. *British Medical Journal,* **320,** 1019-20.

Sams, D. and Boito, H. (1999) 'Taken on board'. *Nursing Times,* **95,** (13), 56-57, March 31.

Sandelowski, M. (1986) 'The problem of rigor in qualitative research'. *Advances in Nursing Science,* **8,** (3), 27-37, April.

Sandelowski, M. (1993) 'Rigor or rigor mortis: the problem of rigor in qualitative research revisited'. *Advances in Nursing Science,* **16,** (2), 1-8.

Savage, J. (2000) 'One voice, different tunes: issues raised by dual analysis of a segment of qualitative data'. *Journal of Advanced Nursing,* **31,** (6), 1493-1500.

Scott, C. and Thurston, W. (2004) 'The influence of social context on partnerships in Canadian health systems'. *Gender, Work and Organization,* **11,** 95), 481-505.

Segal, L. (1990) *Slow Motion: Changing masculinities changing men.* London, Virago Press.

Sheppard, D. (1989) 'Organizations, power and sexuality: the image and self-image of women managers', in D. Sheppard, J. Hearn, P. Tancred-Sheriff and G. Burrell (eds.) *The Sexuality of Organization.* London, Sage.

Sheppard, D. (1992) 'Women managers' perceptions of gender and organizational life', in A. Mills and P. Tancred (eds.) *Gendering Organizational Analysis.* Newbury Park, CA. Sage.

Sherman, R. and Webb R. (1988) 'Qualitative research in education: a focus,' in Sherman R. and Webb R. (eds.) *Qualitative Research in Education: Focus and Methods.* London: The Falmer Press.

Sibbald, B. (2000) 'Primary Care: background and policy issues' in A. Williams *Nursing, Medicine and Primary Care.* Buckingham, Open University Press.

Silverman, D. (2000) *Doing Qualitative Research: a practical handbook.* London, Sage.

Skeggs, B. (1994) 'Situating the production of feminist research', in J. Purvis and M. Maynard (eds.) *Researching Women's Lives from a Feminist Perspective*. London, Taylor and Francis.

Skeggs, B. (2001) 'Feminist Ethnography', in P. Atkinson, A. Coffey, S. Delamont, J. Lofland, and L Lofland (eds.) *Handbook of Ethnography*. London, Sage.

Smith, D. (1987) *The Everyday World as Problematic: A feminist sociology*. Boston, Northeastern University Press.

Smith, J. (2000) 'Primary Care Groups: how are they shaping up?' *British Journal of Midwifery*, **8** (2), 107-109.

Smith, J., Regen, E., Goodwin, N., McLeod, H. and Shapiro, J. (2000) *Getting into their Stride: Interim report of a national evaluation of primary care groups*, Birmingham, Health Services Management Centre, University of Birmingham.

Smith, K., Dickson, M. and Sheaff, R. (1999) 'Second among equals'. *Nursing Times*, **95**, (13), 54-55, March 31.

Smith, P. (1992) *The Emotional Labour of Nursing: How nurses care*. Basingstoke, Macmillan Education.

Spender, D. (1980) *Man Made Language*. London, Routledge and Kegan Paul.

Stacey, J. (1988) 'Can there be a feminist ethnography?' *Women's Studies International Forum*, **11**, (1), 21-27.

Stacey, M. (1992) *Regulating British Medicine*. Chichester, John Wiley and Sons Ltd.

Stanley, L. and Wise, S. (1983) *Breaking Out*. London, Routledge and Kegan Paul.

Stanley, L. (1984) 'How the social science research process discriminates against women', in S. Acker and D. Warren-Piper (eds.) *Is Higher Education Fair to Women?* Guilford, SRHE and NFER-Nelson.

Stanley, L. (1990) *Feminist Praxis: Research, theory and epistemology in feminist sociology*. London, Routledge.

Stanley, L. and Wise, S. (1993) *Breaking Out Again: Feminist ontology and epistemology*. London, Routledge.

Stein, L. (1967) 'The doctor-nurse game'. *Archives of General Psychiatry*, **16**, (6), 699-703.

Stein, L., Watts, D.T. and Howell, T. (1990) 'The doctor-nurse game revisited'. *Nursing Outlook*, **38**, (6), 264-268.

Strathern, M. (1987) 'An awkward relationship: the case of feminism and anthropology'. *SIGNS*, **12**, (2), 276-99.

Strati, A. (1992) 'Organizational Culture', in G. Szell (ed.) *Concise Encyclopaedia of Participation and Co-management*. Berlin, W. de Gruyter.

Strauss, A. and Corbin, J. (1990) *Basics of Qualitative Research: Grounded theory procedures and techniques*. Newbury Park, CA. Sage.

Strauss, A. and Corbin, J. (1998) 'Grounded theory methodology: an overview', in Y. Lincoln and N. Denzin (eds.) *Strategies of Qualitative Inquiry*. Thousand Oaks, CA. Sage.

Strong, P. and Robinson, J. (1990) *The NHS - under new management*. Milton Keynes, Open University Press.

Svensson, R. (1996) 'The interplay between doctors and nurses - a negotiated order perspective'. *Sociology of Health and Illness*, **18**, (3), 379-398.

Sweet, T. (1999) 'Special Brew'. *Health Service Journal*, **109**, 21, June 3.

Szasz, S. (1982) 'The tyranny of uniforms', in J. Muff (eds.) *Socialization, Sexism and Stereotyping*. Illinois, Waveland Press Inc.

Torres, G. (1981) 'The nursing education administrator: accountable, vulnerable and oppressed'. *Advances in Nursing Science*, **3**, (3), 1-16.

Traynor, M. (1999) *Managerialism and nursing: beyond oppression and profession*. London, Routledge.

Treacy, M. P. (1989) 'Gender prescription in nurse training: Its effects on health care provision', in L. K. Hardy and J. Randell (eds.) *Recent Advances in Nursing: Issues in women's health*. Edinburgh, Churchill Livingstone.

Ungerson, C. (1983) 'Why do women care?' in J. Finch and D. Groves (eds.) *A Labour of Love: Women, work and caring*. London, Routledge and Kegan Paul.

Vance, C., Talbott, S., McBride, A. and Mason, D. (1985) 'An uneasy alliance: nursing and the women's movement'. *Nursing Outlook*, **33**, (6), 281-285.

Waerness, K. (1992) 'On the rationality of caring', in A. S. Sassoon (ed.) *Women and the State*. London, Routledge.

Walby, S. and Greenwell, J. (1994) *Medicine and Nursing: Professions in a changing health service*. London, Sage.

Walshe, N., Roe, B. and Huntingdon, J. (2003) 'Delivering a different kind of primary care?' *Journal of Clinical Nursing*, **12**, (3), 333-340.

Watkins, S. (1987) *Medicine and Labour: The politics of a profession.* London, Lawrence and Wishart.

Welsh Office (1998a) *NHS Wales: Putting Patient's First.* Cardiff, Welsh Office.

Welsh Office (1998b) *Putting Patient's First: Establishing Local Health Groups.* Cardiff, Welsh Office.

West, C. and Zimmerman, D.H. (1991) 'Doing gender', in J. Lorber and S. A. Farrell (eds.) *The Social Construction of Gender.* London, Sage.

Weyenberg, D. (1998) 'The construction of feminist pedagogy in nursing education: a preliminary critique'. *Journal of Nursing Education,* **37,** (8), 345-353.

Whale, Z. (1993) 'The participation of hospital nurses in the multidisciplinary ward round on a cancer-therapy ward'. *Journal of Clinical Nursing,* **2,** (3), 55-163

Wheatley, M. and Sweeting, J. (1999) 'Nurses on Board'. *Nursing Management,* **5,** (10), 7-8.

Whitehead, S. (2001) 'The invisible gendered subject: men in education management.' *Journal of Gender Studies,* **10,** (1), 67-82.

Whitford, M. (1991) *Luce Irigaray: Philosophy in the Feminine.* London, Routledge.

Wicks, D. (1998) *Nurses and Doctors at Work: Rethinking professional boundaries.* Buckingham, Open University Press.

Wiles, R. and Robison, J. (1994) 'Teamwork in primary care: the views and experiences of nurses, midwives and health visitors'. *Journal of Advanced Nursing,* **20,** (2), 324-330.

Wilkin, D., Gillam, S. and Leese, B. (2000) *The National Tracker Survey of Primary Care Groups and Trusts 1999/2000: progress and challenges.* Manchester, National Primary Care Research and Development Centre, University of Manchester.

Wilkin, D., Gillam, S. and Coleman, A. (2001) *The National Tracker Survey of Primary Care Groups and Trusts 2000/2001.* Manchester, National Primary Care Research and Development Centre, University of Manchester.

Williams, A. (1993) 'Diversity and agreement in feminist ethnography'. *Sociology,* **27,** (4), 575-589.

Williams, A. (1996) 'The politics of feminist ethnography'. *Canadian Journal of Nursing Research,* **28,** (1), 87-94.

Williams, A. (2000) *Nursing, Medicine and Primary Care* Open University Press, Buckingham.

Williams, A and Heyerdahl, E. (2004) 'Primary care priorities in Europe.' *NT Research* **9** (3) 226-230

Williams, S., Calnan, M., Cant, S. and Coyle, J. (1993) 'All change in the NHS? Implications of the NHS reforms for primary care prevention'. *Sociology of Health and Illness,* **15,** (1), 43 – 67.

Williams, S. (2001) 'Sociological imperialism and the profession of medicine revisited: where are we now?' *Sociology of Health and Illness,* **23,** (2), 135-158.

Willis, J. (1998) 'Last among equals'. *Nursing Times,* **94,** (26), 16-17, July 1.

Wintrob, R. M. (1969) 'An inward focus: a consideration of psychological stress in fieldwork', in F. Henry and S. Saberwal (eds.) *Stress and Response in Fieldwork.* New York, Holt, Rinehart and Winston.

Witz, A. (1992) *Professions and Patriarchy.* London, Routledge.

Witz, A. (1994) 'The challenge of nursing', in J. Gabe, D. Kelleher and G. Williams (eds.) *Challenging Medicine.* London, Routledge.

Wolcott, H. (1988) 'Ethnographic research in education', in R. M. Jaeger (ed.) *Complementary Methods for Research in Education.* Washington, DC, American Educational Research Association.

Wyke, S., Myles, S., Popay, J., Scott, J. and Campbell, A. (1999) 'Total purchasing, community and continuing care: lessons for future policy developments in the NHS'. *Health and Social Care in the Community* 7 (6) 394-407

Appendix 1: Outline and timescale of fieldwork

Phase 1	January 1999 – November 1999

Observation:
PCG board meeting (1)
LHG board meetings (21)
    • LHG1=4
    • LHG2 = 2
    • LHG 3 = 5
    • LHG4 = 3
    • LHG5 =3
    • LHG6 = 4
LHG sub-committee meetings (11)
    • LHG3 = 4
    • LHG1 = 7
Participant observer Wales LHG Nurse Forum (2)
Participant observer RCN skills workshop
Participant observer LHG nurses network meetings at HA1 (3)
 	
Informal interviews with key informants/research participants:
PCG Board nurses (2)
Director of Community Nursing Services, England (1)
LHG Senior Nurse (1)
LHG General Managers (4)
Member of LHG secretariat (1)
Nursing Officer, Welsh Assembly for Wales (1)
 	
Formal Interviews with LHG board members:
LHG board nurses (13)
GP board members (5)	

Maternity Leave	**December 1999 – June 2000**
Transcribing interviews and preliminary data analysis Participant observer at Wales LHG Nurse Forum (1)	**July 2000 – September 2001**
Phase 2	**October 2001 – February 2002**
Observation: LHG3 board meeting (1) Formal Interviews with LHG board members: LHG Board nurses (8) LHG General Managers (2) LHG Senior Nurse (1)	
Interview Transcription Data analysis Writing up	**March 2002 – April 2005**

Appendix 2: LHG membership

Health Authority	LHG	Nurse Participants	GP Participants	Other
HA1	LHG1	Becky Sam Emma	Nick David	
	LHG2	Debbie Sarah		
	LHG3	Linda Kate Charlie	Will	
	LHG4	Claire Rose	Eve Richard	Rita (general manager)
	LHG5	Kim Maxine		Pam (general manager)
HA2	LHG6	Ann Viv		Karen (senior nurse)
HA3	LHG7			Louise (general manager)
HA4	LHG8	Tina		

Appendix 3: Extract from fieldnotes: skills development workshop HA1 02/99

Observation
I arrived 20 minutes early and sat in the room eating my sandwiches. I was feeling a bit apprehensive at the same time eager to get started – to get my hands on some participants!
Sylvie [the tutor] arrived first to set up for the session. I introduced myself – she remembered me from the clinical supervision sessions but didn't know I was doing research. I filled her in - no mention of gender though.
People began drifting in – all in uniform and straight from work except for one nurse from LHG1.
They began talking amongst themselves whilst waiting for others. They all sat at the top of the table with a gap between the first nurse and me. Occasionally they looked at me and smiled. I waited for Sylvie to introduce me or for the right opportunity to introduce myself. I had prepared my introduction (in my head) but I knew what I said would depend on how it 'felt'
Just before Sylvie was about to start I said 'sorry Sylvie can I just introduce myself?' she apologised for not introducing me so I continued ' I'm AH and I'm doing some research at Swansea university. I'm wanting to look at the experiences of nurses on LHG boards and I'm hoping to do this in HA1'...(wry smiles and raised eyebrows) ' I have a background in district nursing and worked for a while as a practice nurse in Nottingham before going to university...' I explained that Gill [senior nurse in HA1] had invited me to the sessions so I could get a feel for what some of the issues were / to see how things were developing
Not much of a response to my introduction – a few smiles. So I asked them how things were going.
I wasn't writing at this point, so I can't remember what they said exactly. I was too busy concentrating on how I came across and what I said in response to their comments.
Claire said they were spending a lot of time on the 'constitutional issues'. Who does what etc also financial issues. This came to dominate subsequent discussion in the workshop. Others murmured in agreement. Then Sylvie began...
Sylvie asked for feedback on emerging issues / problems / queries etc. This I took to be the 'exploring expectations' bit of the workshop although this wasn't made clear
Kim said they had wanted to know how they could access 'the rank and file' of nurses who comprised the various constituencies. 'We need the names of all the nurses' This was so they could introduce themselves as the new LHG board members, touch base with their colleagues and 'let them know who we are and what's going on'

Appendix 4: Extract from fieldnotes: RCN
'Changes in Primary Care' workshop 04/99

After I had given my presentation I was walking back to my seat and Viv said 'I must talk to you
... I want to borrow your acetates...'

She wanted them for a talk she was giving to some Practice Nurses with Ann – the other board
nurse. She turned to Ann for agreement 'you know, we could use them and maybe adapt them'.

I said she could have them. She seemed delighted and took my address, promising to send them
back that week.

Having been slightly 'cool' when I first mentioned the research their attitude to me seemed to
change somewhat – at least Ann's attitude softened although it was never as open as Viv's. They
included me more, kind of confiding in me. I told them a bit more about the research. Viv: 'what
information do you want from us then?' AH: it's not really information I'm after – it's more
your experiences – you know, what is it like being on an LHG?' I explained about my journey
and how I wanted to come to the meetings ' to see what happened, what went on..'

They seemed interested. Ann said the journey had started several months ago for them - in fact
she reckoned it had started some 6 months ago when they first thought about getting involved on
the LHG boards. Ann: ' you may need to take account of that in your research' I nodded rather
vaguely. I don't think I had given them enough information about the research. I was rather
perplexed by her response, but didn't pursue. I asked them whether they would be happy to have
a chat with me sometime. They agreed. (Ann less enthusiastic than Viv). Viv suggested getting
in touch in June sometime and she would arrange for us to have a room somewhere quiet.

Viv: we haven't given you our addresses yet have we?
Ann: well, the list has all the numbers on doesn't it (I felt she didn't want me to have her
address)
AH: yes that is fine – they are your work numbers right?'

I later asked how I would know the venue of the meetings, immediately Viv said, 'well, give us
a ring' and put hers and Ann's phone number down on the paper for me to contact.

I was aware that I had tried to butter Ann up because she has seemed particularly aloof. We went
to the toilet together, she commented about her new hair colour and I said I thought it looked
great.

Appendix 5: Invitation to nurses to participate in Phase 1 of the research

26th April 1999

Dear .....

I am writing to ask whether you would be prepared to take part in a research project looking at the experiences of nurses on local health groups.

I know we briefly met at the recent Wales LHG Nurse Forum and I spoke a little bit about the research. This letter is a more formal approach to ask if you would be prepared to participate in the research and to give you a better idea as to what the research is all about.

I am undertaking the research as part of a PhD at Swansea University and I am hoping to interview a number of nurses in Wales who are currently LHG board members. My interest in this area stems from my own experiences of working in primary care as a district nurse, as well as an interest in the organisational role and position of nurses within the NHS.

The development of LHGs is seen as providing a great opportunity for nurses working at grass roots level to have a direct say in how public money can be best spent on local health care. But if the opportunities for nurses are to be realised, an understanding of those factors that may facilitate or inhibit nursing's contribution to LHGs needs to be developed. An exploration of nurses' experiences of being on LHG boards would contribute to such an understanding.

The interviews are intended to be relaxed and informal, and whilst there are a few key topics that I hope we can explore, the aim is for us to talk about different issues as and when they arise.

The kinds of things we might discuss include:

- what you feel, as a nurse, you can contribute to the working of the LHG
- those factors which you think influence your ability to contribute
- your experiences of board meetings / sub-committee meetings
- any concerns or anxieties you may have about your role as a board member
- personal and professional development issues

The interviews should last no longer than 1 – 1½ hours. With your permission I would like to tape-record the interview. This is so that no information is lost and tapes will be erased after use. Your name will not be mentioned in relation to anything which you say and your name will not appear in any reports or publications arising from the research.

I shall be contacting you again within the next 2 weeks to find out if you are prepared to participate in the research and if so, to arrange a convenient date and time for interview. If you have any queries please do not hesitate to get in touch at the contact numbers/address below.

Many thanks,

Alison Hughes
PhD student

Appendix 6: Invitation to GPs to participate in research

14th October 1999

Dear Dr .....

I am currently undertaking a research project as part of my PhD at Swansea University in the School of Health Science.

The aim of the research is to explore the experiences of nurses on Local Health Group boards - in particular the experiences of nurses in ... Health Authority [HA1].

I have spent the last 6 months attending LHG board meetings and interviewing nurses within HA1. I have also attended various LHG sub-committee meetings as an observer. Whilst this has been very useful, I would much appreciate the opportunity to talk with other key personnel on LHG boards – in particular some of the GPs. This would allow me to develop my understanding of the nursing experience, as well as getting a better idea of some of the issues currently facing LHG boards.

The reason for writing therefore is to ask whether you would be prepared to be interviewed as part of the project. Broadly speaking the kinds of issues I am interested in include:

- The role and contribution of nurses on LHGs
- Multi-disciplinary working / decision making
- Personal and professional development issues

The research has been approved by the Health Authorities Medical Ethics Committee and conforms to the usual standards of anonymity and confidentiality. With your permission I would like to tape record the interview. This is so that no information is lost. Your name would not be mentioned in relation to anything which you say and your name would not appear in any reports or publications arising from the research. Similarly individual LHGs will not be identified.

I shall contact you again in a week or so to find out if you are prepared to participate and if so, to arrange a convenient time and date for interview – preferably before the end of November. I am aware that you are probably very busy – any time you could spare would be much appreciated.

If you would like further information about the research, please do not hesitate to contact me.

Many thanks.

Yours sincerely,

Alison Hughes
PhD student

Appendix 7: Copy of letter requesting observer status on LHG3 sub-committee meetings

16th August 1999

Dear [Chair of sub-committee]

Re: request for observer status on [LHG3] sub-committees

I am currently undertaking a research project as part of my PhD at Swansea University in the School of Health Science.

The aim of the research is to explore the experiences of nurses on Local Health Groups. I am focusing in particular on the experiences of nurses on LHGs in .... Health Authority.

The principal research methods include observation of board meetings and interviews with LHG nurse representatives. Both nurse board members of the LHG (Kate and Linda) have agreed to participate in the research.

Having attended various LHG board meetings across [HA1] and having spoken to Kate and Linda, it is clear that much of the experience of being an LHG board nurse takes place 'behind the scenes', for example on sub-committees. In order for me to get a better understanding of this experience, it would be enormously beneficial if I could observe some of the sub-committee meetings – I am therefore writing to you to ask permission to attend the sub-committee as an observer.

I have discussed this matter with Will who has indicated that as Chair of the LHG, he is happy for me to attend the sub-committee meetings and suggested I contact each sub-committee Chair to request observer status. I have also spoken to both Kate and Linda who are happy for me to attend the meetings.

Broadly speaking the kinds of issues I am interested in include:

• The role and contribution of nurses on LHGs
• Multi-disciplinary working / decision making
• Training and support for nurse board members
• Personal and professional development issues

The research is currently being considered by the Health Authority Research Ethics Committee and conforms to the usual standards of anonymity and confidentiality. Whilst some of the data from interviews and observation may be published, participants' names will not be associated with the research. Likewise individual LHGs will not be identified.

I would like to attend the next meeting scheduled for [date] and would therefore be grateful if you could let me know whether I will be able to attend prior to this date.

If you would like further information about the research please do not hesitate to contact me.

I look forward to hearing from you.

Yours sincerely,
Alison Hughes
PhD student

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Appendix 8: Interview Topic Guide (nurses). Phase 1.

Pre –interview

- Plan for interview
- Re-iterate anonymity
- Brief overview of research (journey, further interviews)
- Send transcript for correction / comment

<u>**Background**</u>

1. Can you tell me how you came to be involved in the LHG?

2. How would you describe your role on the LHG?

- Is it clear?
- Ambiguities?
- Membership of sub-committees

3. How would you describe (sum up) the last 9 months or so?

<u>**Working as a group**</u>

4. What has been your experience of working with the rest of the board?

- Do you feel group member's work well together?
- Opportunities and barriers to working in partnership?
- Medical domination?
- Do you feel board members operate as equal partners?
- Power of executive?

<u>**Decision making / Nursing contribution**</u>

5. Can you tell me about the way decisions are made in the group?

- Do you feel able to contribute to the decision making process?
- What factors do you think influence your ability to contribute?
- gender / power / knowledge / colleague support / knowledge base / confidence

6. What do you feel, as a nurse, you can contribute to the LHG

- Examples - how have you contributed?
- Nurses not informing the agenda – what's your experience?
- Operating at a strategic level

7. If there are problems in being able to contribute, what impact, if any, does this have on the work of the LHG / on you? (Judith Smith – disillusionment)

8. What would the nursing contribution look like in an ideal world?

- How far away from that are you?
- What are the barriers?

9. How do you think others on the board view you as a nurse?

- Credible strategic player? (Antrobus)
- Uniform as key to managing identity – what's your view?

Gender

10. One of the things I am interested in is the role of gender in nurse's experiences of being on LHGs. Does that bring anything to mind?

- Do you think being a woman / nurse has any impact on your experiences?
- How aware are you of your identity as a nurse (and as a woman) when you go to meetings etc.?
- Is that identity something you are conscious of 'managing'? Strategies? e.g. play down or play up your femininity / distance yourself from nursing identity / be the best / conform to gender identity
- What does that feel like?

Training and Support

11. What kind of support are you getting?

12. What kind of training and support do you feel you need to allow you to develop / fulfil your role?

13. Burden of workload? (Judith Smith)

And finally...

14. If I came back in a years time, what changes would you like there to be (for you personally in your role as an LHG Board member and as regards the LHG as a whole)

15. If you were studying the experiences of nurses on LHGs, what kind of questions would you want to ask? Could you try to answer that question now? (Sheppard)

16. Is there anything else you would like to add?

Appendix 9: Interview Topic Guide (nurses). Phase 2.

(Note: second phase topic guides were adapted for participants according to the particular issues each raised during the first phase of fieldwork. Below is the template, which was adapted as necessary).

Question	Prompts
Impressions: How would you summarise life as an LHG nurse?	
Nursing role: How would you describe your role as an LHG nurse? Are those early ambiguities still there? Have your early thoughts changed, and if so, how?	
Nursing Contribution: Can you tell me how you have been able to contribute to the work of the LHG? Specific examples?	Initiatives? Clinical governance? Patient focus? Broader understanding of health?
Where might I see the evidence of your efforts?	Operational plan? Discrete pieces of work e.g. CHD, Diabetes?
What do you think you can bring to the LHG *as a nurse*? OR How have you been able to use your nursing knowledge to inform the work of the LHG	Uniqueness? Reminding board of *patient focus*, broader understanding of health, holistic approach, awareness of health and social care interface, new nurse-led solutions to old problems, *leading* discussions, emphasis on quality?
To what extent do you feel you are informing/ shaping the work of the LHG? (as opposed to simply commenting when asked)?	A 'resource' / more passive?
How much *influence* do you think you have in terms of decision making within the board? Can you give me some examples?	
What factors do you feel influence your ability to contribute	Status & power of GPs/ lead from GM / political& strategic ignorance/ identity as a nurse/ Dr:Nurse baggage/ material factors
Has your contribution (what you say and how you say it) changed over the years?	
How much of the work of the LHG would you say you understood?	

What aspects are you less sure about? *How* have you learnt what to do and how to do it?	Commissioning? In full view of everyone?
Articulating the value of nursing: One of the things to emerge from the first phase of fieldwork is the difficulty nurses have in *articulating the value of their work* and translating this to the broader, political and strategic work of the LHG. What are your thoughts about this? Why do you think this is difficult?	Using their *nursing* knowledge (translating the ideology of caring) to inform the work of the LHG Operational focus? Lack of experience / training & support? No language?
Commissioning: To what extent is the LHG involved in commissioning? How are you (or how do you imagine) contributing to the commissioning process?	 Refer to diagram of the commissioning cycle
Personal / professional development: How do you think you have changed / developed either personally or professionally during this time? In relation to your role on the LHG, what are your current developmental needs? Are those needs being addressed? If not why not? In general do you feel you have received adequate/ relevant training and support for the job? What skills / qualities do LHG board nurses need? How do you think nurses should go about acquiring those skills?	 e.g. Centre for Health Leadership training?
Group working: How is the board working together now? Are there any unresolved issues?	
The future? How do you see the future for LHG board nurses? How important do you think it is for nurses to have had previous	 Opportunities as providers (of community nursing) and as commissioners? Avoid learning on the job in full view

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management / strategic experience?	of board/ better negotiating skills / less intimidated, more confident / board room skills / different contribution
What impact do you think having a nurse on the executive/ secretariat would have?	Currently a lack of nursing voice within support structure
Others: How do you explain the different experiences LHG nurses have on the board (vis a vis their ability to influence)	
How conscious are you of being a nurse?	
To what extent do you think the traditional Dr/Nurse relationship is played out at board level?	
To what extent do you think the professional interests of GPs (as business people) has influenced the work(ing) of the LHG. Has it affected the potential of others to contribute?	

Appendix 10: Interview Topic Guide (GPs). Phase 1.

Background

1. Can you just start by telling me briefly how and why you came to be involved in the LHG?

2. How would you sum up the last 9 months?

3. What have been some of the good bits, and some of the not so good bits?

Group working / decision making

4. How do you feel you work together as a group?

5. History of local Total Purchasing Project (TPP), what impact, if any, has this had on the group and the way it has developed?

   - How multi-disciplinary was the TPP?

6. How much influence do you think the various board members have in terms of decision making?

   - Are board members equal partners?
   - Are nurses able to participate in decision making on an equal basis with GPs?

7. Power of executive – how justified is this perception?

Medical contribution / dominance

8. Medical domination of LHG boards - what are your thoughts?

   - Agenda items
   - GMS issues

9. Do you think GPs are aware of the more general concern re medical dominance?

- Are they under siege / being challenged? e.g. NHS direct, salaried GPs, end of fundholding.

10. What are your thoughts regarding the GP contribution to date?

11. How would you describe the role of GP members?

- Representing their colleagues? Representing the local community?
- Impact of selection process – nominated by colleagues therefore representing colleagues?

Nursing Contribution

12. How do you see the role of the nurse members?

- Confusion amongst some nurses

13. What do you think nurses can contribute to the LHG?

- Same as GPs?
- Nurses emphasising broader, more holistic approach / less 'black and white'?

14. What are your thoughts regarding the nursing contribution to date?

- Are they able to participate on an equal basis with GPs?
- If not, why not? Gender? Dr/Nurse relationship?
- Are they generally seen as credible strategic players?
- Too 'operational'?

15. If there are concerns regarding the nursing contribution – what can be done about them?

- Whose responsibility is it? (Smith *et al*: groups need to determine ways of ensuring that nurses are able to participate)

Other

16. Is the role of the HA clear?

- Fine line between HA 'support' and 'control'

17. Workload / time commitment of board members?

18. If I were to come back in a years time, what changes would you like there to be - for you personally and the LHG?

19. How do you see the future of the LHG?

Consent Form

Research study into the experiences of nurses on Local Health Group boards

Researcher: Alison Hughes

The purpose of this study is to explore the experiences of nurses on Local Health Group boards. Interviews will take approximately 1 hour. Interviews may need to be conducted more than once. The data collected from the interviews may be published but your name will not be associated with the research. Individual LHGs will not be identified.

I confirm that I ....consent to take part in the research.

I give permission for the interviews to be tape-recorded. I understand that at any time I may ask for the tape recording to be stopped. I also understand that on completion of the research, these tapes will be erased.

I understand that I am free to withdraw my consent and terminate my participation in the research at any time without penalty.

Signed...

Date...

Appendix 12: Extract from interview with Sarah (LHG2 nurse board member) with analytic codes. 06/99.

My thoughts prior to the interview:

It was a sunny day and I was quite excited and nervous about the interview. It took me a while to find the surgery. The town is nestled in this lovely wooded valley but the whole place felt so different to me. It felt bleak and grey. What are people's lives like here? I felt so different. I sat in the car park as I was early, then Sarah arrived and saw me. We went in together – me lugging the huge tape recorder around. It feels very conspicuous.

A: If you could just start by filling me in with a bit of background – how you came to be involved in the LHG.

S: I didn't even think I could be considered as one of the nurses, I think probably because that's at some other level. It was [the Health Authority Senior Nurse] who phoned me and asked me to apply and this was 3 days before the interviews, so I rustled through lots of bits of paper and I attended the interview, which I found horrendous. Absolutely horrendous. And I was quite upset that nurses had to go through this when it didn't seem to happen to any other board member, which I discovered afterwards. Why were we singled out for this treatment, you know? And I did, I thought it was very high powered on a subject that none of us really knew anything about, but I got an interview and got the job. I think a lot of that was because I was a practice nurse and I'm not sure how many other practice nurses applied so I often had this feeling that ... how can I put it ... I would have got the job anyway because of my position whether I was the best one for it. Although I do think I can contribute and I am very interested in it, although a little lost at the minute. But I think we all are - all the nurses. More the nurses than anyone else, I don't know why.

A: More in terms of feeling lost?

S: Yes, all the nurses that we've met because I've met them at the all Wales level and we all feel the same. No one is quite sure what their role is which I suppose will come in time; it's just the learning of it.

A:: Do you think other people on the board know what their role is?

S: Maybe not, but they are definitely more used to presenting themselves ... it's the jargon that is used, you know, they seem to understand that, whereas a lot of the nurses a bit lost with this.

A: May be they have been involved on other boards?

S: That's right and they are pretty high powered people, you know, apart from the lay member and the voluntary rep. Mind you, the voluntary rep knows his onions, you know, he really knows his stuff. But everyone else goes to conferences and they've attended boards and so they know the etiquette and protocols which again I don't think nurses do. I think there should have been some form of training into the actual role of a board meeting.

1 2 nursing identity
appointment self process – not doubt – 'me'
2
1
2 nurses lost
3
1 role
2
7 jargon
nursing identity
1 10
lack of experience

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Appendix 13: Extracts from supervision notes

Note: Although I initially kept a record of my thoughts, feelings and experiences in my fieldwork journal, as the research progressed I tended to document them as part of my monthly supervision notes ready to discuss with my supervisor. Hence my 'supervision notes' came to represent my reflexive journal as well as containing more practical questions, comments and update on progress.

Supervision notes

'Feeling inadequate. Not up to standard, not doing it properly. What can I do to feel better about this? It feels a constant struggle to defer my sense of inadequacy'. 8/99

'Am I professional enough, competent enough to be let loose without the kind of supervision and support one normally gets in a job? This suddenly occurred to me as I was observing one of the board meetings'. 3/99

'I feel I lack the time to wallow and immerse myself in data – will I regret not doing so at a later stage? For example, I feel I need to get some insight into how GPs make sense of their power base – they appear to lack self-awareness. The perceived power base of GPs in relation to nurses is a constant theme amongst those I interview. I am beginning to wonder if GPs *feel* they are that powerful. It feels important to find out. But if I go along that line, does it take me away from my focus on the nursing experience? What it might do though' is to allow me to get a fuller picture as to how gender power relations are constructed as part of LHGs.' 7/99

'Feelings about the fieldwork: it feels like I have only scratched the surface and that all I do is keep scratching. Disparate thoughts / ideas, none of which are properly worked through. When will that happen? When do I stop the fieldwork? How will I know when to stop? How much data do I need? Will I have enough?' 11/99

'I'm learning what LHGs are all about and what the nursing contribution could be, at the same time as participants. I'm not coming to this as 'an expert', and I wonder if this will adversely affect the quality of my data. (look back and think I should have asked different questions). In fact, I'm finding it really difficult to get a hold of what the nursing contribution could look like. It doesn't feel solid. The examples I have from participants are small, not the grand possibilities that I had envisaged. And if I haven't properly understood what the contribution should be, how will I be able to argue that the nursing contribution has been compromised, as I'm beginning to feel it is?' 10/00

'Nurses have talked about 'blazing a trail, laying the foundations for those who follow'. They feel a responsibility to prepare the ground for their colleagues. It's interesting how carving out a place for nurses is seen as a once and for all thing. But if nurses' identity as credible strategic players is contingent and if organisations are imbued with masculinity (women / nurses as 'other'), it seems likely that other nurses will face similar difficulties. Nurses' credibility is not a given. This stands in contrast to the

position of GPs (and others?) It also says something about the way nurses themselves theorise organisational culture and their relations with board members. I suppose the question is, are they right? Is my reluctance to see it their way, another example of me not wanting to let go of the 'enemy'? 10/00

'Reflecting on how I have chosen to interpret the data it feels as if I have I've lost my feminism – at least, feminist theory feels alien, unacceptable, reactionary and unreasonable!' 01/02

'Increasingly aware of how complex and contradictory the whole analytic process is – at first glance nurses appear to struggle to contribute, but on closer examination it seems they are doing well, but then others question this - as nurses themselves do at various points. Trying to make sense of this and construct some kind of certainty isn't possible. That is where I think I'm finding a tension. I am still trying to 'prove' something and feel uncomfortable when confronted with the difficulties in doing so. I oscillate between wanting to embrace that uncertainty and acknowledge it and write about it in the text, and on the other hand, I want to be able to say 'this is how it is for them – this is why all this is important and it matters'. Uncertainty undermines this. Is this tension perhaps gendered?' 03/03

'Planning my literature review: I feel overwhelmed by the task before me – this chapter feels really important to get right – to map out what follows, yet I feel incapable, paralysed, unable to make a move...' 12/03

'Thoughts on literature review: I'm realising that the debate about nursing work and the uniqueness of the nursing contribution to patient care (holism) and the struggle to articulate this is a major theme. Wicks (1998) talks about this clash of ideologies (mechanistic model *vs* holistic model) and how nurses in her research resist and subvert dominant discourses. She sounds hopeful, yet I'm not sure I can be as hopeful. She questions the view that medical power is necessarily hegemonic, oppressive, and hierarchical, yet I really struggle to share that view – it runs counter to what I feel, what I see and what I believe. How can I be sure that I do not silence alternative views? I'm aware that I frame my interpretations with reference to the hegemonic power of doctors/ the medical profession'. 02/04

'I'm left wondering how I can acknowledge the impact of my domestic and personal life on the PhD and of the PhD on my personal life. Doing so feels important, but at the same time indulgent, and perhaps unacceptable. I don't know how to do it, as Marshall comments '*we should take the interweaving of biography and research seriously but I find such interwoven living difficult to write from and about*'. 03/04