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Professionalisation in Nursing:

The Swiss Case

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Abstract

In this study, the professionalisation of nursing in Switzerland is being investigated with the help of the theoretical approaches of the sociology of professions. These approaches – demand approach and supply approach – represent two opposing lines of argumentation. In the demand approach, the status of being a profession (monopolised autonomy by state licence, social standing) is ascribed to successful political strategies of the professional group. In the supply approach, the professions are seen as institutions which can only be explained in their relationship to the state. Thus, in one line of thought, the constitution of the professions is viewed as a process parallel to the modernisation of the state. Another line of thought understands the professions also as *bearers of uncertainty* of both individuals and collectives. In the course of global neo-liberal politics, the ethic aspect of this approach has been condensed into the *soul of the professions* – as an antagonist to the soullessness of state and market.

Since the 1950s, leading nurses in teaching and practice in Switzerland have been active to create a new position for professional nursing. Their main concern is to develop autonomous, specific concepts in addition to the traditionally dominant concepts of medicine. As a result, a professional project evolved which aims to gain a state monopoly for professional nursing.

The study shows that the demand approach can only explain single aspects and short historic phases in the development of the profession. In each

development phase, state and market have created the prevailing conditions of nursing like, so to speak, a *mould*. This becomes manifest in each phase depending on the federal structures of the state. This corresponds to the supply approach of the sociology of the professions.

Nursing has not reached the goal of state licensure. However, if the profession thanks to its *professional soul* independently stands up for its patients, it fulfils the role typical of professions in this theoretic approach. This soul was present in the nursing profession from its very beginning.

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My final thanks are due to many of my female colleagues for an understanding of our profession which, in very much an everyday way, sees nursing with its appropriate significance and can make it shine, not too much and not too little. I thank Sister Liliane Juchli and Martha Meier who represent numerous others.

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Introduction

In this study, I explain how Swiss nursing has been shaped and why it has taken on its present form with reference to the accounts of professionalisation offered by the sociology of the professions.

I will consider the revisions that may be required for the sociological understanding of professions as a result of attempting to apply its analyses to the Swiss case.

Finally, I will attempt to assess the prospects for Swiss nursing in the medium-term in the light of this analysis.

The motivation for this undertaking is premised on my interest in the professionalisation process of Swiss nursing. At the beginning, my focus was on the professional group, the nurses' interpretation of their occupation in terms of collective professional aims as well as collective actions within the changing health care system.

I also expected to gain a better understanding of the meaning of gender for the professionalisation process of nursing.

The background of the study is my previous work on the nursing occupation in Switzerland which is mainly concerned with two different focuses. First, I explored the construction and implementation of professional nursing in Switzerland until 1925 in a study (Dätwyler and Lädrach 1987). I analysed two

aspects of this process, first, the foundation and organisation of the first national nursing association and, second, the structure and curricula of the new model of nursing schools. After this study I focused my interest on the nurses' view of their occupation. On the one hand, by studying the professional self-understanding of nurses aged between 30 and 70 (Dätwyler and Baillod 1995), on the other hand by conducting narrative interviews with nurses over 70 years of age (Dätwyler et al. 1999).

This means that I have gained a relatively deep insight into the historical circumstances of the foundation of nursing as an occupation in Switzerland which was first a medical project, second one of the Swiss Red Cross, and third a women's organisation project. I also believe to know what it meant to be a nurse between 1930 and 1970. First of all it meant handling an enormous workload in many different and changing medical domains and holding on to a service ideal on an extremely high level. From my last study, I have learned that nurses are deeply committed to all the needs of their patients, that they want to give comprehensive care and that they know precisely what this means. At the same time, professional politics is of no interest to most of them.

For some decades, the Swiss nursing occupation has been pursuing a self-conscious strategy which the professional group calls 'professionalisation'. Summarising this debate in general terms of the professional group, professionalisation is equated with development, improvement and progress. Professionalisation implies development from amateur, everyday and practical knowledge to expert, i.e. scientifically-based knowledge. This knowledge

should be located in the academy, which should also become the site of professional training. This promises the possibility of connecting research and teaching and of linking the human and material resources required for each. The scientification of knowledge and the construction of formal theory promise to become ways of unification and delimitation from other professions, of founding it on the claim to ownership of a unique and particular body of knowledge. This would provide status equality with the medical profession in order to co-operate not on a hierarchical but equal level. In the end, it is claimed, the result is better nursing.

Yet the professional group is not united in its aims or strategies, neither regarding the striving for a more academic foundation nor regarding the consequences of the 'New Educational System' *(Neue Bildungssystematik NBS)* which entails a new form of stratification of nursing. This stratification is not a form of labour division in nursing but inherent in the systematics of the state educational system and thus imposed on nursing from outside.

Both the professionalisation controversy within the professional group and the current political abstinence of the nurses represent the starting point of this study. I assumed that nursing could have achieved a clearer and more prominent place in the health care system if it had acted in a unified and purposeful way. Therefore I decided to base the study on an action-based and profession-centred approach, largely on the following works:

- The Rise of Professionalism: a Sociological Analysis by Magali Larson (1977)

- Professional Powers: a Study of the Institutionalization of Formal Knowledge by Eliot Freidson (1986)

- The System of Professions: An Essay on the Division of Expert Labour by Andrew Abbott (1988)

The analysis of gender aspects draws mainly on:

- Professions and Patriarchy by Anne Witz (1992)

- Gender and Professional Predicament in Nursing by Celia Davies (1995)

- The Politics of Nursing Knowledge by Anne Marie Rafferty (1996)

When I proceeded with the data analysis mainly according to the concept of the professional project, I realised that this approach did display deep insights into the professional development of Swiss nursing. It did not, however, produce a story of a Swiss nursing professional project as I had expected. Rather, light was thrown on the state and the market. It seemed that I could explain a certain historical phase by the concept of professional project but not the development of nursing over the whole period of time I wanted to analyse.

Revising the literature, I became aware of two aspects which put in question the procedure of my research. I realised that I had been led to what Dingwall criticised in the use of Larson's approach, namely

"(…) to neglect two important qualifications. The first is her acknowledgement that the market is not passive: '(...) the structure of the market in which a profession transacts its services does not depend on the profession's action and intentions – or at least not until the profession gains considerable power. The structure of a particular professional market is determined by the broader social structure (Larson 1977:17-18)'. (...). She also accepts the role of the state: '…to view professional modernization as a project of market control, underlines the central role of the state in the development of this project (…) (Larson 1977:18)'. Having made this concession, however, she offers little analysis of the state, tending to see this as a mere vehicle for the interests of capital" (Dingwall 1996:5).

I had to change the perspective in order to gain an encompassing understanding of the professional development of Swiss nursing from a more interactionist towards a more structuralist/functionalist perspective or from explaining professionalisation in terms of the organizing efforts of professions to explaining it in terms of market demand or state interest.

This meant focusing my analysis more strongly on the conditions under which the development of nursing proceeded. Which institutions were decisively involved? Which role did the state play?

I draw mainly on the following writings:

Robert Dingwall:

- In the beginning was the work... : reflections on the genesis of occupations (1983)
- The sociology of the professions: lawyers, doctors and others (1983)
- A respectable profession? Sociological and economic perspectives on the regulation of professional services (1987)
- Professions and social order in a global society (1996, 1999)
- The implications of healthcare reforms for the profession of nursing (2001)
- After the fall …: capitulating to the routine in professional work (2003)
- Science: A puzzling profession (2004)
- The enduring relevance of professional dominance (2006)

Eliot Freidson:

- The official construction of occupations: an essay on the practical epistemology of work (1978)
- Professional powers: a study of the institutionalization of formal knowledge (1986)
- Professionalism, caring, and nursing (1990)

- Professionalism reborn : theory, prophecy, and policy (1994)
- Theory of professionalism: method and substance (1996)
- Professionalism: the third logic (2001)

Julia Evetts:

- New directions in state and international professional occupations: discretionary-decision-making and acquired regulation (2001)
- Professionalisation and professionalism: explaining professional performing initiatives (2001, 2003)
- From professions to professionalism: a discourse of occupational change (2004)
- The management of professionalism: a contemporary paradox (2005)

Evetts, J. and R. Dingwall:

- Professional Occupations in the UK and Europe: Legitimation and Governmentality (2002)

Terence Johnson:

- Professions and power (1972)
- Governmentality and the institutionalization of expertise (1995)

Terence Halliday:

- Beyond monopoly: lawyers, state crises, and professional empowerment (1987).

The thesis is organised into three parts.

Part I explores the historical and theoretical background of the study.

The first chapter will offer an introduction to some of the characteristics of the Swiss state and its history, and the implications of its form for the supply of health care.

Chapter two

The literature review focuses on the two competing approaches to explain professionalisation either in terms of the organising efforts of professions or in terms of market demand or state interest. It contains selective writings on gender to permit including this multi-faceted aspect.

Chapter three

The aim of this chapter is to describe the research methods used in this study and to discuss questions of methodology. The chapter illustrates the process of choosing the focus of this study and determining the study design and the methodological framework on which these decisions were based. It closes with the description of the research process.

Part II

This part of my study analyses the professional development of Swiss nursing. I classified it into the three phases described in chapters four to eight.

Chapter four

The **first phase,** that lasted from about 1900 to about 1950 I call the *constitutional phase*. It was shaped by the private initiative of two associations which set out to establish a new profession. These two associations, however, were driven by fundamentally different ideas. While the *Schweizerischer Gemeinnütziger Frauenverein* saw the new occupation as 'a feat achieved by women for women', the Red Cross had other motives for supporting it. While the Swiss Red Cross's overt motive was to propagate the usefulness of nursing in both times of war and peace, its hidden motive was related to the organisation's declining importance. Both projects were led by doctors. At the end of the constitutional phase, nursing as a an occupation, or a profession respectively, was implemented and the Red Cross had a monopoly position in nursing training and had at the same time also achieved corporatist status. The Swiss Red Cross and the Women's Association had founded their own model nursing schools. These two organisations founded the 'Swiss Association of Nurses' (*Schweizerischer Krankenpflegebund*).

The **second phase** in the evolution of nursing as an occupation lasted from about 1950 to 1992[1] and I call it the *professionalisation phase*. While the constitutional phase had initially been shaped by private and later by state interest, the occupation as such plays an active part in the next phase of development which was marked by a period of *conceptualising.*

Chapter five

After WWII a phase of conceptualising the diverse tasks began, originating from the practice of nursing.

Chapter Six

With the foundation of the Kaderschule in Aarau, an intense phase of theory formation and specialised training began. In the 1980s, this development merged to some extent with political feminism. I call it the *professional project* because it was the first time that explicit political claims for a higher status and professional autonomy were made in this movement.

At the end of this phase, different competing camps emerged which, however, are not clearly distinguishable from one another. On the one hand the Red Cross, and registered nurses dwelling on the issue of professionalisation on the other.

The **third phase** that nursing is currently undergoing I call the *restructuring phase*.

[1] New rules and regulations concerning professional training (NAB) came into effect.

Chapter Seven

The ‘New Education Regulations’ (NAB) had just been introduced when a new education reform was launched by the government in the 90s. The object of this reform was to make job training in the health service sector more like the system applied in commercial and vocational training which consisted of an apprenticeship in a (private) company and attending a (cantonal) vocational school. This change means that by the end of the historical regulatory function of the Swiss Red Cross nursing will be first exposed directly to the market and, second, put in an educational system with the above-mentioned stratification.

Part III

Chapter Eight

By drawing together the tendencies, actors, movements and interests which have shaped Swiss nursing from 1850 to 2000, I try to answer the question as to which theoretical model best explains this process.

Part I Historical and Theoretical Context

Chapter One: The Swiss Confederation: A historical and political overview of the general conditions for nursing as an occupation

This chapter explains the political structures of Switzerland. A glance at the history should allow the reader to understand the Swiss perspective as demonstrated by their political institutions – in particular their concept of direct democracy and what is defined as 'federalism' (*Föderalismus)*. It will also show that until recently there was a different educational system for the health professions than for any other vocational training.

Primarily, the Swiss state system will be described in its most basic aspects. I will describe, then, in more detail the emergence of the Swiss health care system and the importance of the Swiss Red Cross (SRK) for the development of Swiss nursing. At the end of this chapter I will present some key analytical concepts useful in examining the Swiss political system including the health care system. These were developed by Gruner (1956) and Linder (1983) who demonstrated that the Swiss confederation has been organised along the principles of liberalism since its inception.

1. The Swiss state system

History

The historical development which eventually defined the Swiss Confederation has been mostly characterised by historical pacts of alliances or systems of alliances of cities and rural districts since the 13th century. These alliances aimed to promote or defend the political autonomy of the single city or district. In 1500 Switzerland, the 'Confederation of the Swiss', consisted of *die Dreizehn Alten Orte und Zugewandte Orte* (the Thirteen Old Places and Allied Places). These sent representatives in the *Tagsatzung*, a kind of executive of the Confederation, with two persons who were to defend the common interests of the Confederation without infringing on the sovereignty of the single places or cantons in any way.

The Reformation (Zwingli and Calvin) and religious wars divided the Confederation into Catholic and Protestant and so-called 'mixed cantons' (Protestant and Catholic).

During the Thirty Years' War, the 'Confederation of the Thirteen Old Places' developed its principle of neutrality which was to remain a cornerstone of Swiss policy and which was eventually acknowledged at the Congress of Vienna in 1815.

Industrialisation, which mostly occurred in the Protestant cantons from the 17th century on, brought a potential for conflict, which has remained

subliminal until the present day. Originally – and traditionally, the socio-political system in the city cantons had been ruled by guilds and patricians, and had been built on a system of privileges. Industrialisation, however, created a new class of urban industrialists who were to claim legitimacy and power. The development of a class of industrialists and the growing power of the young work force led to new political groupings and to more and less open fights. From that point on, the Protestant city cantons became more progressive, more in favour of centralised government, and later, – between 1848 and 1914 – dominated by liberalism.

On the other hand, the Five Catholic Places, the original cantons with strict rules of direct democracy (with their *Landsgemeinde* which is the legislative form in which every citizen represents himself in person at the yearly special Sunday election) have been more conservative, more federalist – more in favour of the Swiss version of federalism, i.e. autonomy of the cantons –, more supportive of the church and, at that time, against industrialisation.[2]

In 1848, after the war of *Sonderbund* (separatists) between those two opposed groups with the victory of the association of liberal – so-called 'radical' – industrialised Protestant cantons and liberal Catholic cantons, the constitution of 1848 was established. Its essential features are still relevant today. It gave legal expression to the lessons drawn from Switzerland's history: the unity of the Helvetic State could only be maintained by respecting the individuality of its member cantons.

[2] The results of the national votes still show the same picture, e.g. in the EU vote in 1994

In the years after 1890, the social question reached its peak importance, bringing with it the advancement of the Social Democratic party. It was in this period that the initial association between the early labour movement and liberalism began to break down. The years leading to the Second World War were marked by conflicts between the conservative alliance and the social democratic movement. As a result of the feeling of solidarity which had grown during the war, social policy became more important. Since 1989, after the 'fall of the iron curtain', social and political developments have been called into question on all levels.

Political system

Population

Resident Population (2002):	7.318 million
Permanently resident foreigners (2002)	1.464 million

(Great regional variations in proportion of foreigners to native Swiss population: e.g. from 3% in rural areas to 35% in Geneva)

4 national languages

Distribution of population according to language (2000)

German	63.7%
French	20.4%
Italian	6.5%
Rhaeto-Romance	0.5%
Others	9.0%

Religion:

Distribution of population according to religion (2000):

Protestant	35.3%
Roman Catholic	41.8%
Others and unaffiliated	18.6%
No statements	4.3%

'Federalism' (Föderalismus)

The Swiss Confederation today is made up of 26 autonomous cantons and half-cantons.

The Cantons, as federal states, enjoy a high degree of freedom in their political decisions and administrative autonomy. Each canton (and indeed, many communes as well) has its own constitution and laws. In many cases, the cantonal and communal laws do in fact follow the broad outlines of federal legislation yet still take particular local needs into consideration.

The duties of the federal government are strictly defined and laid down in the constitution. It ensures internal and external security, upholds the cantonal constitutions and maintains diplomatic relations with foreign powers. Customs, financial controls and the armed forces are all subjected to federal authority. The federal government is responsible for arming the troops, maintaining the roads, as well as for forestry, hunting, fishing and hydroelectric power. It imposes certain measures to ensure the sustained economic development of the country (e.g. protecting agriculture) and its general welfare (social security,

etc.). The Church, the educational system, social welfare, the health care system, law, the police, economics and the tax system all remain under the authority of the individual cantons.

In many areas, the Federal Government simply legislates and supervises, leaving it to the cantons to enforce the legislation.

The constitution requires government at the federal and cantonal level to take the form of a so-called semi-direct democracy. The Federal Government is composed first and foremost of the people and the cantons, the Federal Assembly (Parliament), the Federal Council (government) and the Federal Tribunal.

Civil rights

The rights aimed at protecting individual Swiss citizens are laid down by the federal constitution, federal laws and the cantonal constitutions. All Swiss citizens are equal before the law. More particularly, the constitution explicitly guarantees freedom of private property ownership, freedom of trade and commerce, freedom of choice of domicile and worship, freedom of the press, the rights of free association and petition. These rights are standard at the federal level, but the cantons and communes may grant more extensive rights.

In Switzerland, all men (and since 1971, women as well), on reaching the age of majority, have the right not only to elect their representatives in Parliament, but also to take an active part in deciding on legislative and constitutional questions. Two rights are of special interest: the right of ‘initiative’ and the

right of ‘referendum’. Written into the constitution, these rights also to a greater or lesser extent influence the cantons and communes.

The right of ‘initiative’ at the federal level enables the citizens to propose a complete or partial revision of the constitution. (For such an Initiative, it is necessary for 100,000 eligible voters to sign a document setting out their proposals, either in detail or just in general terms.) The federal parliament is entitled to put forward a counter-proposal and a popular vote is then held for both proposals.

The ‘referendum’: There are two types of referendum: the obligatory referendum is used at federal or cantonal level to ensure that all constitutional changes are put to the popular vote; and the optional referendum within 90 days of the official publication of any such bill in parliament. The referendum is also practised at cantonal level, but the way it is used varies from one canton to another.

Cantons and Communes

The confederation has 26 autonomous cantons. The cantons govern themselves autonomously. The citizens elect their cantonal authorities and take part in cantonal decisions.

There are 2,999 communes in the confederation today, each run by a local authority, many of which, like the cantons, enjoy a high degree of independence. It is at this local level that Swiss democracy is most direct. By participating in the local commune assembly (which is increasingly yielding to

elected communal parliaments in the more populous communes), and by voting, the citizens themselves elect their communal or municipal authorities and run their own affairs. The responsibilities of the communes are wide-ranging: administration of public property, such as forests, water, gas and electricity supply; bridges, roads and administrative buildings; schools; the police, fire service, health departments and civil defence, etc; also social, cultural and military concerns and the implementation of certain economic measures imposed at times of war crises.

The administrative autonomy of the communes and the cantons allows every citizen to participate actively in public life and in the way his community is run. The communes also collect direct and indirect taxes.

Parliament

At a national level, legislative power is vested in the Federal Assembly which is composed of two Chambers: the National Council representing the people, and the Council of States, representing the cantons. Two hundred members are elected to the National Council – each canton has at least one member. In the Council of States, the 20 cantons are each represented by two delegates, while the six half-cantons have one member each. Every federal law or decree has to be passed by both chambers, which usually meet at the same time but in separate rooms. Moreover, both chambers supervise the federal administration and the enforcement of justice.

All parliaments in Switzerland are 'militia-parliaments' i.e. the MP's are not full-time representatives but do their parliamentary work as a secondary occupation (about fifty percent of the amount of their working hours). As the Swiss army is also organised as the militia-system, one person can occupy the highest ranking positions within both the army and his own profession at the same time.

The Federal Council

Executive authority is vested in the Federal Council: It presides over the seven Federal Departments (Ministries), ensures that current laws are observed and drafts new legislation. It conducts foreign affairs and authorises the mobilisation of troops. It is elected every four years by the Federal Assembly (the two chambers together). The Federal Council operates by the 'collegiate system', i.e. with collegial responsibility for decisions which means that decisions lie with the whole council, rather than one individual minister. The President of the Confederation, nominated in rotation for a one-year term, takes the chair at Federal Council meetings but otherwise has no specific powers or privileges compared to the other members, and continues as head of his own department. The present composition of the Federal Council was established in 1959 according to a so-called 'magic formula' worked out by the Members of Parliament. Each of the four major political parties is represented: the Radical Democratic, Swiss People's (formerly the Farmers' Party) and Social Democratic parties each have two seats, while the Christian Democratic Party has one seat.

In practice, the election of a Federal Councillor by the Federal Assembly is the result of a complex 'political chemistry'. A subtle and delicate balance has to be struck in terms of language, denominational, regional and political considerations and an acceptable compromise reached. It is because of this that the Federal Council is often considered by the public to be more of an administrative council than a governing body. It should be noted that this same Swiss public rarely appreciates, and indeed openly shows disapproval of any action or decision of a spectacular nature taken by the Federal Council – something that often surprises foreigners.

Semi-direct democracy and its problems

The division of the country into 26 cantons and half-cantons, – each of which enjoy a high level of administrative and political authority given to them by their individual governments and parliaments, – means that national political life is fragmented into quite different regional sectors. The root of all political life is therefore essentially local or cantonal.

Federal affairs nevertheless play an increasingly important role. While there were barely 100 votes held between 1900 and 1950, they number exactly 275 for the years 1950 to 1995.

The number of initiatives put before the Federal Chancellery has also greatly increased since the fifties. In 1990 no fewer than eleven popular initiatives were launched.

One paradoxical factor is that while the number of votes held has increased, participation in elections has decreased. Until the fifties, regular voter turnout was generally above 50%, sometimes reaching 85%; this has dropped considerably and nowadays fluctuates between 33% and 50%. It is a similar story for votes taken at cantonal level where participation is generally even lower – often less than 30%. This apathetic attitude to public issues is the most serious problem facing the Swiss political system and institutions.

Educational system

Education at primary, secondary and advanced school level is first and foremost the cantons' responsibility. Thus Switzerland has 26 different educational systems based on different laws which satisfy the varied cultural and linguistic needs of the country.

The cantons themselves and their boards of education decide on the type of schools, duration of study, teaching materials and teachers' salaries.

Education within the cantons, however, must be acceptable by national standards and be reasonably compatible with neighbouring cantons. The cantons must therefore come to some agreement on educational policies, and share certain tasks which they could not undertake separately. The Swiss Conference of the 'Cantonal Directors of Education' (CCDE) is the committee created by the 'Inter-Cantonal Agreement on School Coordination' in October 1970 and responsible for these tasks.

Compulsory schooling is subdivided into primary schooling which lasts five to six years depending on the canton, followed by secondary schooling ('grade 1') which lasts three to five years and offers various options.

Post-compulsory education: The 'grade I' secondary school system is more homogeneous, although considerable comprehensive changes are being made. Basic vocational training is offered in a combined system of courses at technical colleges and practical training in the industry.

The grammar schools which are generally cantonal or municipal prepare their pupils to go on to university.

Vocational training: For the majority of the 400 non-academic professions, practical training is provided within private companies, government offices, in the various trades and services, with the trainee usually attending part-time college courses for one or one-and-a-half days a week. Apprenticeships last two, three or four years and, on completion of the course, the apprentice is awarded a 'Federal Certificate of Ability'. Vocational training in all fields – except nursing and other health care occupations, and social work until 2004 – is regulated by the state which decrees and ratifies legislation pertaining to training and examinations. The 'Federal Office for Professional Education and Technology' (OPET) is responsible for seeing to it that this legislation is enforced. It falls to the Cantons to organise the type of vocational training needed locally; as well as to supervise apprenticeships and set up the necessary colleges. Along with the Confederation, professional and economic organisations play an important role in this type of training.

Education in nursing was regulated by the 'Swiss Red Cross' on behalf of the cantons until 2003. There was no federal regulation. Since January 2004 nursing and all other health professions are regulated by the Federal State, the 'Office for Professional Education and Technology' (OPET) respectively.

2. The Swiss health system

Health service in Switzerland is federal, which means it comes under the cantons' authority.

The federal government's areas of responsibilities are the control of transmitted diseases, of food, of radiation, of poisons, and of anaesthetics. It is also responsible for the control of medical examinations and national insurance.

The cantons are in charge of health care, prevention, and sanitary inspection insofar as it is not the responsibility of the federal government. The cantons are free to decide on the way and the extent to which they organise health services. That means that there are big differences between the cantons and the health care they offer.

The communes are responsible for general welfare and care of the elderly. In addition, the communes are responsible for medical and dental services for schools.

Private organisations

The Swiss health service is characterised by the large role that private organisations are meant to play in providing important health services (private hospitals – alongside public ones –, the whole system of health and accident insurances, institutions for various disabilities, professional associations, and health leagues, etc.).

The emergence of the modern health system[3]

The current (complicated) structure of the Swiss health service reflects the 'federalistic' and liberal conception of the state dating from the middle of the 19th century. Health was considered as a personal good and the state was only responsible for the care of the poor who became ill. In the course of the 19th century, the general public realised that the old social system could no longer ensure the integration of all members of the society under capitalistic production. Threatened by the growing political and cultural awareness of the workers as a social class, the bourgeoisie felt compelled to take steps to improve the working and living conditions of the factory workers. The search for a solution of this so called 'social question' caused a long-term development which in turn led to the social, political and economic integration of the factory workers, that is to a new social system. Social reforms were initiated both by middle class philanthropists and by the lower middle class

[3] The following paragraph is based on: Dätwyler and Lädrach 1987: 32 - 35; Fritschi 1990: 19 - 24; Valsangiacomo 1991: 24 - 29.

self-help and co-operative movement among tradesmen, as well as increasingly by the state, which in turn sparked strong political controversy.

At the end of the 19th century the network of institutions offering prevention and support was becoming denser and denser. The development of a public health system for all was one of the common social measures undertaken. One element of this complex development was the elaboration and centralisation of the health insurance system. The institutionalisation of a compulsory state health insurance caused another political debate. In the German-speaking part of Switzerland a physician by the name of Sonderegger in particular supported the idea of free care and the establishment of special hospitals which initially were a kind of surgery room in the canton of Zurich. Sixteen of those institutions were opened by private charity organisations or factory owners – if mainly in rural regions between 1868 and 1902 – before most hospitals were built in the capitals of the cantons. Within a short time, these institutions became well equipped hospitals that provided high quality medical care. A law passed in 1896 decreed that the canton of Zurich was obliged to subsidise and promote state (at the community or district level) and private health care.

Nevertheless, the Swiss health system as well as its social system have been characterised by a broad diversity of representative forms: cantons, communities, districts, charity associations and congregations. That means that in Switzerland the state has never had the exclusive responsibility for representing and organising the health and social system. In the second half of the 19th century, this was the origin of a deep ideological-political controversy

about what ‘social support’ was: charity versus self-help, self-help versus state support etc. But, in spite of the diversity of ideologies, the institutions built up an increasingly extensive public health care system co-ordinated by the state.

There was another process linked to the democratisation of the health care system: the development of public authorities who gained more and more control over illness and health. Factory health insurances for example pursued twofold interests: to provide social security for the workers and social control for themselves and to reintegrate sick workers back into the working process. Illness and health had become economic factors insofar as increasingly more money was being invested into training qualified workers and if there was a labour shortage: illness meant loss of working hours. Thus the concept of health/illness was re-evaluated in economic, but also in socio-political and socio-cultural terms during the 19th century: while illness started having a tinge of guilt within bourgeois society, health and a reasonable lifestyle became important social norms. Illness and poverty were now understood as individual violations of this social norm.

The possibilities opened by the scientific and technical achievements promoted a new ideology of nature control against nature dependency. This brought about a change of the self-understanding of academic medical professionals. Rudolf Virchow, 1866: “We know the method how to force nature not only to

open up, but to put its force in our hand"[4]. Illness became a disturbance factor which could be resolved by technical means.

The medical profession as a unified profession was a new phenomenon at that time. At the beginning of the 19th century there was great diversity among those who worked in the field of healing and curing as regards training, clientele, social background and status. The small elite of academic medical professionals belonging to the urban upper class, stood out from the group of trade-oriented, so-called low medical professions (barber, surgeon). Besides these two recognised groups there was a considerable group of *Heilkünstler* (artists in healing) who were the only source of medical care for a majority of the rural population despite their dubious training and practice. But the academic symptom-oriented and philosophical academic doctors did not prove to be superior either. First there was a small group of academic doctors who started claiming to be the only legitimate medical helpers. Together with charitable educational campaigns about health care and prevention, sometimes explicitly directed against 'bunglers and quacks', the process of repressing the other groups evolved over several decades until a training programme for healers was authorised and healing as such was acknowledged by the state. The first Swiss law on healing was passed in 1878 (Fritschi 1990: 26). From the first amalgamation of professional associations on a cantonal level in 1810 to the foundation of the *Aerztlicher Zentralverein der deutschen Schweiz* ('Central Medical Association of the German-speaking part of Switzerland') in 1870 to the 'Swiss Medical Association' (FMH) in 1901 the academic medical

[4] Siegrist, 1977:75

profession developed into the only legal monopolistic healing profession. Once the *Aerztekommission* ('doctors' commission') was founded in 1875, the medical profession was given a regular forum for its interests with regard to the state institutions. Since the political system established at the end of the 19th century, the medical profession had attempted to obtain a power position comparable to the big economic associations of the time which participated in government decision-making processes.

During the 19th century the function of hospitals underwent a radical transformation as a result of very complex social changes that had been taking place, as well as a new scientific approach to medicine and related technical achievements (bacteriology, surgery, anaesthesia etc.). Until then hospitals had been asylums for the poor and ill and dominated by the ideology of charity linking physical care and spiritual welfare. The clientele of asylums was segregated according to the type of illness they suffered, e.g. curability, which consequently led to the differentiation of the institutions themselves: apart from the asylums, the hospitals became medical institutions in which both research and teaching were encouraged and practical experience was gained.

The following quotation from 'Journals for Nursing' published in 1911 illustrates the difficult position of the medical field as a whole and of doctors at the beginning of the 20th century:

"Due to the enormous progress that science has been undergoing clinicians are so totally absorbed by a number of endeavours – determining the nature of illnesses and differential diagnoses, as well as other prime objectives of

teaching – that they lack the time for all the details that require attention in the realm of health care." (in: Dätwyler and Lädrach 1987: 37)

From then on the medical field was to become dependent on qualified nurses. Yet this functional and structural change will have a severe impact on the nursing staff.

The birth of nursing as an occupation

Thus, at the heart of the current state of nursing in Switzerland is the development of medicine and the related notion held by doctors as to the necessity of having a rationalised system of scientific and technical care available around the clock so as to be able to make efficient use of their medical knowledge. In an article in a 1989 edition of 'The Red Cross' magazine, the physician Walter Sahli expressed himself in a clear, simple manner:

"The general public feels that there should be another authority besides the doctor who has the expertise to deal with those details of the healing process that the former cannot take care of himself. There is the realisation that genuine health care is not only the mechanical care of the patient but rather the treatment given during the 23 3/4 hours a day when the doctor is not with the patient" (Fritschi 1990: 61).

In several ways, in principle nursing in Switzerland does not differ from anywhere else in Europe and the United States as regards either the basic organisation of the nursing occupation – either in its framework of concepts, the basic definition and substance of the work or in the main developmental

trends and changes within the occupational field. However, there are some basic differences that require our attention. These seem to concern the actual process of development – and what contributed to formalisation and accreditation, as well as the people and/or institutions that played a leading role.

In chapter four I will take up this question. Here, it is only to be recorded that, when comparing the educational system for the health care professions in Switzerland with the other occupations, we see that it was built on the same liberal principle but it is different in its regulation. The industrial and commercial occupations were and still are regulated by employers' associations and the state whereas nursing was regulated by (public and private) hospitals and the Swiss Red Cross.

Conclusion

In order to understand the Swiss political system, it is important to know that the foundation of the modern federal state gives the cantons a political unity that works according to the principles of a modern democratic constitutional state. "At the same time the foundations are being laid that meet the interests of political liberalism. Rising entrepreneurship needs a government which guarantees property and individual freedom" (Linder 1983: 259).

The establishment of a national market for private entrepreneurial needs does not 'grow naturally' but is organised by the federal government in two respects.

1) The focus for liberalism and entrepreneurship sees the modern state as the institution that liberates the bourgeoisie from a feudal-corporate economic and social order.

2) From a sociological standpoint, it is with the help of the state only that a market can develop which makes economic and industrial growth possible on the basis of private property.

"The victory of economic-political liberalism in the first half of the 19th century removed the reign of town guilds, the economic privileges of aristocratic towns over rural society and the institutions of the old mercantile state. However, totally individualistic competition – or a totally free market – does not fit the interests of the entrepreneurs themselves. Indeed, these individual economic and professional groups tend rather to have a distinct desire to organise themselves into corporate groups to defend their own interests" (Linder 1983: 263).

The foundation of the Swiss national state is a direct consequence of the development that saw economic interest groups organising themselves into national associations. An example of this trend is illustrated by the founding of the *Handels- und Industrieverein* (the 'Association of Commerce and Industry', *Vorort*, 1869), the *Schweizerischer Gewerbeverband* (the Swiss Trade Association) and the *Schweizerischer Bauernverband* (the 'Swiss Farmers' Association' 1897).

The ‘Swiss Trade Association’, the ‘Swiss Farmers’ Association’ and the ‘Association of Commerce and Industry’ are national parent organisations of self-help associations which, by protecting common interests, decrease individual market risks and strive for common benefit by forming an organised market force. Typically they call for supplementary state regulation or support wherever self-organisation does not suffice to attain the goals of the association.

Ackermann et al. (1981) have extensively verified this early pattern of association policy as an example of professional training in trade and industry: First the associations tried to offer and regulate professional training themselves on the grounds of internal agreements. They also set up examinations and diplomas. Not all enterprises fulfilled their educational obligations to the same extent. Those enterprises which did not train apprentices could obtain a double advantage: they saved the training costs and could ‘headhunt’ skilled workers – ‘human capital’ – from enterprises that did fulfil their obligations. In contrast to the industry which consisted of fewer and larger enterprises, the trade associations were not able to prevent such practices and therefore asked for the introduction of regulations in public law. From 1890 to 1910 most cantons enacted laws for professional training, whereby the guidelines set up by the private associations were often taken over practically word for word. From 1884 the Confederation contributed financially to professional teaching in trade and industry. At the beginning of the 20th century professional training and education was extended to commercial, professional and domestic science courses for women.

Therefore we find here a pattern of solution – seeking the most typical of the main characteristics of the association state – which transforms 'private' interest problems into state problems: For private economic interests, solutions are looked for at the level of collective association. When private organisational power does not suffice to achieve these interest groups' goals, the associations try to formulate and declare their goals as 'public interests' which will need the support of other voters and of the government, as well as financial means from the state.

"When associations are so often instrumental in initiating and determining the policy that the federal government will implement in its search for solutions, two important factors may be at play here: firstly, the high degree of organisation that the economic forces enjoy and the corporatist associationism with its long historical background that is typical of their structure; and secondly, the fact that the power of federal government is checked and prevented from expanding by the very concept of *Föderalismus* – i.e. individual and cantonal autonomy." (Linder 1983: 267).

Gruner (1956) interprets this development as follows: with the advent of liberalism, the state was to forgo its original function of regulating economic and social life, which had previously been the prerogative of the authoritarian state. So not only was there no state intervention, but also there were no self-regulating mechanisms in the economy. The economic organisations took over just those tasks of public importance which liberal doctrine had wanted to leave up to the free play of the forces and the free market. It was the carrying

out of such tasks that was one of the most important incentives to organise the economy increasingly along the lines of economic associations. In this way, these associations became the deputies responsible for the 'public good' and for carrying out official functions while remaining responsible for their own administration. It was in this context that the state recognised the associations and officially gave them deputy status.

Against this background it becomes understandable that neo-liberal claims such as those made early on by Milton Friedman (1982) and the more recent ones by Arthur Seldon (1998) had been fulfilled from the beginning in Switzerland. When the federalist state was founded, only so-called federalist solutions – i.e. keeping the 'power' of the central state as weak as possible – could be achieved. Moreover, in 1848 liberalism was at its peak, which led to a liberalist solution: leaving as much as possible to the forces of the free market.

Politically speaking, liberalist philosophy dictates that all activity that furthers the earning of money should be organised privately if possible, but whenever it becomes costly, it should be left to the state, which is then called 'socialising the costs'. This is a good example of organising professional training in trade and industry.

The Swiss way of organising professional training explains why the responsibility could be ultimately delegated to the Swiss Red Cross and why the latter was able to have a free hand in nursing for a long time. There is only one change to be made in the pattern: 'economic interests' must be replaced by 'medical and military interests'. Add to this the marked *federalism*: Health

service is cantonal and the cantons do exactly what serves their institutions. Even today.

The solution reached regarding the organisation of the nursing education is typically Swiss in two respects: As in vocational training, the constitution does not delegate decision-making power to the federal government but rather to the cantons. Development was welcomed and associations turned their attention to the task at hand as long as it was financially feasible. As soon as it was no longer feasible, a federal solution was sought using all sorts of 'tricks' as in the case of nursing training, which was proclaimed as a military concern naturally very beneficial to civilian life as well. The support derived from the medical field was crucial to the implementation of nursing as an occupation. By controlling the curriculum in nursing schools, the medical profession defined the scope of expert knowledge and clinical competencies to be covered in training.

'Social questions' make it necessary to introduce new options and regulations in the area of health and illness. In the process the state – in correspondence with the prevailing liberal approach – is passive. Private, charitable and/or business initiative comes first and only when there is broad consensus does the government adopt preliminary measures such as contributing to the construction and operation of hospitals, and drafting and enacting legislation on health insurance.

The historian Fritschi sees the achievement of a monopoly position of medicine as a 'universal' pattern:

"the endeavour to safeguard the position of scientific medicine by securing a monopoly in diagnosis and therapy. By 1900 doctors were considered to be indisputable experts in issues related to health and illnesses and their respective treatments for all social classes. This process was accompanied by targeted lobbying for their own causes. The so-called 'doctors' commission' founded in 1875 is a body representing the regular interests of the medical profession in Switzerland vis-à-vis the general public and in negotiations with the authorities. By increasingly exercising institutionalised and direct influence on government decision-making processes, the medical profession has achieved a paramount position of power in the domain of public health care comparable to that of the large economic interest groups characteristic for the political system of Switzerland since nearly the end of the 19th century" (Fritschi 1990: 27).

Fritschi who, in his social history of professional nursing in Switzerland focuses strongly on the aspect of patriarchal power, here seems to understand the development of medicine as a professional project definitely in the sense of the demand approach and to criticise it accordingly[5]. It should probably be noted that he identifies the nurses' enthusiasm for their profession, even when they practice it during the war, as masochist and neurotic following the psychoanalytic theory of Mitscherlich[6] (compensation of one's feeling of mourning). In the end, the only explanation appears to be that, under the then

[5] One important reference of Fritschi is Rohde (1962): Soziologie des Krankenhauses: Zur Einführung in die Soziologie der Medizin.

[6] Mitscherlich and Mitscherlich 1967: Die Unfähigkeit zu trauern.

existing conditions (subordination and 24/7 service) the profession could only be practiced voluntarily if one needs to compensate for suppressed feelings.

Fritschi's critical view of medicine and of the relationships between medicine and nursing is shared in a series of further feminist publications on the development of nursing in the 1980s, including the author's. In the centre of the discourse is the patriarchal understanding of gender roles, or the gender ideologies of the modern age. This was taken to be the main cause of the structural and cultural formation of the nursing profession. (For instance, Bischoff 1994: *Frauen in der Krankenpflege. Zur Entwicklung von Frauenrolle und Berufstätigkeit*; Dätwyler and Lädrach 1985: *Die Krankenpflege als bürgerlicher Frauenberuf*; Dätwyler 1989: *Plädoyer für die Abschaffung des Doctor-Nurse-Games*.)

The issue of the status, the structure and the content of the nursing profession will be dealt with further in the following chapters. Here alone the monopoly position of medicine is to be considered briefly. On the one hand, because the medical profession is relevant for the professionalisation of nursing and, on the other hand, because medicine has a paradigmatic standing in the sociology of professions.

On the basis of the professional project approach, the achievement of a monopoly position of the doctors oriented on natural sciences appear to be a well-made and therefore successful project. As Fritschi shows, the doctors knew how to use and establish their influence on the government and the legislation.

On the basis of the *supply approach* within the sociology of the professions it would stand out that the monopolisation of medicine is closely connected with the social tasks of the government (see above). In all this, achieving a monopoly position is so closely connected with the liberal constitution of the Swiss state that one has to consider the thesis of the supply approach to apply to medicine in Switzerland.

Dingwall asks himself why some professions achieve a monopoly position and many other do not.

"How do occupations persuade legislators to look kindly on their pleas? The answer appears to have something to do with whether there is a compelling interest at stake. The nineteenth century decision to license UK pharmacists, for instance, after half a century of lobbying, seems to have turned on the development of powerful new poisons and a moral panic about servants using these against their masters and mistresses, among whom, of course, were many legislators. By restricting of these substances to a group of shopkeepers who had earnestly sought respectability, legislators could dine more safely at their homes. More seriously, perhaps, the development of UK medical licensing at the same time was clearly linked to the development of state involvement in public health and in the supply of healthcare to the poor" (Dingwall 2003: 70/71).

As we will see in the following chapters, the contest between the two approaches, supply approach and demand approach, has to be understood with regard to the historical conditions on which the theories were based.

This is impressively proved by the work of Eliot Freidson. Together with Magali Larsson, Freidson can be seen as a prominent representative of the demand approach. In his early publications *Profession of Medicine* (1970a) and *Professional Dominance* (1970b), Freidson questions the professions´ position of power.

"He (Freidson) concludes both *Professional Dominance* and *Profession of Medicine* with proposals for reforms of the US health care system that would keep it true to the professed, humane, values of the physicians through significant reductions in their professional autonomy and structural dominance" (Dingwall 2006:86).

In the 1970s, criticism of the monopoly of medicine also emerged in various circles in the German-speaking area. Illich's *Nemesis der Medizin* (1975) was here as well given what Dingwall calls a "celebratory treatment" (2003: 689). A similar thing happened to *Die hilflosen Helfer. Ueber die seelische Problematik der helfenden Berufe* (The helpless helpers. On the psychological problems of the helping professions) by Wolfgang Schmidbauer (1977). In 1970, for instance, the journal *Jahrbuch für kritische Medizin* was founded (Argument-Verlag). The series started under the title of *Kritik der bürgerlichen Medizin* (Criticism of bourgeois medicine) and is currently published in two volumes per year. In 1982, a special volume entitled *Pflege und Medizin im Streit* (Nursing and medicine in dispute) came out. Also exemplary are the lifelong endeavours by Professor Hannes Pauli to fundamentally reform medicine. He saw the most effective means for change primarily in a reform of

medical training. The Cantonal Government of Bern commissioned him to start this reform. In 1971, the 'Faculty of Medicine of the University of Berne' accepted the foundation of the 'Institute of Medical Education' (IAE). Hannes Pauli criticised his profession as autocratic and self-centred. He considered the other health professions an integral component of the treatment of the patients. He was in contact with Illich as well as with Freidson. As one of the first, he demanded inter-disciplinary elements of training and further training (Dätwyler 1987, 1990). Ultimately, he demanded a revision of the scientific basis of medicine since the model of natural science was reductionist and did not satisfy the demands of human medicine. (Dätwyler et al. 1995; Pauli et al. 2000; Taverna 2001; Kissling et al. 2003; Steiger 2004a, 2004b).

The remarks on the critique of the medical profession in the 1970s and 1980s in Switzerland clearly show that Freidson and the other critical representatives of the professional project approach met with a certain response. Dingwall (2003) shows this in his acknowledgement of Freidson's work: the critique of professional autonomy had been received to such an extent that the system he had criticised had

"passed into history, to be replaced by a managerial system, whose pathologies he came to assess as far more pernicious in *Professional Powers* and *Third Logic*. The medical profession of the 1960s might have been paternalist and unaccountable but it was preferable to the soulless and impersonal care doled out by corporised medicine. Nevertheless, Freidson continued to hold to the proposition that expert knowledge remained a source of power and authority

capable of tempering the calculative rationality of managed care" (Dingwall 2006:81).

Hannes Pauli was also of this opinion.

Freidson now shared the opinion of the representatives of the *supply approach*, that the government above all determines which occupations are to receive a professional status and which do not.

So far about the discussion of the monopoly of the medical profession, some comments respectively.

After this digression on the medical profession I return to the topic of the Swiss state and the nursing profession. The Swiss system of the formation of professions, directly embedded in the economy and evolved together with the liberal social order, appears to be congruent with the supply or state approach. Johnson (1995: 11) states "Far from emerging autonomously in a period of separation between state and society, the professions were part of the process of state formation."

In this phase, nursing as an occupation appears as a demand of medicine in the course of enormous progress. At this point in time, we see no professional project in nursing corresponding to the demand approach where a professional group aspires to a higher standing and a government license.

Chapter Two: Review of the literature

Introduction

In this study, I look at one specific occupational group which has been claiming professional status for several decades. From my own personal experience I believed that this process was driven by professional interests implying aims, strategies, competition, failure and success. Both aspects – claims and interests of the professional group – suggested applying Larson's concept of the professional project (*The Rise of Professionalism*, 1977) as a theoretical frame of reference. It is defined as a course of action pursued by a given professional group. "The story of professionalisation is largely that of the aspirations of rank-and-file professionals, as interpreted and organized by their leaders" (Larson, 1977:84).

As a further aspect, my role as both a participant and an active observer of the development of nursing in Switzerland since 1970 and my historical studies had taught me to see the nursing profession as part of a complicated puzzle composed of a variety of public and private organisations and institutions.

The following chart (Appendix 1) illustrates the structural framework – institutions and connections – in which nursing is embedded and points to the context in which the developments mentioned occur. There are four identifiable main areas.

- Medicine	The legal monopolist of healing work
- The Swiss Red Cross	The main regulator of education and training (until 2004)
- The State, national and Cantons	Governor of the health system; regulator/provider of health insurance and institutional provision; provider of funds and regulator of education and training
- Professional organisations	Managers of the symbolic aspects of nursing – its public image, its status within the class structure, etc.; lobbyists for the policy objectives of the profession or at least for those elements which they represent.

Due to its inter-relatedness and interaction, the chart is reminiscent of a perpetuum mobile or more generally of a systemic model. Therefore I believed that *The System of Professions* by Abbott (1988) would provide me with a useful theoretical framework for the understanding of the structures which supply a context for the various professional projects. Abbott states that the organisational formalities of professions are meaningless without understanding the context in which the power of the professions' knowledge systems is the most important part.

Both Abbott's and Larson's theories seemed to me equally useful. First, because both of them are rooted in the Chicago School tradition, which means

that the underlying questions are process- and action-oriented. Second, I do not believe, in contrast to Macdonald (1995), that they must be considered as incompatible: I rather see them as complementary: Larson conceives professionalisation as a project that is actively pursued by virtue of aims and goals, Abbott stresses the contextual structures, and by doing so, possibly neglects the actions, aims and goals of the involved parties to some degree.

The theoretical framework of Larson and Abbott promised to be helpful in conceptualising my basic questions about the professionalisation process in Swiss nursing.

What part does each actor, group, interest play in shaping the environment within which Swiss nursing operates? To what extent do the actions of each support or obstruct the strategies and goals of Swiss nursing?

Within the given environment, what part do various actors and interests within nursing play as agents for change or conservatism? What do nurses want, what are the sources of these aspirations, what goals are set and how are they pursued? To what extent do the public advocates of each interest represent the occupational group as a whole? What do the differences in education and status within the occupational group mean for attempts to establish the distinctive niche in the labour market implied by professionalisation?

Organisation of the literature review

By my own perception of professionalising efforts of nursing and on the basis of my reading of selected writings of the sociology of professions, at the

beginning of my study I was unconsciously drawn in a certain direction. I was taken with the theoretical concepts which explain professionalisation in terms of a profession's project because they seemed to apply to Swiss nursing. I realize now that my reading was biased and consequently my interpretations of the literature became one-sided and partial.

The professional project approach meant that I took up a position within the profession, the system of professions respectively. Other actors like the state and market institutions were perceived as either supporting or hindering the professionalising process. I started analysing my data by means of that understanding of professionalisation.

As my analysis got stuck, I was thrown back to theoretical questions. I reconsidered my literature review, focusing now on the other main approach within the sociology of professions which explains professionalisation in terms of market demand or state interest.

The literature review is organized according to the progress of the study. *For clarity's sake, statements concerning my process regarding the theoretical perspective, the change from demand to supply approach respectively, are written in italics.* The literature review begins with the 'professional project' approach. After that I discuss the 'market and state approach'. Selected writings on gender constitute a third section.

1. Professionalisation: organizing efforts of the professions (demand approach)

Within the post-war history of the sociology of professions, Dingwall (2004) distinguishes two contesting approaches, "those approaches that emphasise the demand for professional status and those that emphasise its support". This chapter concentrates on the 'demand approach'.

I will first summarise very briefly the main characteristics of the theories of Larson (1977), Abbott (1988), and Freidson.

Larson (1977) defines a 'professional project' as a process primarily situated in the economical and social order. She therefore divides her work into two main parts, the organisation of professional markets and the collective conquest of status. Even though the two levels are inseparably intertwined, there is a dimension of priority insofar as the professional market has to be consolidated before the specific body of knowledge can be monopolised.

Abbott (1988) differs in his approach insofar as he does not focus primarily on single professions but on the network which professions form and, at the same time, on the network which constitutes the environment, the context of the professions. The concept of jurisdiction may be the core of his work as it is highly elaborated and therefore useful for my study of the nursing occupation.

Freidson's (1972, 1978, 1986, 1990a, 1990b, 1994, 1996, 2001) work stands out by its continuity in the study of the professions. The development of a

comprehensive theory of occupations and professions represents a main concern in Freidson's work. With *Professionalism: The Third Logic* (2001) he completes his trajectory of thought from the 'professional project' approach to the 'market and state approach". Therefore his work is addressed in both the 'professional project' section and the 'market and state' section.

First, I discuss *The System of Professions* by Abbott (1988) because this work gives an extensive account of the features of the field of professionalism. Second, in an effort to envisage what seems important for my research – namely the nature of a project of professionalism – I will discuss Larson's work and Freidson's early writings.

Abbott's study mainly deals with inter-professional competition: control of knowledge and its application means dominating outsiders who attack that control.

The book moves from an individualistic to a systematic view of professions. Abbott's theory implies a loose definition of professions:

"exclusive professional groups applying somewhat abstract knowledge to particular cases" (1988:8).

Abbott distinguishes four concepts of professionalisation: functional, structural, monopolistic and cultural. Synthesised, that would be:

"Expert, white-collar occupations evolve towards a particular and cultural form of occupational control. The structural form is called profession and consists of

a series of organisations for associations, for control, and for work (...). Culturally, professions legitimise their control by attaching their expertise to values with general cultural legitimacy, increasingly the values of rationality, efficiency, and science" (1988:16).

Abbott identifies five hidden assumptions in that synthetic concept which he considers to be false: that change happens only in one direction, that the evolution of individual professions does not explicitly depend on that of others, that the social structure and cultural claims of professions are more important than the work they do, that professions are homogeneous units, and that professionalisation as a process does not change with time. Following Abbott, his theory should be an alternative in that it reverses the problematic assumptions of professionalisation theories – it begins by focusing on work, not on structure.

"The central phenomenon of professional life is thus the link between a profession and its work, a link I call jurisdiction. To analyse professional development is to analyse how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual professions themselves" (1988:20).

Abbott bases his theory on work, jurisdiction and competition. Professions constitute a system within which certain sets of tasks are tied together by jurisdiction. The strength and weakness of those ties depend on the processes of actual professional work.

The work of professionals is continually being changed by technology, politics, and other social forces. Which human problems lie in professionals' hands differ from society to society, from time to time.

"For behind the world of professional work lies a rationalising, ordering system that justifies it with general cultural values, at the same time generating new means for professional work" (1988:58).

Jurisdiction has a cultural and a social structure.

"To understand the actual claims, then, it is less important to analyse their particular content than their location, their general form and the social structure of the claiming professions themselves" (1988:59), i.e. the specific audiences, settlements and the internal structure of the claiming group. I would now like to summarise these concepts.

Audiences

Jurisdictional claims can be made in several arenas: the *public opinion* which is the place of images, the *legal system* which can confer formal control over work, and the *workplace* which blurs and distorts the other two.

Public opinion: This arena plays an ultimate role in America, less so in Europe. Professional authority often confers obligation (less in America). And: claiming public jurisdiction of tasks is a pervasive activity. After the Second War television has taken over parts of that function.

Public claims develop over a period of a decade or more: images are fairly stable.

In the public arena, the nature of discourse about jurisdiction is sharply constrained: differences of public jurisdiction are differences between archetypes.

Finally, there is the assumption that the professional tasks are objectively defined (no subjective qualities).

Those qualities of public arena are heightened in the second one,

the *legal system* which is more specific: Contests for legal jurisdiction occur in three places: legislature, courts, and administrative or planning structure.

Legal jurisdictions for professions are even more durable than are public jurisdictions: they can last for centuries. As a result of this extreme formality, the legally established world is a fixed, static world that rejects the living complexity of the professional world.

Third arena, the *workplace*: the typical worksite of professionals seems to be an organisation where the standard of inter-professional division of labour is often replaced by the intra-organisational one. That is, professional boundaries, even formalised in job descriptions, are blurred in reality.

In the workplace – in contrast to the other two arenas – the actual complexity of professional life has its effects.

In summary, there is a profound contradiction between the formal arenas and the informal, the workplace. Professionals must reconcile the sharp contrasts. If they did not fight for active maintenance the public picture would be eclipsed. Professions have to use methods to reemphasise the public picture at the workplace. Physicians invoke their clear public relations, nurses emphasise, vis-à-vis physicians, the functions and knowledge that both groups share: public clarity is directed downwards, workplace assimilation is directed upwards.

"It is difficult to judge the long run relation of the two major spheres of jurisdictional claims. Dominant professions seem to be successful in hiding from the public the excessive assimilation of professional knowledge at the workplace" (1988:68).

Dingwall takes up the topic of the imagery under the term of "creation myth". He states that all institutions have their own creation myths.

As he shows, creation myths serve specific purposes in the emergence of professions. Such professions for instance need a story to legitimise new functions. If, on the one side, the creation myths "inspire newcomers and transmit a culture to them, remind established members of the mandate that they claim and serve as weapons in struggles with competitors and with those who control the occupation's environment" (Dingwall 2001:66), on the other hand they have a demoralising effect if the newly trained realise in the practice that they do not have to do the jobs they expected from their training (also cf. Dingwall 2003, 2006). Dingwall (2001) shows with the example of the nursing

concept of ‘emotional work’ that historic embellishment may well steer the politics of the professional group in the wrong direction.

Archetypical images are part of the creation myths. As a consequence, one gets the feeling that nurses have always existed and that one knows how an original, real nurse has to be.

Settlements

Full and final jurisdiction is the standard image of jurisdiction, but only one of the possible settlements of jurisdictional dispute. Abbott differentiates five other important settlements.

1) Nursing can be taken as example for the model of *subordination*. Florence Nightingale envisioned an administrative and custodial equal with the medical profession, which failed because of medicine which “controls a complex division of labour in which a number of such subordinate groups take their place” (1988:71). Subordinate jurisdiction is a public and legal settlement which often results from a failed attempt to gain a full jurisdiction, as in the case of nursing. Those attempts often arise through workplace assimilation.

   Today subordinate groups are often directly created as the division of labour below dominant professions without contests, which is a great advantage for the professions with full jurisdiction: extension without division of dominant perquisites, delegation of routine work, legal and public relations are easily settled in this way. In all, that is an uneasy

settlement: professions depend on the subordinate groups and assimilation threat them. Strong maintenance strategies are necessary – honorific, uniforms, but also countless acts of exclusion (nurses don't need to know why) and of coercion.

2) *Settlement by division of labour,* which can arise from a contest in jurisdiction, followed by division of jurisdiction into functionally interdependent but structurally equal parts. Those settlements start at the workplace (one profession relies more and more on the other). Maintenance is difficult because of the increasing degree of assimilation and the obscurity of the boundaries.

3) Midway between subordination and division of labour*: intellectual jurisdiction*, which means that a profession keeps the control of the cognitive knowledge of an area but allows practice to outsiders.

   "Such a jurisdiction is extremely unstable, since there is little preventing the outsiders from developing academic, cognitive programs of their own, and indeed psychology has done that extensively" (1988:75).

4) *Advisory jurisdiction*: a weak form of relation, often between professions with full jurisdiction. One profession is legitimately allowed to interfere in the actions of another one. Classic example: the relation of the clergy to medicine and psychiatry. This form is not only protective but also offensive (e.g. Dr. Spock: advice for confused parents by a physician). Public claims are essential to advisory jurisdiction. And: "where there is

advice today, there was conflict yesterday or will be conflict tomorrow" (1988:76). That is, advisory jurisdiction can be the place where invasion or defeat starts.

5) This last settlement is fundamentally different from the other four. Those are (or become) formal explicit claims in the public or legal arenas. This one is a pure workplace settlement: *jurisdiction by client differentiation*, which can actually be in contradiction to the officially established structure of jurisdiction. In principle, it works on the basis of class and status differences of the clients and reflects the available demand for the services of a profession: full jurisdictional professionals for the upper-class clients, subordinate professions for the mass (e.g. medicine of the 19th century). This mechanism must be hidden before the other two arenas. These settlements are implicit, although they can lead to contests.

   "Most importantly, they reflect forces external to the system of professions itself – large swings of demand. As a result, client differentiation settlements typically coexist with patterns of formal jurisdiction that crosscut them" (1988:79)

With regard to the external influences on the profession, Dingwall (2006) raised the question of whether the professional dominance, as Freidson advocates it in *Third Logic,* continues to be justifiable against the background of the changes in the state/society relations. He points out that medicine is becoming increasingly a consumer good and the patients its customers. As a consequence, the physician is less and less the state-commissioned 'warden' of

the sick – and thus of the costs of the healthy system – but a businessman. In this case, the task of the state would be consumer protection rather than maintaining monopoly of the doctors.

I come back to Abbott's concept of jurisdiction. Besides audience and settlement, Abbott sees as a further realm for jurisdictional claims the internal structures of the professions.

Internal Structure

The social structure of the claiming groups is a further aspect of the jurisdictional relation. There are three major aspects to be distinguished within a profession's social organisational aspects: groups (associations), controls (schools, examinations, ethics codes), and workplaces. What defines a group as a profession – its claims or its function? "To say a profession exists is to make it one" (1988:81), is important for entering competition, but more important is how the profession competes. That is, how does the social organisation affect the kinds of jurisdictional claims professions make and their success in achieving them? In summary, the following aspects are of importance:

1) The more strongly organised a profession is, the more effective its claims to jurisdiction.

2) The existence of a single, identifiable national association is a prerequisite for public or legal claims.

3) Relatively less organised professions can have certain distinct advantages in workplace competition (computer professionals).

The social structure of professions is neither static nor is it uniformly beneficial. The mature profession is constantly subdividing under various pressures: market demands, specialisation, and inter-professional competition.

"The central organizing reality of professional life is control over tasks. The tasks are defined in the profession's cultural work. Control over them is established, as we have seen, by competitive claims in public media, in legal discourse, and in workplace negotiation. A variety of settlements, none of them permanent, but some more precarious than others, create temporary stability in the process of competition" (1988:85).

Because of the exclusivity of jurisdiction, professions build a system: changes in one profession have an effect on all the other ones. Of the various exclusive properties of professions, jurisdiction is of prime importance.

"Since the carnivorous professions model does not recognize the actual limits on professional dominance, we must find a model that does" (1988:88).

The vacancy model requires questioning of inter-professional jurisdictional relations. How are jurisdictional openings created? Sources of disturbance can be external: emergence of new groups through client differentiation or through forces leading to enclosure (e.g. Nightingale's nursing model), new technologies, organisational changes. Internal sources of disturbance can be: development of new knowledge and skills, structural and organisational changes.

In this way, vacancies arise in the system of professions, causing a mechanism of shift, which Abbott describes as a change of the relevant level of abstraction by means of cognitive strategies (reduction). During this process, amalgamation or division can lead to further changes in the jurisdictional relations. These various effects propagate until the balance of forces stops them.

Before turning to the sources of disturbance of the system of professions (i.e. Freidson's variables, cf. 1986:8), Abbott summarises his model:

"Its fundamental postulates are, (1) that the essence of a profession is its work, not its organisation; (2) that many variables affect the content and control of that work; and (3) that professions exist in an interrelated system" (1988:112).

Changes in professions are to be analysed by the different forces affecting this system, especially by focusing on jurisdiction, that is, on the larger task area.

Finally, Abbott locates his model in the logic of Hughes, focusing on jurisdictional interaction and going further "by treating jurisdiction not only in the work environment but also in the much more formal public and legal environments I have tried to handle what I regard as the classic problem of interactionalism – its inability to explain the evident stability of many interactions over time" (1988:113).

Following Abbott, the system model assumes that professions are internally homogenous. Actually they are not. Social and cultural trends interact with them. Social change opens and closes jurisdiction, cultural forces reshape professional knowledge.

How does internal differentiation affect the system of professions?

Various forms of internal differentiation have profound effects on the system of professions.

Principally, they *can generate or absorb system disturbances. Status differences* can weaken jurisdictional control by the phenomenon of regression (professionals work merely with their pure knowledge). They can also absorb *fluctuations in demand* for professional services by division (degrading and elevating can increase the output). *Client differentiation* may weaken jurisdictional control by the varied power of clients.

Internal differences can be created by *careers* (e.g. students take on "low" work). Professions with rigid career structures and reproduction systems can not react easily.

Relations between the professions are also affected insofar as different professions can be *bound together* because of internal differentiation by organisational structure, while they normally compete in the system.

In the end, the big variety of internal differentiation is responsible for the mechanism that keeps the public picture of professional life separate from the workplace picture.

Thus, internal differentiation functions as absorbing mechanism for jurisdictional change before system disturbances have gone very far.

Concerning the aspect of power, Abbott states that while professional *power* actually exists in many forms and by many sources, it is *limited* by external forces i.e. by the power of other dominant professions, by clients and payers, and by the state. If professions fail to deliver their service, all ability of maintenance is undermined.

A dominant position can not be held by building up a large *reserve* because dominant positions confer short-run power, not long-run one. Power is important for the inter-professional competition, but in the long run of professional development the equilibrating forces discussed before are decisive.

Although Abbott describes the influences of the environment and their significance for the professions, since in his description they appear as the environment of one profession and not as superior institutions, for instance the state, I only realised much later that The System of Professions *cannot be assigned to the demand approach as clearly as I believed in the beginning.*

Finally, Abbott describes the influence of historic developments on the professions.

How do historical social processes influence the system of professions?

Abbott describes the evolution of *technology* and the *rise of organisations* as opening and closing forces in jurisdiction. The direct consequences of these processes are positive insofar as new areas of professional work have been created. Indirect impacts are both subtler and more far-reaching. One of them is the commodification knowledge (e.g. computer in this century), another one

the dominance of organised capital. Finally, as indirect effect the problem of adjustment emerged. Psychiatrists and psychologists adjust the individuals to the organisations, helped by social workers.

Social change has a dialectical effect on professional work: it creates and destroys it by historical events. Technologies and organisational forms appear unpredictable.

Bureaucratisation has been a further important change, compounded by the emergence of the multi-professional organisations. By that process professions with administrative work within their jurisdiction (e.g. law) have been damaged because bureaucracies have stolen that work. The multi-professional organisation forms have promoted the separation of workplace and public competition for jurisdiction. *Physical capital* has become more necessary for the corporatively organised society which leads to an increasing dependence of professions (exception e.g. psychiatry).

Finally, there has been a change in the audiences for jurisdictional claims because of the change of the *role of the state and powerful associations*. France is an example for a strong interventional policy with a separation of training and performance, control of jurisdiction, prices and service delivery, and the hierarchical control of lower state involvements by higher ones. That model implies quite different competitive structures and strategies for professional claims than the American model where the state is much less involved, but where the public arena is still the most important.

Some professions employ *co-opted external authority* in inter-professional competition. At the same time dominant oligarchic professions have developed so much that fewer and fewer professions control more and more. That leads to questions about the 'new class' argument. Abbott analyses the interrelation of oligarchy, external powers, and the new class. One meaning of oligarchy implies the externally co-opted power. Because so much external authority co-opted, co-optation has ultimately transcended oligarchy. While, beyond these competitive effects increasing co-optation has drawn professionals as individuals together, there is no 'class intervention or opposition. The professionals are absorbed by their actual work or firms.

Thus, increasing co-optation has not decreased competition but has changed its location.

The social changes of the last two centuries have affected the system of professions in many ways, but not in its central constitution. Individual professions have changed, have been advantaged or disadvantaged, sometimes destroyed or created.

"This process has been most obvious in the ceaseless building and dismantling of jurisdiction of professional structure by technological and organisational changes. But the bureaucratisation of professional structure, the changing balance of audiences for claims, and the rise of co-optation have ultimately left us where we started. Significant inter-professional competition continues, but in different places and involving different arrangements of 'friendly' groups. Changes in knowledge have, in fact, had more drastic effects" (1988:176).

As a further area of far-reaching influence on the system of professions Abbott emphasises substantial changes in the professional environment.

Knowledge change concerns two simultaneous processes: the increasing amount of professional knowledge and the replacement of the old one. The former constrains professions to subdivision, the latter to abstraction.

The emergence of artificial intelligence has had a profound effect. Through this process all professions will lose parts of their jurisdiction so that they will defend non threatened areas (e.g. librarians: specialised bibliographers versus general reference librarians).

"On the one hand, professional work is replaced by machine work. On the other, the machines enable new forms of professional work and new expectations for professional services. Essentially the race is between two forms of creativity. The growth of professions to this date shows which has won so far" (1988:184).

The basis of *legitimacy* of professional work lies in cultural values. Those values undergo autonomous shifts. Professions legitimise their work with personal, social, or political values translated in terms of results. Probably the most striking change of social values has been the emergence of personal values like happiness, health, self-actualisation, personal culture, and so on.

Change in values can recast the meaning of a profession's legitimisation without any change in the arguments themselves: e.g., historically, science concentrates more on rationality and efficiency, character has come to mean –

for psychotherapeutic professions – successful completion of personal therapy and wide personal experience.

Thus, the major shift in legitimisation in the professions has been from the reliance on social origins and character to scientification or rationalisation of technique and on efficiency of service. But those shifts have not disturbed the jurisdiction of the established professions. The main role of new values seems to serve as ideology for new groups.

Dingwall and Freidson in his late work see the question of values as more deeply rooted, less subject to the zeitgeist, because they see the professions as bearers of functions in a specific social role. I will come back to this later.

While *universities* first were places for training in a common sense (education), they have developed to professional schools where inter-professional competition is taking place. In that process different forms of co-option have been established in different countries.

Neither transformation of knowledge (which is basically the same: expert knowledge), nor changes in legitimacy have in principle changed the system of professions. But, in fact, the university has not been able to challenge knowledge change: professional associations and employing corporations have taken over big parts of its task (continuing professional education and managing courses). In addition, corporate capitalism involves the universities more and more by directing education towards the immediate goals of commerce. This thrust will divide the professions in dependent ones and in less

dependent ones. These external forces will change the nature of competition by attenuating even further the professions' power of controlling their own work and careers.

Abbott's analysis represents a broad systemic conceptualisation of the professions and provides insight into the complex structures and processes which form the context of the professions. Therewith his perspective is wider than Larson's occupation – focussed view because it takes into account the environment of the professions.

Nevertheless, some questions remain which seemed important to me: First, the issue of gender remains unsolved. Possibly, this is a consequence of his systematic representation of the world of the professions: Gender does not affect the system in a serious way. Conversely, it does affect professional women's careers (Evetts, 1994). Second, Abbott's weak definition of professions "to say a profession exists is to make it one" (1988:81) is misleading because his actual restriction on professions is not very clear: the question how occupations become professions remains unanswered. Obviously, Abbott has been questioned on this point, specifically on the statement that "for me the crucial environing question is how societies structure expertise". In a footnote, he records that Freidson disagreed feeling the environing question is how societies structure work. "Jim Davis, Robert Dingwall and a number of other questioners through the years have raised the same issue: whether I have not given a general theory of the division of labour" (Abbott 1988:387). Third, the system of professions, in spite of Abbott's action-based approach, seems to me

static, as has been said by critics (Macdonald, 1995; Allen, 1996), although the concept itself contains and provides permanent movement.

Yet, for me, the model of jurisdiction, or the system of professions respectively, reflected in an almost ideal typical way the current ideas about state, aims and claims of nursing. The reason being that I still had the notion that nursing was in the centre and that the factors Abbott describes were arranged around it. From this perspective, Abbott with The System of Professions *offers an extensive basis for analysis.*

I now turn to the work by Magali Larson (1977)

Larson does not take into account the aspect of gender in her work *The Rise of Professionalism* either. But by focusing on specific occupational groups, their 'project' of developing 'upwards' provides the specifically detailed view which I had been missing in Abbott's analysis.

Larson sees professionalisation

"(...) as the process by which producers of special services sought to constitute *and control* a market for their expertise. Because marketable expertise is a crucial element in the structure of modern inequality, it appears *also* as a collective assertion of special social status and as a collective process of upward social mobility" (Larson, 1977:XVi).

I was especially interested in this aspect supposing that professionalisation was not necessarily coupled with social status assertion. In fact, I found in

Swiss nursing both an early phase of professionalisation motivated first of all by structuring the bundle of tasks which medicine, nursing school and administration had assigned to the nurses and a later phase when the nurses started to claim academic status and distanced themselves from less-educated groups.

Drawing on the work of Larson also means drawing on the early writings by Freidson. Larson's theory is largely based on *Profession of Medicine* by Freidson (1972), and, vice versa, Freidson's writings take into account Larson's work. In the 1970s Freidson's and Larson's work had an important impact on subsequent research on the sociology of professions.

Freidson (1994) conceives professions as groups aiming at domination and control over work, avoiding subordination, occupying key positions within the institutions. Control over work by means of expertise is the dominant concept in his model of professions. Control over work is the foundation of a dominant position within occupations. This control is based on autonomy and power, it is achieved by means of exclusive knowledge and professional organisation. The relation between professional knowledge and policy has to do with ideology, individual behaviour, and self-control. As professional 'agents', the owners of this exclusive knowledge establish themselves on the labour market where they set the standards of their profession, establish and defend market shelters, occupy key positions in government, and build advisory committees. In this way professionalised occupations escape or resist the exercise of administrative authority over work. In fact, expertise is the actual co-ordinator of the division

of labour, that is the structural relations among occupations are organised by the occupational principle. In other words, the professions do have control over work. Although bureaucratisation seems strong, the professions have reached positions higher than ever before. Thus, following Freidson, professionalisation can be seen as a major social movement of the 20th century. The growth of the occupational principle may turn the post-industrial society into a professional society.

The concept of occupation

"can be treated sui generis as activities around which groups can be formed as their members seek autonomy and control over their particular and distinctive work. The variety of occupations can be conceived of as a variety of successes and failures in their 'market project', some being creatures solely of their employers' demands, others gaining shelters of varying degrees of autonomy. Analyses of the conditions for success and failure link together the conventional variables of occupational analyses which have for too long remained disconnected" (Freidson 1994:91).

Altogether, the theories of Abbott, Freidson and Larson allowed me to envisage an ideal type of professionalisation which I decided to apply to Swiss nursing.

The model of the *professional project* can be described as a sequence of actions of an interest group (see Appendix 2):

1) There is, first of all, a group of persons who have a special service in common which is distinguished from other services or goods.

2) Professional work is based on special knowledge. The professional knowledge is at the heart of professionalism, serving as strategic means and representing the content of the service at the same time, it is the reason for the extensive autonomy of the professions in creating formal knowledge and controlling professional practice and, vice versa, it is the reason for status, prestige and respectability (Abbott: set of tasks bound together by jurisdiction).

   Professional knowledge is defined as esoteric, abstract, scientific, approved by its scientific community: It is expertise (Freidson 1994).

   The relationship with the purchaser of professional services rests on trust.

3) The professional group depends on the marketability of its goods. It is, therefore, obligated to build a market for its service in order to gain control over supply and substance of demand (Larson: monopoly; Abbott: jurisdiction; Freidson: shelter). That means, according to Freidson (1986):

   – contingencies of market shelters (method for restricting the use of a particular kind of labour by consumers, method of identifying those members – recruiting, training, labelling)

   - collective negotiation

- establishment of a market shelter (carving out firm demarcation boundaries, best way: dominant position)

- the social psychology of occupational membership is a very important element in the context of market shelters: only a long-term perspective allows members of the professions to identify themselves with their occupation.

4) In order to gain an optimal monopoly, the group needs the state to protect it by law (Abbott: legal system).

5) The professional group depends on public opinion, too: social norms and values build the cultural ground of the professional project (Abbott, Freidson).

"This discretionary power, which goes far beyond mere technical autonomy, derives from monopoly: a monopoly of competence legitimized by officially sanctioned 'expertise', and a monopoly of credibility with the public. Of the two, the first is more important: it leaves the public without legal or credible alternatives, and it restricts the control by outside agencies over the actual ethicality of the transaction of professional services" (Larson, 1977:38).

In other words, the professional project occurs in two dimensions at the same time, the economic and the social order whereby

"the process of organisation for a market of services (...) has theoretical precedence: for indeed, in order to use occupational roles for the conquest of

social status, it was necessary first to build a solid base in the social division of labour" (Larson 1977:66).

6) "The success of their (i.e. occupational communities, BD) efforts become visible when they collectively outrank (or eliminate) competitors and when they also obtain supervisory or controlling authority over related occupations" (Larson 1977:69).

The professional project is about competition (compare Abbott on internal structure) and it is about power and status.

"He (Freidson) argues, in fact, that the status of profession is relative to that of other occupations and inseparable from their subordination to professional dominance in a structured work setting. He proceeds to show that physicians define the content of practice and even the content of training for a host of allied and highly skilled occupations, such as nurses, anaesthetists, therapists, laboratory technicians, radiologists, chiropractors, and the like. Now, all professions – and perhaps all specialized occupations – gain what E.C. Hughes calls the power to 'delegate dirty work'" (Larson 1977:37). The state and the public constitute both the limitation of the professional project and the main sources of professional power.

Larson's analysis shows how the occupations called professions organised themselves to gain market power. The historical analysis illuminates that the development of professions was part of the broad social change ('the great

transformation') and took advantage of capitalism or the free market respectively.

"(...) the constitution of professional markets which began in the nineteenth century inaugurated a new form of structured inequality: It was different from the earlier model of aristocratic patronage, and different also from the model of social inequality based on property and identified with capitalist entrepreneurship. In this sense, the professionalisation movements of the nineteenth century prefigure the general restructuring of social inequality in contemporary capitalist societies: the 'backbone' is the occupational hierarchy, that is, a differential system of competencies and rewards; the central principle of legitimacy is founded on the achievement of socially recognised expertise, or, more simply, on a system of education and credentialing" (1977:XVII).

Larson concludes:

"The persistence of profession as a category of social practice suggests that the model constituted by the first movements of professionalisation has become an ideology – not only an image which consciously inspires collective or individual efforts, but mystification which unconsciously obscures real social structures and relations. Viewed in the larger perspective of the occupation and class structures, it would appear that the model of profession passes from a predominantly economic function – organising the linkage between education and the market place – to a predominantly ideological one – justifying inequality of status and closure of access in the occupational order" (1977:XVIII).

At the first glance, the concept of class which is especially important in Larson's theory, seemed not to apply completely to Swiss nursing because 'class' could have a different meaning and yet a different relevance for Switzerland. The political structure and culture of the direct democracy, legalised in 1848 in the *Bundesverfassung* (Federal Constitution), have been characterised by the democratic participation of all social classes, geographical regions, the four official languages, and the two state religions. *De jure*, this concept provides equal rights and opportunities to all citizens and thus is intended to reduce class differences. *De facto*, class differences are manifest in the structure of income and wealth. In this respect Switzerland is characterised by one of the strongest inequalities in Europe.

However, this does not mean that the question of social status has not been of importance, since both the social background of the individual nurses and the social positioning of the occupation were debated extensively in the first decades of the last century (Dätwyler/Lädrach, 1985; Fritschi, 1986; Valsangiacomo, 1991). Furthermore, nursing leaders in management and education have come from a higher middle-class background, until recently at least. In other words, the connection between class, education and professional positions and interests within the nursing occupation, as has been elaborated by Dingwall et al. (1988), represents an important issue in the analysis of Swiss nursing, too.

What Dingwall et al. (1988) show for Great Britain, namely a possible fission between the class of higher educated nurses and the 'handywomen' class, is

reflected in the contribution of Elzinga (1990) for the case of Sweden. He addresses the aspect of class and of social mobility respectively. He discusses the significance of the nurses' attempt to gain recognition and leverage of status by the scientification of their knowledge. He considers the process of scientification of nursing and the class of recruitment of health-care workers in connection with the growth of the welfare occupations (dependent on the developing of the welfare state) and the college and university reform of 1977 which requires all higher vocational studies to have a scientific knowledge base. Referring to this aspect, Elzinga notes that a larger number of health-care workers come from the working classes and, on the other hand, approximately 80 per cent of the student population come from the homes of academics. That means

"in their ambitions to professionalize, nurses thus find themselves entering an academic world where the middle classes and middle-class values dominate" (in Torstendahl, 1990:153). He describes the development of the occupation in connection with the changes in the hospital-care system, whereby, in the recent phase, "one witnesses a return to the original notion of nursing as a calling, which is now grafted onto a scientific core with the help of a philosophical discourse and the incorporation of humanistic studies which hopefully would contribute to a holistic perspective and attention to quality of life. Thus the aspect of 'calling' assumes an ideological role, and other forms of academic knowledge are introduced in order to professionalize what previously was an unquestionable part of the tacit knowledge of the craft" (in Torstendahl, 1990:157).

He analyses the development of nursing research and its institutionalisation by the state and the claim to be acknowledged as a scientific discipline by the ideological and philosophical grounds which are used for legitimisation. He concludes that the differentiation that was introduced by scientification represents a breakaway of an elite and therefore cannot be seen only as a promotion of professional aspirations because the conflicts between doctors, nurses, nurses' aids, and other categories of health professionals are caused by objective factors (wage differences, gender relations, differences relating to knowledge traditions, and occupational roles).

"Whereas a professionalisation strategy leans heavily on the scientification of nursing knowledge, this alternative – trade-union activism – as a strategy seeks to put research in perspective, noting that it sometimes serves as an alibi for inaction when it comes to changing power relations" (in Torstendahl, 1990:172).

In other words, what is called 'professionalisation' as far as foremost concerned with scientification could describe processes of fission, segregation or dilution and thus of new formations of power relations.

Thus, class, or social mobility, applies to Swiss nursing if we refer it to the scientification endeavours, including the concomitant factors mentioned by Torstendahl.

Doubts: does the 'professional project' approach suffice for Swiss nursing?

Essentially, the theoretical frame could lead me through the development of the Swiss nursing occupation until the educational reform at the turn of the millennium. In fact, I found a distinct professional project of nursing but in the 1970s. Certainly, the concept of audience helps to explain the status of nursing. The concept of settlement is useful to asses the position of nursing in relation to medicine. The concept of vacancy or shelter respectively, applies insofar as the emergence of nursing was more than the result of either delegation of 'dirty work*' by the medical profession or by division of labour due to technical progress. It does not apply insofar as this vacancy became not occupied by competition or any other purposeful action by nurses. Rather nursing was filled into a mould. Therefore Dingwall's analysis of the emergence of new occupations may be important. He states that*

"the dominant model throughout is one of occupational development as a process of fission. (…) Whether their theories are ultimately derived from Marx, Durkheim or Simmel, most sociologists subscribe to a view that, as societies develop, work becomes more complex and the division of labour more specialized through the dissection of occupations" (Dingwall 1983).

Analysing the emergence of health visiting in Great Britain, Dingwall shows that the concept of fission cannot sufficiently explain the constitution of new occupations. By introducing the concepts of 'fusion' and 'capture', he accounts for the fact that health visiting represented something new within the official economy. This may be the case for Swiss nursing, too.

The professional project of Swiss nursing was abruptly challenged by the education reform. I realised that my perspective was no longer correct. It was not adequate for interpreting the far-reaching reform by the state but as an outsider attack as Abbott sees it.

Although Abbott wrote, "for behind the world of professional work lies a rationalising, ordering system that justifies it with general cultural values, at the same time generating new means for professional work" (1988 58*), he did not add much that was specific. Larson also noted, that the state and the public constitute both the limitation of the professional project and the main sources of professional power, but Dingwall criticises that her approach neglects*

"(…)two important qualifications. The first is her acknowledgement that the market is not passive: '(...)the structure of the market in which a profession transacts its services does not depend on the profession's action and intentions – or at least not until the professions gain considerable power. The structure of a particular professional market is determined by the broader social structure (Larson 1977:17-18)'. (…). She also accepts the role of the state: '(…) to view professional modernization as a project of market control, underlines the central role of the state in the development of this project (…) (Larson 1977:18)'. Having made this concession, however, she offers little analysis of the state, tending to see this as a mere vehicle for the interests of capital" (Dingwall 1995:5).

These insights prompted me to revise my literature review pursuing now a broader view than before.

First of all I had to remind myself of the development of the sociology of professions.

On the development of the sociology of professions

In 1980 Dingwall states that sociological research was grounded largely on the works of Talcott Parsons and Everett Hughes (Dingwall and Lewis, 1983:1). Both traditions had left open questions which led to empirical work on them: the relationship between values, organisation and practice, the role of the marketplace, monopoly power, and the wider context of the professions.

"The sociology of the professions stands at some kind of turning point. The 1970s were invigorated by a sequence of major theoretical contributions, most notably from Freidson (1970), Johnson (1972) and Larson (1977). Established traditions were seen to have reached the limits of their original paradigm and the research problems given within it. (…) Professional work must be studied not just in the context of a division of labour but as part of a network of social and economic relations. (…) Throughout this collection, contributors, explicitly or implicitly, suggest that a separation of a sociology of professions from a sociology of occupations has been a blind alley" (Dingwall and Lewis 1983:11).

1990 Larson (in Burrage 1990) acknowledges that a sea change within the sociology of professions has led to a change of the conception of the professions which demonstrates that in different states and cultures at different times profession means a different phenomenon. Torstendahl (1990) stresses the

variety of variables which eventually defines the professions, e.g. the differences of the knowledge base and the influence of the state.

Over time, two main directions became apparent, which Dingwall describes as

„a contest between those approaches that emphasise the demand for professional status and those that emphasise its supply. 'Professional status' is here understood as a legally-protected monopoly in the legitimate practice of some knowledge-based craft or skill associated with enhanced opportunities, relative to other members of a society, for obtaining an elevated level of material and symbolic reward. 'Demand theories' stress the effect of occupational organisation and self-promotion, leading to the capture of the state, or the legislature, and the passage of laws that create monopoly, closing a market and excluding competitors. 'Supply theories', by contrast, stress the extent to which monopolies are created in pursuit of some wider state or market interest that leads to the co-option of an aspirant group, which is given a monopoly to support discharge of this function" (Dingwall 2004).

1996, concerning the demanding approach Dingwall retains the

"increasing disquiet about both the theoretical and the empirical basis of this argument. (…) Fenn and I pointed to the general weakness of occupation-oriented analysis in explaining why the state chose to create market shelters through favourable regulation: at any historical point far more occupations were seeking this protection than were ever afforded. We suggested that

professionalisation might be a response to market failure rather than a form of market failure, as the conventional view proposed" (Dingwall 1996).

Dingwall located a shift from demand theories of professionalisation to supply theories.

In summary, we can therefore say, that within the sociology of the professions there is agreement on a number of issues. These are:

- professions, professionalisation located in the economical and the social order

- importance of knowledge

- importance of monopoly/jurisdiction/shelter/closure

- importance of the marketplace, competition

- importance of state, culture

- importance of status/social stratification

- all characteristics interrelated, dependent on historical changes

- control of work

Control of work is the most important of the characteristics of professions. Evetts offers a useful definition:

"In general, then, it no longer seems important to draw a hard definitional line between professions and occupations but, instead, to regard both as similar

social forms which share many common characteristics. The operational definition of professions can be highly pragmatic. (…) Although some researchers continue to be absorbed by the problem of definition, some general conception such as 'the occupation control of work' (Freidson) is probably sufficient to delineate the intellectual field" (Evetts 2001).

The contest is about the mechanic of the professional system, whether it is driven by the professions or by state or market demands.

Admittedly, I only understood these facts when I worked my way through the literature a second time. Today, I realise that this happened for two reasons. First, insofar as all three authors whom I used to support my argument do include the environmental aspects, I took these features for granted within the theoretical frame of 'the professional project'. This was especially the case for Abbott and 'professionalism reborn' by Freidson. Second, my interest in nursing implicated an occupation-oriented standpoint and therewith went together with the theory of the demand approach. I practically needed my data to spell it out for me that a different perspective was necessary in order to be able to describe the development of nursing in Switzerland.

2. Professionalisation: state interest or market demand (supply approach)

After the discussion of the *demand approach*, or the professional project respectively, I will now address the *supply approach* (Appendices 3, 4).

Following Abbott, control over work results from successful inter-professional competition and subdivision. The different development phases of Swiss nursing show competition for jurisdiction from 1950 on. Only with the claim for academic education did jurisdictional claims for full professional status arise. To some degree, nursing was successful in achieving theoretical jurisdiction of what concerns the concept of the *nursing process*, control over work, and academic education for a small group of nurses. But the recent development introduced by the educational reform (*Neue Bildungssystematik* NBS) makes it clear that the nursing occupation is actually far from being able to control its work. According to the *demand approach*, this failure would have been caused by a wrong or weak strategy by the professional group, or the success of other players respectively. Indeed, this interpretation corresponds to the most common reading of the professionalisation process within nursing insiders. Consequently, professionalisation strategies focus on inter-professional competition, jurisdictional claims, and status.

The effects of the educational reform of nursing illustrate that we need a wider approach than Abbott's and Larson's. The reform goes back to the federal vote on a new law concerning the vocational training. The '*Neues Berufsbildungs-*

gesetz' (introduced in 2004) should unite all non academic occupations under the same law.

Johnson (1995) and other scholars state that recent policy changes by government or basic alterations of the character of the state make it necessary to review the theoretical concepts of the sociology of the professions. In the case of Swiss nursing, the role of the state has to be closely considered.

Johnson (1995) comments on the state/profession dualism within the theory of occupations: "The dominant conception of the state/profession relationship found in the sociological literature is a systematic source of serious dispute and controversy. (…) While the professions are seen as acting to maximise autonomy, the state is presented as continuously extending its apparatus of control throughout society, including over the professions" (Johnson 1995:9).

This dualism is mistaken and misleading, as "a history with only two possible outcomes, autonomy or intervention" (Johnson 1995:11). He understands the professions as an integral part of governmentality as Foucault has conceived it.

"In short, the state, as the particular form that government has taken in the modern world, includes expertise, or the professions. The duality, profession/state, is eliminated" (Johnson 1995:13). In his view, state and professions emerge together.

"The establishment of the jurisdictions of professions like medicine, psychiatry, law and accountancy, were all consequent on problems of government and, as such, were, from the beginning of the nineteenth century at

least, the product of government programmes and policies. Far from emerging autonomously in a period of separation between state and society, the professions were part of the process of state formation" Johnson 1995:11).

Dingwall also underlines this, referring to Herbert Spencer's work, that he saw the emergence of professions as intimately linked to the development of modern industrial states (Dingwall 1996).

In contrast, Abbott conceives the state as an audience for professional claims (very similar to Larson who focuses more on class). Johnson (1995) states:

"In centring on the interplay of jurisdictional claims, Abbott focuses on the professions as an emergent set of properties arising out of occupations strategies. The state remains conceptualized as a pre-constituted reactive agent rather than itself an emergent property or the system" (Johnson 1995:18).

Johnson's argument is that politics change professional jurisdiction.

"The point is that changing government objectives have had the effect of shifting the boundaries between what was regarded as contentious and what was accepted as neutral. To put it in another way, the arenas of professional neutrality and autonomy are transformed, not as a product of changing occupational strategise as Abbott would have it, not as an effect of technical change, as suggested by Freidson; but as a result of changing government objectives and policies" (Johnson 1995:20).

The distinct feature of a profession, control over its own work, is always contingent; in other words, what professions have won can be lost and removed (Johnson 1995; Dingwall 1996; Abbott 1988).

Johnson's conclusion that "we cannot understand what is happening to the professions today if we frame our questions around the issues of autonomy and intervention" (Johnson 1995:21) seems to come close to Swiss nursing in the state of its education reform.

According to Johnson, we should understand the state/profession relationship "as the interplay of integrally related structures, evolving as the combined product of occupational strategies, governmental policies and shifts in public opinion" (Johnson 1995:16).

Concerning the role of the state, Saks (1995) points out that the different modes of state regulation need more attention. By comparing the response of the medical profession to unorthodox medicine in Britain and the United States, he shows the consequences of the varying modes of the state regulation of the professions. He shows that for one profession the regulation can vary within the same society because, as in the case of the United States, some professions are licensed by the federal government and at the same time by state and other territorial jurisdiction. This instance seems to be close to the current situation of Swiss nursing.

In his contribution to the English Insolvency Act 1986, Halliday (1996) reaffirms Freidson's statement "the pertinence of corporatist theory to

understanding the position of the professions in various nations" (Freidson 1994:6). He shows how the state "may use the professions as agents of economic surveillance and enforcers of commercial morality" (Halliday 1996).

Dingwall sees the relationship between state and professions as something different. In the centre is the significance of the state licence. In the following I try to present his line of thinking.

In their analysis of the regulation of the professions, Dingwall and Fenn (1987) state:

"Professions are not ordinary service occupations, although, of course, they do share many characteristics and behaviour patterns as a result of similarities in their market position. Nevertheless, when clients purchase a professional service, their discretion, and that of the service-provider, is limited by the terms of the professional contract with the state" (Dingwall and Fenn 1987).

Role and function of the professions are distinct:

"First, for professions to be able to perform their proposed function, they must be seen to have at least an arm's length relationship with the state which implies that on occasion they may come into direct conflict with it. A profession which becomes the servant of the state loses its moral authority. A state which seeks to become the master of its professions undercuts the possibility of a market-based economy. It must either go down the road of centralized planning or collapse into a Hobbesian state of anarchy. Second, professions are nonetheless broadly circumscribed by the state because they

owe their existence to a framework of law which provides the protection for their cartel. It makes no sense to study professional/client transactions *in vacuo* without attending to this context. The professional is not a free actor in the classical economic sense" (Dingwall and Fenn 1987).

This analysis by Dingwall and Fenn relies foremost on the works of Parson's who described the emergence of the professions as a product of modernisation, an ordering structure in a modern society respectively (1987; Dingwall 1996).

Trust and uncertainty

In his approach to the sociology of professions, Dingwall draws also on the works of Adam Smith and Herbert Spencer.

"In his general critique of mercantilism – monopolies and regulated markets – Smith, makes an important exception for the professions, which he identifies as lawyers, physicians, the clergy and a loose group of intellectuals (scholars, artists, teachers, etc.). In this sector alone, corporations and guilds are not a restraint on trade because they promote trust in the suppliers of these esoteric services and accredit the specialized knowledge and skills of their members" (Dingwall 2004).

But how can we know that we can trust the professionals?

"We trust our life, health and reputation to people without having the personal expertise to determine whether they are or are not capable of supplying the service we require. The profession's licence is the equivalent of the hallmark

that tells us that a bracelet is indeed made of solid gold and not of plated base metal. The professional deals with things that are necessarily uncertain" (Dingwall 2004).

As mentioned above, Spencer saw the emergence of professions in close connection to the modern industrial state. He assigned an important role to the religion in an industrialising society. Eventually,

"professions are not only the bearers of scientific knowledge, they are also, in effect, the secular guardians of the sacred, the priesthood of the modern world, but a priesthood which acknowledges the ultimate unknowability of things, deals in uncertainties, and recognises the openness of the world to change. The professional system is the regulating system of the modern society, whose function is to accommodate society to this reality" (Dingwall and King 1995:18-19 in Dingwall 1996).

Dingwall had noted in 1983 that the sociology of the professions was at the time based to a large extent on the work of Hughes (see above).

Hughes's interest in the professions lies in the division of labour. Two concepts are of particular importance: licence and mandate. Occupations have implicit or explicit licence to perform activities different from others on an exchange relationship. By virtue of a sense of community, the group claims a mandate concerning conduct, content, and delivery of the shared activity.

Abbott's concept of *jurisdiction* incorporates both of Hughes' concepts of *mandate* and *licence* which each, however, represent a different idea. The

differentiation is, however, important for the explanation of professionalism and the respective claims of occupational groups.

For Hughes, professions are a means to manage the society's uncertainty.

"Not only do professions presume to tell the rest of their society what is good and right for it: they can also set the very terms of thinking about problems which fall in their domain. They exemplify in an extreme form the role of trust in modern societies with an advanced division of labour. The professions are licensed to carry out some of the most dangerous tasks of our society – to intervene in our bodies, to intercede for our prospects of future salvation, to regulate the conflict of rights and obligations between social interests" (Dingwall and Lewis, 1983:5).

According to Hughes, occupations are characterised by a specific set of tasks and roles. Within this set there are tasks which are regarded as honourable and respectable, and others that are considered as 'dirty work'. This is an important concept in Hughes's writings and represents one element within the process of permanent change within the division of labour. The way occupations manage their 'dirty work' (concealment, delegation, integration) illuminates the specific claim of occupational boundaries (Dingwall and Lewis 1983).

Dingwall (2004), referring to Powell and DiMaggio (1991), points to the significance of institutional isomorphism. "If we consider the pressures for isomorphism, the convergence of institutions on particular models that are regarded as legitimate, even if not necessarily efficient or effective, then we

can see that only normative pressures might come from within an occupational group, The other types, coercive and mimetic, are both essentially environmental, requiring an institution to adopt a certain form because of the demands of state or market."

Dingwall finds the concept useful above all because it can be used to describe the attempt to get a grasp on uncertainty by technical and organisational means.

"Although it is debatable whether Weber ever understood modern society as an 'iron cage' in the way that was depicted by Parsons's translation (Baehr 2001), the metaphor is given considerable resonance by DiMaggio and Powell (1983) in their analysis of the tendency of organisations operating in the same field to adopt similar forms, whether or not the form is appropriate for the particular ecological niche inhabited by a particular organization. They describe three kinds of pressures that operate on organizations to achieve this result: *coercive* pressures are direct legal or other external sanctions as in the application of generic safety legislation or the requirement that business partners adopt ISO 9000 quality standards; *mimetic* pressures reflect the impact of the most successful business model in the sector on other competitors – if the leading company buys IBM computers, we all buy IBM computers; *normative* pressures are those associated with the identity of organizations, that 'an entity like ours' necessarily adopts certain values of collective behaviour and corporate citizenship" (Dingwall 2004).

In summary, Dingwall's theoretical frame of thought illustrates professions as parts of developing societies, historically emerging together with the modern

state, characterised by a distinct vital function in the society, namely to manage uncertainty by constituting trust into professional services, and bound in an interdependent relationship with the state by virtue of a contract.

Dingwall points out that these characteristics of professions reach beyond the nation state insofar as a global market will need the professions, too. Professions will rather be re-invented than abolished by government attack (1996).

Evetts (2001, 2003), Dingwall and Evetts (2002), and Freidson (2001) sustain the relevance of this theoretical approach by investigating it in relation to world-wide economic developments and ongoing globalisation. Evetts emphasizes the fact that the present-day concept of accountability is likely to replace the concept of trust, with the result that professionals will have to be held more liable for the work they do:

"In general, then, reclaiming and reinterpreting the concept of professionalism entails the professions themselves leading the way in the monitoring and assessment of professional competences and performance, and in demonstrating accountability, in the same ways in which in their different formations and histories they have monitored initial education, training and licensing" (Evetts 2001).

Freidson (1996), emphasising the necessity of a theory of profession in order to connect the international research on the subject, formulates his model of professionalism or occupational control. The model is based on the work and

the knowledge needed to perform it. The generic content of the occupational control is the specific knowledge and skill, whereby Freidson distinguishes between institutional constants and institutional variables that represent the contingencies of the process of professionalisation. The constants (Larson: structural elements) or defining elements (Larson: resource elements) are: an officially recognised body of knowledge and skill, an occupationally negotiated division of labour, an occupationally controlled labour market based on training credentials, and an occupationally controlled training programme associated with a university. The variables are: the organisation and policy of state agencies, the organisation of the occupation itself, the dominant ideologies of the time and place, and the particular bodies of knowledge and skill.

"One analyses how the particular configuration of contingent variables found in one or another time and place facilitates or obstructs the creation and maintenance of professionalism. All those variables are, of course, in interaction with each other" (Freidson, 1996:4).

With his latest work, *Professionalism: Third Logic,* Freidson (2001) achieves his life-long aim to conceive professionalism in a theoretical model. It consequently puts the professions in an inter-dependent relation to both the economy and the state.

With this work, Freidson offers an ideal-typical model of professionalism.

"I use the word "professionalism" to refer to the institutional circumstances in which the members of occupations rather than the consumers or managers control work" (Freidson 2001:12). More concretely, Freidson's defines professionalism "as a logically distinct and theoretically significant alternative to currently received models for conceptualizing the organization and control of work" (Freidson 1994:8). Professionalism represents the third logic together with the market and rational-legal bureaucracy. After the attacks of neo-liberal policies on the professions, their progressive commercialisation respectively (Evetts 2001), Freidson (like Dingwall) defends their monopolist status.

"I will show in this book that monopoly is essential to professionalism, which directly opposes it to the logic of competition in a free market. Freedom of judgement or discretion in performing work is also intrinsic to professionalism, which directly contradicts the managerial notion that efficiency is gained by minimizing discretion" (Freidson 2001:3).

Pointing to the normative aspect of professional ethics he speaks of the soul of professionalism.

"The proponents of professionalism must necessarily exercise a strong, principled voice both in broad policy-making forums and in the communities where practice takes place" (Freidson 2001:217).

Not only today, this is a significant topic in nursing, not only today when, above all in institutions for long-term nursing and taking care of the aged, the staffing levels – concerning quantity as well as quality, are for financial

reasons kept so low that ethically nursing is almost untenable. And it is a significant topic in the history of nursing during National Socialism (see also Freidson 2001).

Professionalism: the third logic highlights Freidson's movement from the demand to the supply approach which, as I have shown, is also a historically based shift in the sociology of the professions.

It is, perhaps, necessary to address some current differences between the Anglo-American and the German-speaking sociology of the professions. Referring to the *demand approach* Mieg (2001) states: "From the viewpoint of a power approach, the public service orientation can be used as an ideology and a tool to legitimise a collective social mobility project" (Mieg 2001:31).

In the course of the development of capitalist society, this orientation tends to increasingly commercialise professional performance and thus causes professions to seek an increasing amount of power (cf. also Weidner 1995). It is this trend that threatens to 'proletarise' and ultimately to de-professionalise these professions (Weidner 1995). It is against this background that an interactionist approach began to be seen as an alternative for interpreting the concept of profession because its main focus was examining interactions with clients. The interactionist approach led to the development of the concept of professional behaviour (Oevermann 1996, Schütze 1996), or professional performance (*professionelle Leistung*). In this way, the conspiratorial character of the professional project approach (Mieg 2003:31/32) could be avoided. Borchert (in Mieg 2003:270), also points out that Oevermann's neo-functionalist

approach is seen as an alternative to and in opposition to the power approach. Oevermann adds the idea of 'the role of proxy in conflict resolution', or mastery of a pattern in interaction as specific to a profession (Oevermann in Mieg 2003:34, Dröge 2003). Dröge uses the term 'professional occupations'. Weidner's (1995) concept of professional nursing behaviour is based on Oevermann's theories. He argues that classical occupations are undergoing deconstruction while permitting pseudo-professional occupations to come into the forefront.

Nevertheless, German-speaking theorists maintain their basic critique against characteristics of professionalism. Interestingly, the definitions of professional performance by German-speaking theorists end up with the same attributes as are recognized by the Anglo-American theories, but are connoted critically. The public- service orientation of professionalism causes wages to be termed '*fees'* or '*honorarium*', with the result that professionals are hardly ever remunerated on the basis of the time they spend working. In addition, there is the problem of standardising operations, the problem of setting standards and a lack of clear assessment criteria as professional expertise is in direct confrontation with the layman's access to information, thus, the client has no other choice but to trust the professional. Finally, there is the mandate from society which defines performance assessment as the task of the profession in question - i.e. autonomy.

Evetts (2003) believes that the question of definition is less important than the question of the social significance of what the term profession or professionalism denotes.

"Although some researchers continue to be absorbed by the problem of definition, some general conception such as 'the occupational control of work' (Freidson) is probably sufficient to delineate the intellectual field. Instead we should move on to consider the power of the discourse of 'profession', as well as attempting to understand the similarities and essential sectorial, historical and comparative differences between professions as a generic group or social institution. The expansion of the service sector in the developed world, the growth or re-emergence of professions in both developing and transitional societies, indicate the strength and persistence of professions as a social form" (2003:51-52).

Borchert (in Mieg, 2003:270) also believes that the time of the great debates in occupational sociology have seen their day but in a different sense, namely that the concept of profession is outdated and that the sociology of professions is being marginalised. In his view, most studies carried out today typically focus on jobs in the field of social services and in education which have not been capable of attaining the official status of a profession. On the basis of the concept of professional performance, he asks the question of the legitimisation of the claim for specific occupations. "But even under the most favourable circumstances, a generally recognized evaluation of the performance according

to strict criteria inside the profession is no longer conceivable“ (Borchert in Mieg 2003:311).

The concept of *professional performance* of the German-speaking sociology tries to solve two problems: first, it tries to make professional service measurable in time, cost, quality measurement etc (cf. above, Dingwall on *isomorphism*). Second, it detaches the single performance from a professional body. Since there will no longer be leading professions, Kurtz's question is consequential: "Should we not rather (…) start out from expert and knowledge professions which are all the same able to act professionally and show professional performances?" (in Mieg 2003:106).

In my opinion, the concepts of professional acting and professional performance do not solve central questions as for instance the questions of uncertainty and also the question of control: *quis custodiet ipsos custodes* (Dingwall 1987, 2004). The operationalisation with the help of a series of measuring instruments is a misapprehension. The problem of uncertainty remains (Dingwall 2004).

Criticism of the '*power approach*' cancels itself out since, through the new structuring of the professions, several of them claim *professional acting or professional performance* and thus a higher status.

This sociological approach, however, represents the basis of the current political debate on healthcare professions in German speaking Europe.

Nursing as a female occupation

With the theories I have discussed so far, one fundamental problem remains unsolved, as mentioned earlier, i.e. the problem of nursing as a female occupation. The theories neither address questions about the gender-related value of work and the consequential sex-segregation within work, nor do they account for the fact that the professions rest on specific subordinate work (e.g. clerks, nurses) which is performed by women to a large degree.

Within the sociology of the professions, gender represents a difficult topic, first, because it was neglected until recently, second, because of its high complexity: gender is socially pervasive and therefore hard to capture and to apply as a concept. The attempts of theorising patriarchy (e.g. Walby, 1986, 1988, 1990, 1997) provide important insights, but they cannot sufficiently explain the processes within the world of the occupations. Witz (1992) introduced the concept of 'discursive strategies' in order to capture the gender-related nature of social interaction, terms and language. This discourse is based on power and aims to maintain an established power relation; as an instance, I remember that the first curriculum of the *Lindenhof* nursing school (established in 1899) prescribed the instruction and examination of Latin medical terms but explicitly prohibited the nursing students to use them in front of doctors.

Witz (1992) claims that the sociology of professions needs a correction of its gender-related self-image. In her theory, a combination of the concepts of patriarchy and profession explains the historical intersection between patri-

archy and capitalism in structuring gender relations and sex segregation in employment.

Witz and Savage (Savage and Witz 1992) criticise previous studies and theories. Organisation theory was dominated by Max Weber for many years (formal rationality). Authority, power, inequality, or social division were rarely mentioned. Feminists have shown the gender blindness of many of the studies by bringing inequality into the focus principally by means of two approaches: first, by locating female subordination in the separation of public from private life, and second, by arguing that gender was also an axis of stratification. They have argued that organisations do not exist in some abstract sense and power is not due to the stratification system, but rather has to do with human agents and their relations. In other words, they pointed out that the problem of gender inequality tended to be dealt with at the level of a stratification system, instead of being understood in terms of the conduct of specific organisations.

The classic model of bureaucracy is a historical phenomenon which is directly linked to the use of women, that is, the bureaucratic career (a central part of Weber's definition of bureaucracy) is defined in gender-related terms. The model of the male career rests upon another assumption, namely the existence of the person – the wife – who is at her husband's service.

"Many organisations imposed marriage bars on their female work force, forcing them to retire upon marriage, and so become full-time housewives. Male workers, on the other hand, were expected to be able to draw upon full-time domestic service-renderers so that they could work long hours, get work

done by their wives, and so forth. Modern bureaucratic hierarchies both helped to construct the idea of the dependent housewife and drew upon this for their own advantage" (Witz and Savage, in: Savage and Witz, 1992:12).

Even if there have been changes in the patterns of men's and women's careers and even if women have entered bureaucratic hierarchies, that does not mean that organisations are less patriarchal today. "Rather it testifies to the fact that organizations themselves have restructured and that the types of areas into which women have moved are those which tend to be barred from effective organizational power" (Witz and Savage, in: Savage and Witz 1992:12).

In other words, the sociology of the professions ignored female professional projects.

"This is because it takes what are in fact the successful professional projects of class-privileged male actors at a particular point in history and in particular societies to be the paradigmatic case of profession. I shall argue that it is necessary to speak of 'professional projects', to gender the agents of these projects of occupational closure, and to locate these within the structural and historical parameters of patriarchal capitalism. Professional projects are projects of occupational closure, and I propose a model of occupational closure strategies which captures the historical configuration of the gender-related politics of occupational closure" (Witz 1992:39).

The model of occupational closure consists of a four-fold distinction between the following strategies: *exclusion, inclusion, demarcation, and dual closure*, the latter including usurpation and exclusion.

'*Exclusionary closure'* means that an already dominant group defines the membership, the exclusion of those who are ineligible by the elite respectively.

'*Demarcating closure'* refers to strategies defining the boundaries between subordinate occupations. This kind of closure – as a recent example – is illustrated by the proposal of a medical professor at the University Hospital of Bern to define nursing research as 'non-academic' in order to make clear the difference from medical research.

'*Inclusive closure'* defines strategies used by subordinate groups to achieve the required attributes of dominant groups. An example represents the use of the term 'academisation' in Germany and the German-speaking part of Switzerland, which is mostly used as synonymous with professionalisation. Another prominent example of inclusion strategy by the nursing group represents the concept of nurses' diagnoses which has been a world-wide project at the top of the agenda of occupational development for a few years. Empowering nurses to establish a diagnosis themselves can be understood as a strategy to attack or undermine the concept of medical diagnoses which are probably the most powerful tool of this profession.

'*Dual closure'* describes a double strategy of an occupational subordinate group which defines its own field in contrast to dominant groups and practises

exclusionary closure at the same time. Nurses have succeeded in securing for themselves part of the medical field by basing the difference on gender. At the same time, gender represents a tool of exclusion. However, in the case of nursing this specific dual closure strategy makes up part of what Davies (1995) calls 'the professional predicament in nursing' and thus remains ambiguous.

Similar to Witz, Davies (in: Savage and Witz 1992) claims that the only way of understanding nursing adequately is to see it as part of a gender-related society and gender-specific organisational structures. She suggests conceiving gender as relation, more precisely as power relation. She points out that many studies about nursing that are based on gender-linked stereotypes are at risk of blaming nurses for their unsatisfactory situation.

"Could nursing ever have put its own house in order? Has it had the power to do so?" (Davies 1995:13) She suggests that first one must look at the framework in which the struggle to understand and to develop nursing practice actually takes place, for this framework is gender-linked. This approach broadens the view in the direction of the societal devaluation of women and the work they do.

"A look at the cultural codes of masculinity and femininity that are found in this gendered world and how these serve to oppress women will provide the context for a closer and very different approach to some of the discontents outlined here" (Davies 1996).

Certainly the pervasive character of gender is accounted for in a valuable manner by the concept of the professional project, the differentiation of social closure and the concept of 'discursive strategies'.

Nevertheless, the question of the contradiction or predicament of nursing is still unanswered. Over the last few decades, a large body of writings about nursing and professionalism has emerged. They include works focusing on the following aspects: nursing as a profession (Bock-Rosenthal 1996; Keogh 1997; Lambach 1998; Landenberger, 1995; Salvage 1988; Weidner1995a; Witz, 1994; Hellige 2005), sociological concepts (Burau 1996; Kuhlmann 2003); power and empowerment (Arnold, 1996; Fulton, 1997; Odendahl1994), policy (Cheek, 1997), and the gender dimension (Walby 1994, Witz1988, Kuhlmann 2002).

If Dingwall et al. (1988) portrayed the lines and fields of the social history of nursing, and, by doing so, drew up an encompassing historical map of the social forces and interests within and around the nursing occupation since its emergence, Rafferty (1996) focuses on the history of the politics of nursing knowledge.

She argues that, concerning changes in nursing training, historians have tended to underestimate the role of government policy and instead have overestimated nurses as leaders. Reformers among nurses often adopted strategies pioneered by medical reformers (examples: registration debate and the campaign against Sarah Gamp).

"Consideration of government policy reveals not only the limited extent to which internal reform within nursing can be achieved without government support, but also that initiative does not necessarily reside with occupational leadership" (1996:184).

"Nurses were only ever one of a number of groups ambitious to reform training; furthermore, they were not necessarily the first or the only group to take the initiative. Nurse education policy was more product of conflict than of consensus, and its implementation was predicated predominantly upon political and economic contingencies. In this respect I have argued (...) that it is in the context of convergence between government and occupational priorities that the implementation of nursing training policy can best be understood. At the same time, though, I have acknowledged other social forces, such as class and gender politics, that also need to be taken into account" (Rafferty 1996:186).

Rafferty points to the difficulty of capturing those concepts as well as to corresponding studies exploring the construction of nursing as an occupation by its gender and class composition. Following Rafferty, recent sociological analyses have propagated further the 'vexed relationship' between nursing and professionalisation. Referring to the works of Witz and Davies who make evident that nursing does not fit into the traditional understanding of professions, Rafferty states

"moreover, nursing itself is caught in a contradiction in so far as it provides the necessary support for medicine to maintain its dominance, thereby perpetuating the subordination of nursing to medicine. Thus the question has to be asked: to

what extent can or should a female-dominated occupation strive to become a profession, especially if that occupation can never, by its very nature, 'arrive' at the state of full professionalism? Furthermore, to what extent is the notion of 'profession' incompatible with the career patterns and lifestyle opportunities of women? Indeed, is the idea of a female-dominated profession a contradiction in terms?" (Rafferty 1996:186).

Addressing the aspect of scientification of nursing knowledge, Rafferty refers to the double dilemma of nursing as being not esteemed by society and as infiltrating the essence of a discipline. Actually, the sociology of knowledge and professions have not sufficiently analysed the fine-grain detail of how different groups mobilise 'epistemologies of esteem' to legitimise their claims to expertise. "What we still need to develop is a vocabulary with which to articulate the processes by which the micro- and macro-politics of knowledge production and utilisation contribute to discipline building and, in turn, the creation and consolidation of disciplinary hierarchies" (Rafferty 1996:187).

Concerning the concept of science, Rafferty illuminates another facet of this dilemma, namely the relation between professional expertise and the authority of science. The intellectual identity of nursing is to a large extent based on science, although on social science.

"This identification is also a response to medicine's appropriation of the intellectual high ground of sciences – it is part of a desire to cleave a cognitive course which distances nursing from medicine. Thus nursing's alignment with social science can be read as a strategic attempt to circumnavigate the

intellectual hegemony of medicine. But while social science may provide one form of escape route from medical dominance, it by no means eliminates the epistemological web in which nursing is enmeshed in health care" (Rafferty 1996:188).

Nursing is actually encapsulated by the surrounding occupations; its future depends on the extent of success in defending its space in clinical and academic environments which in turn depends on its power relationship with other disciplines. In fact, what Dunlop (1986) discusses under the title 'Is a science of caring possible?' has been a central and controversial discussion. Rafferty asks by which criteria or standards the achievements of nursing as a discipline could be evaluated. She urges that more research has to be done including race, gender and class in order to account for the intellectual and social subordination of nursing and the micro- as well as the macro-politics within which the cognitive and institutional boundaries between disciplines of differential status are negotiated.

Rafferty warns of a strategy of concentration on knowledge as the key to power because of the danger of missing the importance of the superstructure: "Any strategy for radical change must be multi-focal, multi-purpose and multi-stranded" (1996:191).

In Switzerland the debate about professionalisation in nursing is, as mentioned above, characterised by and focused on scientification of nursing knowledge. This is accompanied by a controversial debate about the nurse's role and duties. One axis of controversy is represented by 'professionalisers' and

'assimilationists' (Dingwall 1988), another by the French and German-speaking part of Switzerland which advocate principally different strategies, a third, in the wider context, by managerial and organisational developments as a result of economic constraints.

In fact, the discussion is characterised by the same features as Dingwall et al. (1988) elaborated under the title 'professional autonomy and economic constraints' years ago (cf. also Thornley 1996a).

Dingwall and Allen (2001) and Dingwall (2000) illustrate the problematic nature of the claim for uniqueness of emotion work in nurses' work. They "argue that recent developments in health-care raise questions about the benefit of claims of this kind and suggest that a little more realism about the nature of nursing work might make for a more sustainable professional future".

Freidson (1990b) has argued similarly. He highlights that the bundle of tasks, the structural *mould* of nursing respectively would be enough of a basis of professionalism.

"But professionals (...) should struggle for the right for themselves exercise responsible control over both cost and the quality of the care down at the workplace, where the need of concrete people are served individually by the exercise of caring judgment. There is the crux of the matter: if professionals are really to be professionals, they must exercise control over their own work responsibly, in their own way, and in the interest of their clients" (Freidson 1990).

To end this literature review, there remains to point to the "sheer complexity of any attempt to understand this varied and fragmented occupation'" (Dingwall et al. 1988:228), that is nursing.

Chapter Three: Method and Methodology

The aim of this chapter is to describe the research methods used in this study and to discuss questions of methodology. The structure of the chapter follows the research process.

The background of this study is my previous work on the nursing occupation in Switzerland which is mainly concerned with two different focuses. First, I explored the construction and implementation of professional nursing in Switzerland until 1925 in a study. After that study I turned my attention to the nurses' view of their occupation. On the one hand, narrative interviews with nurses over 70 years of age were carried out, and on the other nurses aged between 30 and 70 were interviewed to determine their definition of themselves as professionals and their view of their profession.

The foregoing studies have enabled me to gain relatively deep insight into the historical circumstances which fostered and shaped the development of nursing as an occupation in Switzerland. I can also reasonably assume what it meant to be a nurse between 1930 and 1970.

Since about 1970 within nursing the professionalisation of nursing as well as the claim for professional status represented a permanent theme.

Objective and design of the study

My first objective was to understand this debate on professionalisation. What does professionalisation mean? Why does the question set of such vehement

controversies? Where does a process of professionalisation lead? When does it start? Why does it start?

After a first literature review I decided to focus my research on Switzerland and this with the aim to explore the professionalisation process of nursing in Switzerland within the period of time between the beginning of professional nursing (from 1850 on) to the present. The main emphasis of the analysis will be put on the situation of nursing in German-speaking Switzerland

"Methods must be selected according to purposes; general claims about the superiority of one technique over another have little force." (Hammersley and Atkinson, 1983, cited by Allen, 1996: 128).

It seemed obvious to me that for my research interest only a *qualitative approach* could be considered. The rationale for this decision was primarily pragmatic: I couldn't see that I would have data to measure or causal relationships of variables to analyse.

On the other hand, I had a number of qualitative interviews with nurses, which covered a long timespan, as well as comprehensive historical literature. My first interest was to analyse the interviews with the nurses who worked between 1930 and 1970 in order to find signs of professionalisation. In doing so I hoped to derivate the specific character of the professionalisation process in Swiss nursing from the perspective of the professionals. In a next step I wanted to evaluate these results in the light of the recent development of the professionalisation debate as well as of the sociological concepts.

A qualitative approach seemed appropriate (cf. Denzin and Lincoln 1998:8). Murphy and Dingwall (2003: 84) point to the flexibility of qualitative research design as an advantage of this methodological approach: "(…) the researcher is free to follow up interesting leads and to open up new dimensions as they arise during the data collection". The importance of this aspect of a qualitative research design only became manifest to me in the course of my research.

My study represents a case study, more precisely an instrumental case study, insofar "a particular case is examined to provide insight into an issue or refinement of theory" (Stake in Denzin et al. 1998). The case-study format permits researchers to use a large number of varying sources of data for purposes of analysis – i.e. not only data from interviews but also information from relevant documents (Flick et al. 1991).

Research process and changing of design

After I had decided in favour of the theory of the demand approach because of my literature review, I wanted to know whether the nurses who worked between 1930 and 1970 aspired in any way to an improvement of their status and to autonomy. I established categories based on the model of the professional projects by Larson (1977) (see appendix 2) and structured the interviews accordingly.

After that, I had planned additional interviews with nursing personnel who worked after 1970. I assumed that in this way I could comprehend the professional project of Swiss nursing with its development.

My plan was as follows:

	Semi-structured interviews with	
	Rank and file nurses	Professional leaders/officers in nursing
Active between 1930 and 1970 Place of work	n =19 Bern/Zurich/Eastern part of Switzerland	n = 11 (German speaking) Switzerland
Active since 1970 until now Place of work	n = 25 Bern (Inselspital)	n = 25 Bern (Inselspital) and (German speaking) Switzerland

In a first phase I analysed 11 interviews conducted 1991 in the context of a research project on the social history of nursing. All 30 of the respondents were trained nurses, 19 of them rank and file nurses and 11 professional leaders/officers in nursing. The selection of the interviewees is a 'convenience sample' and was born out of necessity, accessibility and familiarity. The people questioned were from Central Switzerland and the regions of Zurich / Eastern Switzerland as well as Bern. Among those interviewees were 'free nurses' and nuns; the ratio of 'free nurses' and 'nuns' corresponded to the time in question. The selection of interviewees is not representative but the interviews were conducted with typical members of the nursing profession.

The interviews had revealed that those nurses who had been dynamic and committed to their jobs had had to take over executive-level positions, in part against their own will. Due to the fact that only nurses in higher-ranking positions were represented in political committees, active change – if placed in the hands of health care professionals – has exclusively been effected by nurses in high-ranking positions. In other words, aspirations towards professionalisation seemed to be found in that occupational category.

This is why I decided to concentrate primarily on statements made by professional leaders and officers in nursing for my evaluations.

Four of these nurses were from the educational sector, six from the management sector, and one from both sectors. Two of those who had been working in the educational sector were matrons, one was director of a school for further education in nursing, and two were teachers. The group who had had careers in management were senior officer nurses. Three members of the sample were religious-order nurses. One of the nurses was male.

The analysis of these interviews produced an amount of results that I had not expected. Actually a professional project could be identified. In order to follow its further development after that it seemed more sensible to carry out additional interviews with former representatives of the *Kaderschule* – in lieu of the originally planned 25 interviews with professional leaders/officers – as well as interviews with 3 currently active rank and file nurses. All the same, as the professionalisation of nursing per se is the topic of discussion in this thesis, the profession as a whole must be kept in mind. Therefore, the statements made

by rank-and-file nurses will be compared to statements made by the entire group studied in certain cases.

For this reason, the following sample was chosen for the present study

	Semi-structured interviews with	
	Rank-and-file nurses	Professional leaders/officers in nursing
Active between 1930 and 1970 Place of work	n = 19 Bern/Zurich/Eastern part of Switzerland	n = 11 (German speaking) Switzerland
Active since 1970 until now Place of work	n = 3 Bern (Inselspital)	n = 4 Bern (Inselspital) and (German speaking) Switzerland

Once all the interviews were analysed and thus on the temporal axis the 1990s were reached, I realised that I could not get any further with the demand approach. I had to turn to the supply approach. To the extent that in this approach the professions are explained in close connection with the state, I had to pay more attention to the historical-political context that I had originally thought and refer to written sources.

While for the period of time after 1930 interviews with members of the nursing profession were available from prior projects, for the time before that documents and above all secondary literature had to be analysed and revised.

The analysis of selected secondary literature where the history of nursing in Switzerland is represented focused on identifying important facts regarding the development of the profession and on representing them in concise form. The restriction to important facts was due to the condition that only those were considered which are found unanimously in various sources or in the literature – historical research of my own was not feasible in the framework of the present study.

For representing the development during the most recent period of time (cf. chapter 7 The New Educations System in Nursing), the current documents of the cantonal and national administrations in charge were used and interpreted. Since I have worked on several reform committees in the Canton of Bern, it was also possible to use the experience from my role as a 'participant observer'.

Interviews

Qualitative interviews play an important role in qualitative research (cf. Murphy and Dingwall 2003). "The important point here is that all interview talk, like all other naturally occurring talk, is always contextually constrained". Murphy and Dingwall claim that interview data have to be interpreted in relation to the context of their production.

Kvale (1996) describes qualitative interviewing as ‘wandering together with’ the interviewee. “He sees the interviewer as a travelling companion of the interviewee trying to elicit his of her ‘stories of the lived world’– if we genuinely want to hear, to understand an individual we must provide a way for her or him to speak in a genuine voice” (in: Cisneros-Puebla e al. @2004 FQS).

For the present thesis, two groups of interviews were used:

- The interviews with women who witnessed the process of the professionalisation until 1970 which were represented by using a system of categories developed from the concept of the ‘professional project’.

- The interviews with former representatives of the *Kaderschule* in which facts already known from the analysis of the secondary literature were even more focused on in order to comprehend the concerns and motives but also the experiences made and the resistance encountered by these ‘driving’ forces. (The interviews with the rank-and-file nurses were in the end conducted but not included in the analysis because of the adapted knowledge focus.).

The first group of interviews is therefore an important base for identifying the decisive elements in the process of professionalisation. The analysis of the interviews showed how clear impulses for the development of the profession were given which were continued at the Kaderschule. This insight led to a change of the focus which was now on selected persons from the Kaderschule.

Yet from the analysis of the interviews also originated the image of the mould, the form of the profession prescribed from outside, and thus a central insight of the study. The interviews turned out to be the haystack where one has to look for the needle. That was why I left the detailed interviews in the text.

When analysing the interviews, attention was paid to minimising potential bias on the side of the interviewees. As described above, the statements in the first group of interviews were attributed to the earlier developed system of categories and checked by an independent person. Thereafter, for the representation of the results only facts were used where there was high agreement in the statements. This was to ensure that there would not be any subjective blurring of the result presented.

For the second group of interviews – the talks with the members of the *Kaderschule* – the point was to gain deeper insight into the occurrences which were already known after studying the corresponding secondary literature. Since the gain of information only had a supplementary character, here as well serious bias could be excluded, particularly since here the statements of the 4 interviewees have been compared as much as it was possible.

The interviews took place in the private rooms of the nurses who all were over 70 years old. Our visit was carefully prepared, the nurses knew exactly the purpose of our visit and the time of the interview. They were pleased and some of them prepared old documents to show us.

The respondents spoke about their experiences from a present-day perspective while basing their reflections both on present and former norms. They were completely aware of the fact that their descriptions of the situation of the nursing profession at their time would appear like a catastrophe today. At the same time, they kept the conditions of the time in mind, in a general way and especially concerning the state of development in medicine and the nursing profession. Thus the interviewees expressed neither bitterness nor regret, nor did they gild their past.

Trying to answer the question of "what is the informant doing with their report?" (cf. Murphy and Dingwall 2003) I believe that first of all the nurses tried hard to provide us informations of the former conditions and contents of nursing. It was a kind of professional meeting, a talk between professionals (cf. Cisneros-Puebla et al. 2004).

Data collection

The data was collected in several steps, depending on the research process:

1) Collecting and analysing the relevant documents on the development of nursing.

2) Categorising and analysing the 30 interviews of research project on the social history of nursing.

3) Selecting the interviewees and carrying out the interviews with 4 retired key actors from the Kaderschule.

4) Selecting the interviewees and carrying out the interviews with 3 currently active rank and file nurses.

The interviews were taped and then transcribed. These transcripts and also those of the interviews that had been conducted in the previous study were fed into the programme Nvivo and form the basis for the analysis of the data.

Data analysis

For data analysis of the first group of interviews I have chosen the method of *content analysis* (vgl. Mayring 1983).

First, a system of categories was elaborated based on professional project.

The evaluation of the literature analysis had yet another function: it formed the basis for understanding and interpreting the statements in the interviews and has therefore provided a necessary means of controlling for subjective bias.

Three analytical steps emerged from the theoretical framework and from the material collected.

1) In a first step, the interviews were appraised using concepts based on the main categories of Larson's concept (claiming group, work, trust, knowledge, state, closure/monopoly, public, market).

2) In a second step, the content of the statements were appraised as positive, negative or neutral.

The respondents evaluated most of the statements as either negative or positive/neutral.

Negative associations:

fear, stress, illness, employer, work-related stress, atmosphere, occupational classification, emphasis on employer, employer or the market, food, other-directedness, salary, material, similar to nowadays, social insurances, superiors-hierarchy, opposition, housing, working hours

Positive and neutral:

improvements in nursing care

With the results of these analyses, which reproduced the most important elements of a professionalisation project, I hoped it would become possible to gain a tentative picture of the professional project in Switzerland between 1940 and 1980.

QSR Nvivo

I decided to use an electronic programme for qualitative research called QSR NVivo to evaluate the interviews.

„QSR NVivo is designed to hold and manage in a highly linked and integrated way everything to do with an entire Qualitative Data Analysis research project. This can include not just data documents (the interviews, field notes, historical documents etc.), but initial proposals, bibliographic notes, and data on any

medium your computer can handle. This comprises the so-called Document System, with many special qualitative-analysis facilities for organizing, linking, and exploring documents and their parts.

NVivo is not just a document-handling program however. It works by having a second database (called the Node System) of all the concepts and topics and people and places and ideas relevant to your project, and providing powerful tools for relating, categorizing, characterizing, coding, and manipulating the Document and Node Systems together. Much of this has to do with generating the Nodes from the documents, the data within them, and the features and themes the researcher sees in them (...)" (NVivo Online help, What is Nvivo?, Copyright © 1999 - 2001 QSR International Pty Ltd).

Reaching a decision as to how best to work with the Nvivo programme required a fair amount of time and thought. Precisely because the programme is so versatile – it contains a large variety of possibilities to choose from – and because it is easy to use right from the start, there is a danger of error which could occur if one were to code a vast number of documents, thereby producing an unwieldy number of categories.

In the end, I was far from exhausting all the possibilities the programme offers. Rather, I used it on a basic level as an ordering support. For me the most helpful function was the system of 'nodes' (single categories) and 'trees' (groups of nodes).

The first step involved categorising the interviews by using the categories from Larson's professional project.

Next, the categories were analysed, e.g.' work'. This in turn produced new sub-categories; on the one hand, new subject matter was generated, and on the other hand, an evaluation scale was developed (positive, negative, neutral, e.g. 'food').

In this way, work done on all of the originally chosen categories generated a second group of new categories. An example of this is that statements that had relevance for the category of socialisation could be located in and selected from a number of other categories, such as 'knowledge' or 'work'. Nvivo is extremely useful and efficient in carrying out these steps.

I also entered the first draft of the chapters in Nvivo, which was very helpful in carrying out searches for suitable quotations and integrating them into the final version.

Another helpful asset was the ongoing documentation of tasks and comments by the programme. I was not able to use the ‚Notes' programme to its fullest benefit. With time it became impossible to keep all the notes in clear perspective, much in the same way as too many slips of paper become unmanageable, because in the end I could not retrieve the notes, as they could not be found where I thought I had filed them. That is why I started to write notes which were filed in the diary document.

However, I soon realised that a lot of material accumulated in this way. It was very easy to establish new categories but increasingly more difficult to keep the overview of the branching out thing. There was a danger of getting lost in the system and thereby losing one´s own thoughts. At a certain point, I spread out all the print-outs on the floor and 'thought myself through' it all with the help of my research questions. Then I continued with the 'work' category as I described the analysis in chapter 5.

While writing the chapters I realised that the greatest help of NVivo was possibly the simple process of comparing the content of my own text with illustrative statements from the interviews to check for agreement. By clicking onto one word in a statement, the whole text of the original interview is opened, along with the excerpt that is marked. The programme proved useful in coding: it was easy to retrace the steps involved by using coding stripes. In all of the above-mentioned ways, the application of Nvivo proved to be a support on a practical level.

Reflexivity

Demonstrating the method of data collection and data analysis has a long tradition. Hammersley and Atkinson (1983 cited by Allen, 1996: 131) showed the importance of this procedure in research methodology. They formulated a premise upon which social science research is based. They state that it is an inevitable fact of research that researchers are part of the world they are studying.

Because understanding the actual process of generating data is of prime importance for assessing the validity and reliability of research results, it seemed appropriate to present the basis for the decisions on the research design within the framework of this thesis, rather than relegating them to an appendix.

Reflexivity is an important factor in the research process. It seemed fruitless to attempt to eliminate any influence the researcher would have on the field of study. However, it seemed to be more sensible to avert possible bias by showing possible sources of bias and examining what effects they could have.

The concept of reflexivity also emphasises the role of the researcher in creating and interpreting data. "He or she is the research instrument *par excellence*" (Hammersley and Atkinson, 1983: 18; cited by Allen, 1996). The researcher is by no means a neutral research instrument; on the contrary: it is the researcher who has to make research decisions time and again: which facts to take into consideration, who he wants to speak to, and which questions to ask. These decisions are just as much based on personal value systems as on theoretical assumptions. Thus it becomes imperative for the researcher to disclose the values and theoretical assumptions underlying his work, so that it is possible for the reader to examine the reliability and validity of the methods chosen at any time.

In my case this means to reflect on the question of how my own background and experiences as a nurse had influenced the research. Cisnero-Puebla et al. (@2004 FQS) interviewed qualitative researchers on the subject of interviews in qualitative social research. The authors describe the special situation of

conducting qualitative interviews with colleages who were experts in qualitative research: "(…) if we genuinely want to hear, to understand an individual we must provide a way for her or him to speak in a genuine voice. As qualitative researchers interviewing other qualitative researchers, it would not do to simply ask questions and await responses; that would be antithetical to the notion of a qualitative interview: Our goal for the interviews on this issue is that they do reveal the interviewees' stories of their lived world, in their genuine voices" (ibid.).

It was similar for me. My background represents a previous knowledge which made approaching the subject easier on the one hand, but susceptible to bias. In my case I do not believe that it would be basically different if a sociologist had conducted the study since I had been only for a limited time working directly in nursing. In this respect, I always saw myself also as a participant observer. Thus I do not think that the nurses would have told me anything substantially different in their interviews than they would have told interviewers from other professions. Based on my own experiences of being interviewed, an interview with an 'outside' person is different insofar one has to explain a lot that is subject-specific.

The risk of me reading things into the data from my own experience was minimal since the interview data were either checked for agreement and/or by referring to written sources. A further important control to avoid all these risks were personal and formal supervisions.

Human subject protection

In view of the relatively small number of actors – especially in leading positions – preserving anonymity could be a problem. It is obvious that all the names of persons, places and institutions are kept anonymous but this did not offer sufficient protection. For this reason this difficulty was mentioned during the negotiation with the interviewees. They were all the same in agreement that their statements would be used.

Part II Nursing as an Occupation

Chapter Four: Emergence and Constitution of Swiss Nursing

In chapter one, I showed that, in the 19th century, the political governmental structures of Switzerland were formed against the background of a liberal understanding of the economy. The nation state is to intervene as little as possible. This is ensured by the federalist system. In addition, a strong corporativism makes it possible to transfer to the nation state functions and projects declared to be of public interest. The cantons have sovereignty over education and health. The financing is the responsibility of the cantons as well as of the nation state. The sharing of costs between the nation state and the cantons causes permanent political conflict.

At the end of chapter one, we saw that modern medicine established itself around 1900 as a profession and proclaimed the need for qualified nurses.

In this chapter, I will focus on the emergence of the nursing occupation. In the foreground will be the question about which were the powers or authorities that gave the nursing profession its form and function.

In the sociology of professions, the emergenecy of professions is understood foremost as the consequence of the division of labour in the course of the growing complexity of labour in developing countries. The division of existing

professions caused debates about jurisdiction, status, dominance and subordination. In Abbott's (1988) theory, the issue of the continuous division of the professions and as a result the ongoing contest about the position of the professional groups is central. As a rule, newly emerging professions are still subject to the dividing or delegating professions. Abbott and other authors see the emergence of the nursing profession as a consequence of the mechanisation of medicine and also see it as subject to the medical profession (for instance Freidson 1990b, Dingwall 2001).

However, Dingwall (1983) illustrates in a study on the emergence of health visiting in Great Britain that the concept of 'fission' is not sufficient to explain the constitution of new occupations. By introducing the concepts of 'fusion' and 'capture', he accounts for the fact that health visiting represented something new within the official economy.

Or is medicine basically a 'by-product' of the nursing profession and the emergence of the profession an original, autonomous story, as it is frequently represented in the history of professional nursing? Accordingly, Florence Nightingale, Agnes Karll[7], Henry Dunant, Theodor Fliedner[8,] Hildegard von

[7] Agnes Karll, 1868-1927, reformer of German nursing.. Within the *Allgemeiner Deutscher Frauenverein)* (General German Women's Association), Agnes Karll planned the standing rules for the *Berufsorganisation der Krankenpflegerinnen Deutschlands sowie Säugligs- und Wohlfahrtspflegerinnen* (Professionals association of nurses as well as infant-carers and welfare carers), founded 1903. She was the first chairperson of this association.aus.

[8] Theodor Fliedner, 1800-1864, reformer of the apostolic welfareand social office.

Bingen[9], and other charismatic figures would appear to be the founders of the nursing professions, those personalities who had seen the sign of their times and dedicated themselves to their 'project'. Through them, or through their work, the 'essence of nursing' is personified in an exemplary way. Furthermore, from historic models of taking care of the sick from antiquity to modern times, universal core elements of nursing are being developed. In Ancient Greece, diet, the theory of healthy living, is in the centre; in Ancient Rome, it is hygiene, in the Middle Ages, *caritas,* compassion. The development of nursing into a formal profession appears to be the logical consequence of modern medicine where nursing with its historic or universal elements will from now on be integrated (cf. e.g. Seidler, 1966, see Dingwall 2001: 66). The new profession around 1900 is reserved for women. Ideal cases and heroic story are spread in reports, studies, lectures and journals.

"After the profession of wife and mother for which woman has been chosen by providence more than for any other, the nursing profession is certainly the one to give most satisfaction to the mothering instinct dormant in each female heart" (Lindauer1928). Or: "(…) The heart of a nurse always remains that of a person who carries a warm soul inside and permeates all institutions with the pure goodness of her being…" (*Blätter für Krankenpflege,* February 15, 1911:18-19, in: Valsangiacomo 1991:87).

The Swiss Red Cross kept publishing '*hagiographic'* articles on Florence Nightingale, "the heroine of the Crimean military hospitals" or the "queen of

[9] Hildegard von Bingen, 1098- 1179, Benedictine nun, abbess since 1136. Her publications focus on religion, medicine/nursing, music, ethics and cosmology.

the nurses". With the excessive praise of this pioneer, it was hoped to give more prestige to the nursing profession "all the more, since the Englishwoman came from the aristocracy.

"When the well-educated young lady entered this depressive environment (meaning the hospital of Sutari E.V.), her only sacred defence was the modest dress of a young servant, and yet to our wounded soldiers she appeared to be heaven-sent…." (Valsangicomo 1991: 87).

Even if in nursing of the 1970s the ideals of serving and subordination were criticised and rejected, personalities such as Florence Nightingale continued to be seen as an example, now in the light of female emancipation as a woman with courage and initiative.

"All institutions have creation myths, stories about how they began and how they came to be what they are today. Those stories are so much part of the landscape of our culture that we often have difficulty in recognizing them as stories, designed to fulfil an entirely different purpose than that of the sceptical historian" (Dingwall 2003: 67).

As Dingwall shows, creation myths serve specific purposes in the emergence of professions. Such professions for instance need a story to legitimise new functions.

"Whitaker and Oleson (1964) studied the role of 'official histories' in the construction of occupational identities, looking at the ongoing reframing of the biography of Florence Nightingale to legitimize changes in the practice of

nursing. Although this occupation was constantly migrating to new kinds of work within the medical division of labour, its identity was sustained by the manipulation of the powerful cultural symbol of Nightingale's work" (Dingwall 2003:7).

If, on the one side, the creation myths "inspire newcomers and transmit a culture to them, remind established members of the mandate that they claim and serve as weapons in struggles with competitors and with those who control the occupation's environment" (Dingwall 2001:66), on the other hand they have a demoralising effect if the newly trained realise in the practice that they do not have to do the jobs they expected from their training (also cf. Dingwall 2003, 2006). Dingwall (2001) shows with the example of the nursing concept of 'emotional work' that historic embellishment may well steer the politics of the professional group in the wrong direction.

Archetypical images are part of the creation myths. As a consequence, one gets the feeling that nurses have always existed and that one knows how an original, real nurse has to be. Abbott (1988) also uses this concept of the archetype. Similar to Dingwall, he sees the significance of the archetypical images of professions in connection with professional claims. According to Abbott, the public opinion as the place for images is one of several arenas where professions can make jurisdictional claims.

In connection with the traditional emphasis on great personalities in the history of the nursing profession, Rafferty (1996) states in her study on the history of the politics of nursing that, regarding changes in nursing training, historians

have tended to underestimate the role of government and instead to overestimate nurses as leaders.

"Nurses were only ever one of a number of groups ambitious to reform the training; furthermore, they were not necessarily the first or the only group to take the initiative. Nurse education policy was more product of conflict than of consensus, and its implementation was predicated predominantly upon political and economic contingencies. In this respect I have argued (...) that it is in the context of convergence between government and occupational priorities that the implementation of nursing training policy can best be understood. At the same time, though, I have acknowledged other social forces, such as class and gender politics, that also need to be taken into account" (Rafferty 1996: 186).

Rafferty makes it clear that the representation of leading personality is not enough to do justice to reality. Dingwall is of the opinion, that the awareness of the reality on the basis of historic data gives profession a stronger chance than referring back to an imaginary Golden Age.

"All occupational mandates include the occupation's myth. These are the stories that are told to new recruits about the origins of the occupation, about its glorious achievement, its gains and losses in struggles against competitors, its heroism under difficult environmental conditions and its general worth to humankind. To describe these stories as myths is not to ridicule or belittle them" (Dingwall 2001: 66).

Yet a critical examination would much better serve the present of a profession (cf. also Dingwall 2003).

This leads us to the question of how the emergence and the development of the nursing profession in Switzerland can be explained if one goes beyond the mythic tale of the history of the profession. Which interests and powers led to the constitution of the profession? Is it a professional project, possibly one that was prevented, as Abbott thinks about the project of Florence Nightingale in Great Britain since in a field controlled by medicine full jurisdiction is excluded (Abbott 1988:71)? Or was it above all the government interests to newly and differently organise nursing? Did the establishing of the profession result from a process of 'fusion' or 'capture' (Dingwall 1983) or was it primarily about medicine having to delegate tasks?

Around 1900, there were no definite ideas in medicine concerning the medical auxiliary functions which had to be fulfilled and how and by whom they could be taken over. The nursing staff of the time was envisioned working in the institutions but in future to be equipped with the necessary medical specialist knowledge and technical ability. These were catholic and protestant nuns who had an orally passed-on repertoire of knowledge as well as untrained staff.

Thus in 1898, a German doctor wrote an *Anleitung zur Krankenpflege* (Manual for nursing) and had the following to say:

"Only the doctor can precisely judge the qualities of the nurse and can decide whether she is suited for nursing; (…). It will one day appear to be incompre-

hensible that, even at the end of the 19th century, for the major part there were nuns and clergymen, who did not know about disease and treatment, had the first say about the training, the employment and the distribution of nurses" (in: Valsangiacomo 1991: 68f).

In Switzerland it was foremost two private organisations, represented by physicians who realised the idea of professional nursing: they founded and directed two nursing schools which became models for professional education in nursing in Switzerland. They founded the first nursing association and headed it until 1932, and they edited the first nursing journal. The two personalities came from two different institutions and two different political backgrounds. Anna Heer represented one of the first major women's organisations, the *Schweizerischer Gemeinnütziger Frauenverein* (SGF) which represented the middle-class women. Anna Heer upheld the convictions adhered to ad the 'Conference for the Interests of the Women' 1896 in Geneva (*Kongress für die Interessen der Frauen*) concerning the significance of female welfare and volunteer work for charity. She thought that nursing as a new occupation was an important duty to society for Swiss women. Walter Sahli represented the Swiss Red Cross and thought that this new occupation was a good solution in both senses to fulfil the actual dual function of the Red Cross as defined by Henri Dunant, which was to be professionally prepared for war and at the same time to respond to the needs of the medical profession which at that time expressed the need for professional support in the emerging modern hospitals. Heer and Sahli agreed on the principal ideas about what kind of occupation nursing should become and what was needed to realise the project – that is, a

solid education, professional organisation, and a journal. Eventually, it was the Red Cross which became the leading and finally the regulating institution in Switzerland, while the SGF retired into the background.

The question here is why the Swiss Red Cross aimed at assuming the key role in the sector of vocational training. From its very beginnings, its main objective was preparation for war and this primarily involved "improving the status of health care in war and peace" (SRK-statutes dated April 25th, 1882). Translating this goal into practice was initially very difficult because concentrating on preparation for war proved not to be a method that held wide appeal, and neither did focussing on health care seem to be a successful strategy at first. The person who brought about a change was Walter Sahli (see chapter one) who suggested different procedure: "The SRK's main objective – preparation in case of war – should be pursued with methods that would generally also be recognised as social achievements in times of peace" (Fritschi 1990:67). That is why Sahli suggested establishing a nation-wide organisation of professional nursing.

"By choosing nursing as the most important civilian area of work, the SRK succeeded in correcting its image which – as Sahli had predicted – was a turning point in its development. Civilian health care was increasingly seen as 'a work of brotherly love under the sign of the Red Cross', thereby suppressing the militaristic origins and the main mission of that organisation in the minds of the general public" (Fritschi 1990: 69).

Evidence of the successful translation of this concept into practice is the founding of various new nursing schools in different places in Switzerland and the implementation of corresponding training concepts under the auspices of the SRK. Mention should be made of the fact that the Red Cross as a private organisation made this area of occupational training its business, similar to other areas of vocational training, where it was organisations connected with industry and commerce that began to be in charge of professional training programmes (cf. chapter one). All of these organisations – the Red Cross included – had to make it their business to be commissioned by the state to do so and - if possible – to obtain the financial means to be able to fulfil this task.

According to the constitution of 1874 the duties related to the public health care system are not under the control of the federal government. Medical care, which in the course of the 19th century was increasingly acknowledged as a public responsibility, therefore was the domain of the communities' and the cantons' administration. However, these authorities were so overtaxed, due to the strongly increased and fundamentally changed demand for personnel, by this responsibility that the SRK tried to find a nation-wide solution for all of Switzerland. The question had to be solved

"what kind of interests were the ones that paved the way for a general advancement of professionalised nursing despite the fact that there were no constitutional guidelines on health policy. The corresponding debates that ensued in the government and in the general public throw light not only on

their understanding of health care, but also on the expectations the statesmen had of the role of women and their duty to the nation" (Fritschi 1990: 79).

In a petition to the Federal Council in 1900, Sahli suggested that the federal government should recognise the SRK as the sole organisation to be allowed to assist the army medical services in caring for the sick and injured in case of war. As a countermove he committed the SRK

"to making an incessant effort to sign contracts with doctors who were not commissioned by the army, with organisations in charge of medical care (facilities run by religious orders, nursing schools, etc.), and with individual care providers in case of war, and thereby remaining responsible for the provision of part of the trained nursing staff." (Fritschi 1990:82).

In accordance with the new image the SRK wanted to project, he also suggested not simply adding the requested subsidies to the budget without any special mention but rather bringing them into parliament by introducing a bill and a corresponding communiqué. "In this way the matter can be discussed 'in public' and the public can ultimately be asked to directly take part in the efforts of volunteer help, as an eminently patriotic and social-minded enterprise and for the support of the Red Cross" (Fritschi 1990: 82). The Department of Defence prepared corresponding communiqués.

In a first attempt, these communiqués of the Department of Defence failed due to the resistance of the Cabinet, which – apparently due to financial constraints, as the management of the SRK criticised (cf. Fritschi 1990:85) – turned down

the applications for subsidies. The SRK then directly filed a "petition regarding the augmentation of the military medical corps in case of war" in Parliament as did the 'Swiss Non-profit Organisation of Women' (SGFV), which had been collaborating for some time with the SRK on this issue. The Cabinet sent both bills for assessment on to the Department of Commerce, which in turn requested compliance with the Department of Defence's request 'regarding the training of nursing staff'. The decisive factor was that the Department of Commerce fully supported the arguments put forward in the petition: "(...)better training of free nurses is an absolute necessity for our fatherland for economic reasons in general and for cases of epidemics in particular, as well as in war time" (Fritschi 1990: 86).

On June 25th, 1903 both the Senate and the House of Representatives unanimously passed the 'Federal resolution dated June 25th, 1903 regarding voluntary medical aid for war purposes'.

"This resolution gave the SRK the recognition and support of the federal government that they had been hoping for so long. Similar to the so-called top business associations, the SRK succeeded in establishing itself as a top provider of volunteer medical aid and health care. In the years to follow, it was to become increasingly independent of the federal government – financially as well as ideologically – and instead ranked as a semi-public organ" (Fritschi 1990: 92).

Apparently the military argumentation in the Federal Council alone was not enough. Only once it was formulated more generally and more 'medically',

was the attempt approved. The formal linkage with the national military medical service is a corporatistic solution which is so typical for Switzerland.

However, the Swiss Red Cross still had a long way to go until the final recognition as the only state authority for the regulation of nursing education and eventually of all other health professions. As a next step after the resolution of 1903 the initiators of the first 'free' nursing schools founded and directed the first nursing association. The aim was to further nursing as a civic ('free') modern occupation and to generate a formal difference between qualified and nonqualified nurses.

What did Sahli envision? While head secretary of the voluntary medical service, he had become aware that the nursing personnel needed in case of war would not suffice by far and he stood up for an increase and above all for an appropriate training of nursing personnel. He saw in this an excellent possibility to establish the Red Cross in the population with the help of a meaningful activity during times of peace:

"The Red Cross needs (...) a major task, an extensive activity during times of peace. (...) Not only in the murderous war, no, also during the much longer times of peace, in the days of illness and sorry where people are particularly open and grateful for kindness and friendliness, the Red Cross should stand guard" (Sahli, Walter, 1903, *Das Schweizerische Rote Kreuz und die Krankenpflege,* special publication from VIII. *Jahresbericht des Schweizerischen Zentralvereins vom Roten Kreuz*, Bern, p. 5, in: Dätwyler and Lädrach 1987:52).

It was an important concern for Sahli to support the free nursing staff. In his assessment, the confessional associations of nursing had been deprived of the features of professionalism by considering nursing to be exclusively a Christian labour of love[10]. But the modern demands of the population and, above all, of medicine urgently required a change of thoughts. For Sahli, definite possibilities for improvement lay in the training tasks, in the organisation of job opportunities and in a union of the free nursing personnel. Thus in 1899 the 'Red Cross Nurses' School' associated with the Lindenhof private hospital was opened in Bern. In 1901, an employment agency was affiliated with the school, and in 1910 – together with Zurich – the *Schweizerischer Krankenpflegebund* (Association of Swiss nursing) was founded.

The *Schweizerischer Gemeinnütziger Frauenverein* (Swiss Charitable Women's Association) also committed itself to the improvement of the nursing training – and this some years before Sahli (Valsangiacomo 1991:88ff; Dätwyler and Lädrach 1987:44ff). Upon its initiative, as early as in 1894, the training of nurses was made part of the programme of this association. The most competent advocate of the nursing issue in the association was the doctor Anna Heer. She firmly fought "for a better training and suitable placing of those nursing professionals who, 'not belonging to any religious order, practice the nursing profession out of their own pocket and on their own responsibility'" (Dätwyler and Lädrach 1987:45) Anna Heer had definite ideas

[10] Walter Sahli was familiar with the fierce debates in Germany concerning the medicine's claim to leadership (cf. Kruse 1987)

how the training would have to be structured: “First there was an ‘in-depth and controlled professional training’ of nurses, taking into consideration when selecting the trainees their character, intelligence and schooling (secondary school)” (Dätwyler and Lädrach 1987:47). Heer also saw the necessity to found her own Nurses´ School, together with her own hospital. And finally, she fought for the improvement of the social position of the nurses, which she thought required the forming of a union.

Like Sahli, Anna Heer saw her ideas translated into practice: In 1901, the Nurses´ School was opened in Zurich and she realised her other concerns together with the SRK after she had in the meantime made the acquaintance of Walter Sahli.

This meant that the first milestones in the formalisation of ‘free’ (not related to a specific religion) nursing were reached. We can note that the establishment of the nursing profession is the result of the common interests of various groups. A first leading group is the medical profession which took up the – in Germany strongly debated – demand for a secularisation of nursing and was able to implement it without noticeable resistance. Another interest group is the Swiss Red Cross which, at the end of the 19th century, had difficulties to legitimise itself and was suffering from a dwindling number of members. Sahli saw the training and supporting of nursing personnel as a new base of legitimisation for the Red Cross. The third interest group is the bourgeois women´s movement which thought nursing to be an ideal task for bourgeois women. With the leading figures of Heer and Sahli, it was possible to combine all the interests

and submit them to the nation state as a bundle of requests. It must be noticed that the government gave the supervision to the Red Cross and not to SGF (which in view of the missing women´s right to vote would have been difficult anyway).

There is no doubt that medicine, or the progressing mechanisation, was the driving force for the request for qualified medical auxiliary personnel and thus for the abolition of the catholic and protestant churches' leadership in nursing. It is possible to see the foundation of professional nursing as a professional project of medicine according to Abbott's theory (1988), or of the permanent jurisdictional changes within the system of professions. But it cannot be ignored that it was the government which determined if and how and by whom nursing was to be regulated. With the solution decided upon, issues of national importance such as epidemics or war as well as the liberal principle were taken into account since the Red Cross was not given more than an indirect influence on the training of the nurses.

In the view on the history so far, those concerned are missing, the nursing personnel. At the conference in Geneva, Anna Heer talked about the existent personnel as well as about the state of the training at the time which urgently needed to be re-organised (Dätwyler and Lädrach 1987: 46ff). One of the measures was the foundation of a union for the personnel who were intended to not only improve the employment conditions but also the degree of the training. Heer and Sahli initiated the foundation of the *Schweizerischer Krankepflegeverband* (KPB) in 1910 as an umbrella organisation of regional

nursing associations. Until 1931 the chair was held by doctors. Because Swiss law did not allow the licensing of nursing by a state exam, the association (*Krankenpflegebund*) itself initiated an exam for persons who had been working as a nurse without a formal education. The exam (*Bundesexamen*) was a crucial solution for the implementation of the new occupation as well as for the discrimination of qualified and nonqualified personnel in the field of health care, since this exam created the possibility to reach formal qualification as a nurse without going through the three-year training in a boarding school. In this way, women who had been nursing for years or those who could not afford being trained in a school, were able to fulfil the increasing demand of a recognized qualification. And, at the same time, the Red Cross and the professional organization could support their request for the standardisation of professional nursing (cf. Dätwyler and Lädrach, 1987: 68ff).

The *Bundesexamen* existed from 1913 to 1947. It was also the nursing association, which accredited the nursing schools. The cantonal governments as well as the medical association (FMH) supported this solution.

In 1927, leading nurses discussed membership in the International Council of Nursing. It became clear that the Swiss association failed to fulfil one condition of membership. The ICN required self-government of the national association. This issue led to the division of the association. The recognised nursing schools founded a new association, the Nationalverband, in 1936 and were affiliated by the ICN.

From this time on until the amalgamation within a new association, the *Schweizerischer Verband diplomierter Krankenschwestern und Krankenpfleger* (SVDK) in 1944, the surveillance and accreditation of the nursing schools was increasingly questioned by the Red Cross. In the *Krankenpflegebund*, they had differing opinions since the discussion was simultaneously about the issue of the abolition of the *Bundesexamen*. There were those who were strongly in favour of keeping the supervision of the train as well as the *Bundesexamen*, while other, for example Lydia Leemann, matron of the Zurich Nurses' School, thought that the exam was outdated and that new regulations were needed. The Red Cross administration decided to take the regulation of nursing schools in its own hands. By the first directives concerning the accreditation of nursing schools in 1944 the regulatory authority had passed to the Red Cross. At the time, the examining commission consisted exclusively of doctors. This process reached its final form with the convention between the Red Cross and the Cantons in 1976 (Valsangiacomo 1991:401-411).

Within the sociology of professions licensure and control over knowledge, schools respectively, counts as a crucial characteristic of professionalism and thus represents an endpoint of the professionalisation process. Interestingly, in the case of Swiss nursing licensure and control over knowledge by the professional association stands at the very beginning of nursing as an occupation. The association accomplished even a national state exam. In the course of the debates between the representatives of the union and those of the Red Cross, both licensure and control over knowledge passed over to the state. The professional group had lost its position as licensing institution and, for the time

being, given up their attempts at a professional project. In all this, however, we must not forget that the association was not only in the hands of the nurses.

At the end of this phase, nursing as an occupation or profession respectively was implemented and the Red Cross had a monopoly position in the training of nurses and at the same time had also achieved corporatist status. The new occupation was recognised as an attractive modern occupation for women. And the Red Cross maintained its leading position in nursing.

In the middle of the last century, nursing was an officially recognised occupation as an auxiliary medical profession. As stated at the beginning of this chapter, within the sociology of the professions nursing as an occupation has always been associated from its beginning almost exclusively with medicine, the relationship of dependency respectively, (see e.g. Davies 1976; Dingwall 1983; Freidson 1990b; Davies 1995; Dingwall and Allen 2001). This can also be confirmed by Swiss nursing.

At the beginning, I asked the question whether the emergence of nursing in Switzerland could be seen under the aspect of the concepts of ‘fusion’ and / or ‘capture’ (Dingwall 1983). In the next chapter, the interviewed nurses will show us that this interpretation corresponds better to their work than to view it exclusively as either the result of delegation of medical tasks (Hughes 1971) or division of labour work.

At the end of the millennium, the question of EU-compatibility arises. The fact that the diploma training course can only be started at the age of 18 but is not

clearly considered to be a tertiary education is cause for the reform of the education system still going on today and creating quite a stir.

With the reform of the 1990s aimed at integrating the care training into the general education system, the SRK in its private-state function becomes obsolete. The nursing training – like the other professions – is to be integrated into the market economy. The process proves to be difficult since the question of the employer is different if nursing training is state-subsidised and regulated by the cantons.

Chapter Five: The Nurses' Bundle of Tasks

After we have seen in which political structures and processes nursing was constituted as an official occupation around 1900, this chapter is intended to give an inside view. What does it mean to be a nurse?

On the one hand, even before the reform initiated by the Red Cross and the Women´s Association, there had been women who worked in nursing, as Anna Heer pointed out in 1896,

"Deaconesses and Sisters of Mercy who in most cases have enough training and make up for any deficits in general knowledge with the willingness for sacrifices and dedication to their job which is already required by their religion. A good part of hospital and private nursing (Community Nursing, *Gemeindepflege*, BD) is done by them" (Dätwyler and Lädrach 1987:46).

Then there were the so-called *Lohnwärterinnen,* the paid caregivers. Anna Heer: "(…)

We have regions (…), where the sick are being taken care of almost exclusively by complete laypersons, former nannies and similar people who know little and talk a lot" (Dätwyler and Lädrach 1987:46).

Anna Heer regretted that it was often no more than a coincidence that nursing was professionally practiced such as by nannies or 'unsuccessful wives'. On the other hand, with the federal decision of 1903, the nationally supported

reform of nursing meant a new kind of training, new schools and the organisation of all qualified nurses in a union.

My interest is now focused on the question of how the nurses themselves experienced their profession and its development. Whether they – explicitly or implicitly – had a professional project as their goal. If so, what would it look like? What was important for the nurses, which were their aims?

Thus, in accordance with my original research plan, I was trying to find out whether the nurses had a professional project. I looked into the issue by analysing of interview material. As a frame (Appendix 2) for the analysis of the data, I used Larson's theory of professionalisation (cf. Macdonald 1995:32). Do tendencies towards professionalisation appear – and if so, how?

Data

In 1991, eleven senior nurses were interviewed about their professional lives between 1945 and 1980. The aim of the interviews was to gain insight into work that dated back as far as possible.

Four of the nurses interviewed are from the educational sector, six from the management sector, and one from both sectors. Two of those who had been working in the educational sector were matrons, one was director of a school for further education in nursing, and two were teachers. The group who had had careers in management were senior officer nurses.

Three members of the sample were religious-order nurses. One of the nurses was male.

These eleven interviews are part of a total of 30 interviews conducted in the context of a research project on the social history of nursing. All of the respondents were trained nurses.

The interviews revealed that those nurses who had been dynamic and committed to their jobs had to take on executive-level positions. The fact that only nurses in higher-ranking positions were represented in political committees means that active change – if placed in the hands of health care professionals – has exclusively been effected by nurses in high-ranking positions. In other words, aspirations towards professionalisation are to be found in this occupational category.

All the same, the profession as a whole must be kept in mind. Therefore, the statements made by high-ranking nurses will be compared to statements made by the entire group studied in certain cases.

Three steps of analysis arose from the theoretical framework and from the material collected.

1) In a first step, the interviews were evaluated using concepts based on the main categories of Larson's theory (claiming group, work, trust, knowledge state, closure/monopoly, public, and market).

While the categories work (including work conditions) and topics of knowledge were particularly frequently mentioned, statements concerning public, market, state and trust represented a clear minority.

2) In a second round, the content of the statements was assessed as positive, negative or neutral.

The respondents assessed most of the statements as either negative or positive/neutral.

Negative associations: atmosphere, employer, fear, stress, illness, food, housing, material, occupational classification, opposition, non-autonomy, salary, social insurance, superiors/hierarchy, working hours.

Positive and neutral: Caretaking

Positive aspects: improvements

The respondents spoke about their experiences from a present-day perspective while basing their reflections both on present and former norms. They are completely aware of the fact that their descriptions of the situation of the nursing profession at their time would appear like a catastrophe today. At the same time, they keep the conditions of the time in mind, in a general way and especially concerning the state of development in medicine and the nursing profession. Thus the interviewees express neither bitterness nor regret, nor do they gild their past (compare chapter four).

As next the nurses' statements assigned to the category of work will be analysed. I focus on this category for two reasons: first, because it was the most extensive, and second, because the work performed by the professionals is regarded as a basic concept for the analysis of the professions within the sociology of the professions. For instance, Abbott claims that his theory should be an alternative in that it reverses the problematic assumptions of professionalisation theories – it begins by focusing on work, not on structure. "The central phenomenon of professional life is thus the link between a profession and its work, a link I call jurisdiction. To analyse professional development is to analyse how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual professions themselves" (Abbott 1988: 20).

Similarly, Freidson states that an adequate theory of professionalism must begin by building a foundation on the analysis of work, for it is work, and the control of work, that must form its core (Freidson 1994:3).

Work

What did the nurses do? Who ordered what was to be done? What were the nurses' interests?

In the first step of the analysis of the interviews, I tried to distinguish the statements which described the content of and statements which concern the work conditions in order to be able to organize the statements given.

The following few statements shall illustrate that the actual work done by nurses and their work conditions is closely interconnected. Work content, medico-technical developments, work load, working hours, spare time/recreation, wages, board and lodging as well as socio-psychological norms are integral parts of a distinct entity. The workplace was determined by the school or the religious order. The work schedule required the whole person, the nurses lived in the respective institution, professional and the private life were one and the same.

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After graduating from nursing school, I was transferred to C. (a sanatorium in the mountains for patients with tuberculosis). They told me it would only be for a few months. But I ended up having to stay there for three years. But I had to go up there for the first three years because I was still under contract with the 'mother house'.

And when I got up there by mail coach – I arrived at about half past five, they told me to go straight into the ward and to get to work.

I shared a room with another nurse. And there were no nurses on duty at night. We had to put our patients' bells into our rooms and if they rang for us, we had to go and see what they wanted.

Some of the patients there were very ill. First I worked in the medical department and after a while I was put in charge of a unit for severely ill patients. (...) We started at 5:40 a.m. and worked through until lunch-time. I was in charge of 37 patients. Some of them were able to get up and get dressed. But a lot of them were terribly ill. I had a very difficult ward there. (Interviewer: Were you alone?). Yes, I'm glad you asked that question. There was no trained nurse on duty at night and the first kind of help we

got was a nurse's help in charge of four floors. She helped us out as best she could but she had enough to do herself. But the girls brought the patients their meals. It is not the same sort of work as you do in a hospital. And with time we had to get up so often at night, we had to take care of the most serious cases of lung bleeding, fatal ones and all, and we had to stay awake before and after operations, we had to sit and wait, before operations until 1:00 a.m. and night duty lasted until morning. And then we had to work full-time the next day. And then (...) we just couldn't keep that up any longer. So then we said that we would like to have a nurse instead of a nurse's aide for the night shifts so that we could at least get some rest. But it had to be a nurse. And naturally, they employed a young nurse for the job. That was obvious.

So coming back to the question about working hours (...) we worked until 1:30 p.m. and then we were off until 3:30 p.m. that was the time of day when the patients rested.

But we had to take the buzzer up to our rooms. And when we went out like when we went shopping we had to ask a work-mate to listen in case anyone rang for us. We didn't have an official lunch break.

And then we went back to work and worked until we officially got off at 10:00 in the evening. But I often stayed until 11.00 p.m. because I cleaned up. We had to do the laundry ourselves, get everything ready for the following morning, and sometimes a patient rang for something or there was something else to be done. So it was very strenuous in C.

And working on surgery was very hard too.

Later on I was transferred to surgery and I had to take care of the first patients who had had lung operations, in other words, the first segmentomies and pneumonectomies. I cared for these patients because I was so experienced in treating

lung patients. At first we only had thoracoplasties and then new operations were introduced by Professor B. from Zurich. And I (...) as there was no intensive care unit I had those patients in the same room as the patients from the other departments as well. But that had to be stopped, they had us in charge there for the whole day and eventually another nurse was assigned to the ward. We were under a lot of pressure. The patients were seriously ill, those who were not very ill did not undergo that procedure. They were told that it was their last chance. Maybe they'd survive and maybe they wouldn't. But it was very interesting and it was a matter of trust between the doctor and the nurses.

(I: How was the working relationship between doctors and nurses?) We had a very good one. Yes (...) I must say he sometimes trusted the nurses more than his interns who didn't come from this area of the country and just wanted to get some practical training. We, on the other hand, had been in the mountains for quite a number of years.

And up there in C we sometimes had to move the beds out onto the balconies, to make the beds outside in winter, and the patients used to even sleep outside in winter if they wanted to.

0602/58

(I: What about your private life? At the beginning you didn't have any. What about later on?) Well, we worked until we collapsed. We never would have quit. We couldn't have anyway. I mean when there was a patient who needed us, that was our duty. And we didn't mind. No. We liked doing it. Yes, because we enjoyed our work (I: Yes, that's it. You were totally committed to your job.) Yes.

0206/56

And then we got paid for some of the extra work we did. But it wasn't anything like it is nowadays. Yes, and also if I think what it was like when we were ill (...) oh my goodness, they didn't contribute anything towards our health insurance. And our salaries...we earned Fr.120.- a month and that didn't include room and board. But at that time you rarely had a room to yourself. You almost always had to share it with somebody else (I: But that eventually got better, didn't it?) Yes, yes. Whenever we were lucky enough to get a whole day off at a time. We were never allowed to sleep long. And at that time the nurses were very overtired and were very susceptible to disease.

Basically, this period was still dominated by the so-called 'mother-house principle'. This means that the nurses were under a lifelong contract with their school, the 'mother house', which in turn had contracts with the institutions (hospitals, homes, communities) regulating number of nurses, their functions and work conditions. The matron of the school decided about the nurses' place of employment and her respective position. In return, the school guaranteed medical care in case of illness and housing in old age. In the case of the interviewees, only the three nurses from a religious order worked under the strict rules of this system. Nevertheless, the so-called 'free schools' also worked according to similar principles. In any case, the nurses lived in the hospital, too. The nurses had to assume three different social roles: they had to educate, supervise and provide guidance to their pupils. Although under private contract, trained nurses were appointed more or less explicitly by their own school.

Both Walter Sahli and Anna Heer, the Swiss Red Cross and the *Schweizerischer Frauenverein* respectively, had adopted the 'mother-house principle' in their own new schools. Nursing education as a model was basically built on this principle until the recent educational reform. It was only in the seventies and later that the function of the matron as head of both nursing school and nursing service was divided into two functions, redefined as director of nursing and director of the school.

Nurses used to live on the hospital premises up until the 1970s. In the 1940s they often only had a bed in a hospital room that they shared with other co-workers. The amount of rest and sleep they managed to get was dependent on their job. From the mid-sixties, hospitals built staff housing providing a certain degree of privacy. Besides the fact that nurses never could have afforded having a place of their own, they never would have allowed themselves to do so anyway nor would their working hours have enabled them to live off-grounds. Staff housing was often located in a pleasant neighbourhood, such as at the edge of a park on the hospital premises. It took another ten years until nurses' working hours and wages had improved to such an extent that they could have afforded to rent an apartment of their own. Male nurses were allowed to live off the premises after they got married. Their salary was increased accordingly.

A study conducted by VESKA and the 'Secretariat for Nurses of the Swiss Nursing School' in 1944 reveals the following information:

"Of 5738 day nurses in 24 hospitals (eight of which are nursing schools), 2865 of them live in a room that has one bed, 1956 have two beds, and 283 have 3 beds in their room respectively; in 33 hospitals, 12 of which were nursing schools, nurses sleep in 4-8 bed-rooms. Of the two hundred forty-nine night nurses, 209 live in single rooms, 36 share 2-bed, and 3 have 3-bed rooms. Two hundred twenty-five nurses did not answer the question concerning housing.

Respondents specified the kinds of rooms they slept in as night nurses as follows: 'a quiet room', 'an attic room', 'extern', 'nurses' day office', and 'an own' could not be taken account for everywhere. All the same, the fact that two-thirds of night nurses today have single rooms may be regarded as significant progress compared to the living conditions nurses used to have.

The VESKA Commission is aware of the wide range of problems involved in providing single-room accommodation to all accredited nurses. On the other hand, the commission knows that nurses desperately need to relax and rest in a congenial room of their own after having been on duty which is both physically and emotionally strenuous. What would other professionals such as teachers say if they were expected to share a room with others? We regard the nurses' wish for a single room as legitimate and justifiable" (Leeman 1944:6).

Nurses who lived in and for an institution were an optimal workforce both for the hospitals they worked for and the physicians they worked with: their 24-hour presence could be taken for granted at minimal wages. The interviewees' reports about board and lodgings, salary, free time, and recreation clearly reflect this situation.

Living in the hospital meant that nurses were socialised into a professional life which encompassed every realm of life. The reports by the nurses on this subject are positive as well as negative.

As regards the general situation of the nurses, we should keep in mind that, first, most of the interviewees were trained during or just after World War II. Although they hardly spoke about the implications of the war, they primarily expressed gratitude and modesty in a general way. In the later 1950s, medical and economic progress created increasing quantitative and medico-technical demands on them. Second, that women in Switzerland at that time were far from attaining the right to vote.

Before we let the nurses have their say, four theoretical remarks should be made.

1) Both the Swiss Red Cross and the *Schweizerischer Frauenverein* replicated the 'mother-house principle' in their own new schools. Training in nursing basically followed this principle until the recent education reform. It was only in the seventies and later that the function of the matron as head of both nursing school and nursing service was divided into two functions, redefined as director of nursing and director of the school.

Where the structure is concerned, 'free' professional nursing combined forms of organisation of the religious orders (community, hierarchy and obedience) and the professional auxiliary functions, above all in the hospitals. Following Freidson's (1978) subdivision of work into various categories of the economy,

modern professional nursing in Switzerland would be a mixture of formal and informal occupations, with not too small a portion of 'subjective occupations'. According to Freidson, in addition to the official labour force, which consists of official occupations, there is a series of forms of work or professions which, although they do not show up in the official economy, still contribute to the economy, such as for instance smugglers or housewives. In the Swiss setting, the nurses within the structure of an internal religious order provided 24/7 all-round service. Whereby the 'subjective occupations' are characterised by the fact that they are not practised for money (Freidson 1978:4). In the initial years, we find a series of articles which vehemently stress that the nursing profession was characterised particularly by the fact that it was not practised merely for the salary but because of an inner impulse (cf. Dätwyler and Lädrach 1987, Valsangiacomo 1991).

Dingwall (1988) states that, in England, the structures of nursing were modelled on a Victorian household with the corresponding hierarchies and functions. The model of the 'mother-house' coincides with this where the tasks are concerned, but there are higher expectations regarding community, obedience and selflessness.

2) Integrating the nurses' medical competence into religion-specific organisational structures and the integration of the nursing nuns into the new structures of training and practice appears to be a central and characteristic feature in the development of professional nursing in Switzerland. However, the 'trench fighting' of German nursing between those profes-

sionals which were organised in a religion structure and those which were secular and organised in a union (cf. Kruse 1987) did not exist at the political level in Switzerland (it did indeed exist in everyday practice, as the interviews show).

The significance of the share the religious orders had in the constitution of the profession must not be underestimated, since it implies an inner distance to medicine due to the Christian, ethical and moral ideology of the order – the Christian concept of nursing represents a different world from that of the medicine of natural sciences and technology (cf. in the following the statements on ethics). With reference to Herbert Spencer, Dingwall (for instance 1995, 1996, 2004) assigns central significance to the aspect of religion for the professions. "Professions are not only the bearers of scientific knowledge, they are also, in effect, the secular guardians of the sacred, the priesthood of the modern world" (Dingwall and King 1995:18 in Dingwall 1996). Could it be this – older – part of the construction of the modern medically-oriented profession which the society as well as the nurses themselves basically sees as their origin and from which it builds its claim to professional status?

3) Getting back to Dingwall's (1983) claim that the concept of 'fission' (according to which the occupation of nursing is understood as delegated medical tasks) is not enough to explain the emergence of occupations. It is obvious that professional nursing in Switzerland contains both, 'fusion': an amalgamation of life form and the culture of religious orders and trained

medical assistance. At the same time, as we will see, this new occupational construction 'captures' the, at that time, existing forms of nursing (see above *Lohnwartsystem*).

4) To the extent that the schools, or the matrons, were responsible for the training, at first glance the profession seems to have control over the work – which is the most central characteristic of a full profession. However, where the curriculum was concerned, they were subject to the administrative board of their respective institution, as a rule of the hospital and the Red Cross. This higher administration consisted mainly of doctors. And with this, the structure of the new profession of nursing really corresponded to the nursing project as it was described in the preceding chapter. A corporative project of medicine and of the state, represented by the Swiss Red Cross, shared and supported by the civic women´s movement.

1. They could call us at any time

Sie konnten einen jederzeit holen 305/ 31

Work conditions

When we try to assign the statements on work rather to work conditions than to the content of work, the nurses' accounts concern primarily their housing within the hospital. They described the quality of both accommodation and food. Beside wages and working hours, work place and function as well have

to be regarded as parts of their working conditions because the nurses could rarely make their own choices about these issues.

In the following section, various aspects of the nurses' work conditions will be described. From the outside, one cannot help but notice the economic aspect: unmarried career women who lived where they worked was an extremely cost-effective solution since salaries – being women's salaries – were low and the number of jobs available could be kept small.

The reports by the nurses take us into a seemingly closed world which functions according to prescribed laws. The nurses say that life in this world was hard and stressful but also challenging and interesting.

Davies laments (1995), that the organisational structure of nursing is just the same: nursing is an organisation of itself within a superior organisation. That was why it could not gain significance and status. The concept of profession would be fundamentally gendered and, for that reason not applicable for women.

Witz (1992) sees professions as a male concept. As a rule, a professional could rely on being supported by women privately as well as professionally.

Abbott's system of professions, or the processes within this system, in a certain way correspond to the nurses' situation. Although professional nursing at the time cannot be seen as a competitor for full jurisdiction in Abbott's sense.

Now I would like to let the nurses speak. Let us follow their account of their professional lives, let us try to understand their point of view. I report all the aspects which have been mentioned. To make for easier reading, the statements are grouped according to their content.

Housing

Boarding was reported by the interviewed nurses to be a stressful experience even though most of the respondents accepted it as a typical feature of their profession.

0201/32

I couldn't visualise living as a boarder for my whole life. I didn't much like having a room which always smelt of tooth-paste because of the sink was in it. (I: And it only would have been possible not to live on premises if you worked in the out-patient clinic). At that time, yes. The head nurses had to live on the grounds as well. They might have had two rooms but at the beginning of the 1950s everybody still had to live on the premises.

207/16, 17

We shared a room in the school building with two or three other nurses. And God beware that you were on night duty. Everybody came to our rooms in the daytime. So that was a disadvantage. (...) Nowadays you couldn't offer that as an option to nursing students. That would be a catastrophe. They would go out on to the streets and strike. But at that time (...) we were young and we didn't know anything else and somehow we enjoyed it.

0306/53

I lived there too. I ate at the hospital for 43 years (...). At the beginning I slept in an attic room. First, four of us shared a room that didn't have a sink. We couldn't even make ourselves a cup of tea or anything. We never got any time off and we weren't allowed to have any visitors.

0207/16

And of course on the top floor where the wards were, up in the attic or someplace we had a room with some sort of sink in the hall, that was our bathroom. If we wanted to take a bath, we had to go down to the first floor to the patients' bathroom. Well, nowadays young people would say that that was out of the question. But I have to admit that the situation didn't strike us as particularly unfair at the time. Sometimes when we see each other nowadays we talk about these things. Then we say, "Can you remember (...)" But it was nothing special for us at that time.

Food

The interviewees did not talk much about the food they were served. It was merely part of their work conditions and it was only mentioned in connection with a particularly bad experience.

0603/5

(...) But the food there was miserable, absolutely miserable. We had to eat in the dining-room. But we sometimes got there late. We didn't have teams at that time. There was only us, night and day, they hauled us out of bed if there was an emergency (...) But then, the food. Firstly, if you came late, the food was cold. Nobody warmed it up for you. And when we had a normal meal there it sometimes happened that notes from the unit for patients with infectious diseases were to be found on the vegetable

platters or on our plates. There were often wood-lice and bugs in our food, sometimes even pieces of glass were to be found who knows why. And pebbles and anything else. It was disgusting. I lost 15 kilos within one year. We had to buy ourselves food from the little money we had. But whenever we had to get up at night there were always something to eat – because of the doctors on duty. They always served us corned beef for years and years. And in the afternoon – we often didn't make it to afternoon tea or only when it was already very late – there were two bars of butter for all 5 of us. And one of the pieces belonged to the head nurse because she had once had to go to a spa for a cure. And she shared it with us, two bars for the five of us. (...) Yes, they didn't want to (...). That was after the war. There were shortages in the hospitals: there was little food and little money around.

While many of the conclusions about the specific boarding situation seem credible (leisure time to recuperate from work, living on the premises for practical reasons), yet in the following quotations the aspect of pure discipline shines through.

0603/21

And eating (...) very little time was reserved for eating. The head nurse dictated the rules and we had to take our knitting along. When we finished eating the little we had been given, we had to get our knitting out and start working. And at precisely 12:30 she got up and uncovered the food.

35 If we had time off, we weren't allowed to eat in the nurses' dining room in plain clothes. We had to eat all by ourselves in the tea kitchen.

Free Time and Private Life

Nurses' free time was at the employer's disposal. Nurses were not supposed to have their own lives. The boarding-school situation served as a method of controlling their way of life and thus exerted a strong influence on socialization.

Days or hours off and vacations were decided ad hoc. Your free time was determined depending on the amount of work there was to do.

0502/10

You couldn't really go out in the evening. Neither to a concert nor anywhere else. We never had time off except on Friday. And the order was given beforehand that we couldn't leave the premises. That we had to stay in the hospital, our day off was supposed to be used to rest. But I went home all the same (...) I was always home-sick as a child.

0206/27

All of the teachers used to live on the fourth floor where the department of physiotherapy is situated now. That way we were there if anything would have happened at night or whatever. And I used to live in this small room on the left and my office was on the right hand side in the old school building. (I: So you were in control to some extent due to the way the rooms were arranged). Yes. And we used to occasionally go and check - sometimes Sister H., one or the other nurse went to check if everything was in order. If the sinks were really dirty (...) (laughs). Once somebody happened to come along while I was cleaning and I said I'd like 50 Rappen (half a Swiss Franc). (laughs). And we never used to have keys. I was the only one who had a

key to the house over there. And if somebody came late, I had to go to the office to get the key. That wasn't very practical (...) (laughs).

0207/32

And as long as we were on a ward, somebody came and told us that we would get the following off. Yes (...)(I: Such decisions were taken at the spur of the moment). Yes. I remember well when we got to N. how Mother E. stood up and said "You there at the end of table E, you're going to N. tomorrow, aren't you? So I packed my things and went to N. (I: You were not informed?). I have no idea. The same thing happened with my holidays. She used to tell me that I could leave for vacation that very day. "You're off from today on." Yes, that's right. (I: What was that like? You were not so young at the time?) Well, inwardly we talked back. Of course, we talked back too even if everybody talks about the young people nowadays talking back. We also opened up our mouths. But we did so in silence, we didn't dare to do so otherwise.

Working hours / workload: We just worked

At that time, work permeated every aspect of nurses' lives. Their work and their private lives were inseparable. But the fact that they experienced their long working hours as very stressful is why improved working hours have retrospectively been regarded as substantial progress.

Working hours and the pace of work were defined in terms of workload and occupational self-image.

Night shifts lasted 12 hours over a period of several weeks without a day off.

Explicit description of nurses' workload is rare. It is usually described indirectly in terms of the duration of a shift and how strenuous it was.

0602/50

(I: You slept there as well then?) Yes, always.. (I: You slept in the hospital?) We had a room in the hospital.(I: You were on call day and night.) Yes. We heard the children crying. That wasn't always easy. We sometimes went to help the nurses who had night duty when we saw that they had to a lot to do so that the children got their bottles on time and the other patients got what they needed. I mean we often had children who were seriously ill at that time.

0201/23-25

At my time – that was the in the late 1940s and the 1950 – I found the working hours were very strenuous. When I began working as a nurse our working week had officially been reduced to 60 hours.

But even at that time, I used to keep a diary sometimes, and I remarked again and again about "how dead tired I was". Afterwards, when I switched to the City Hospital of Waid, I think I still had a 52-hour working week. And that is when I started telling myself that under those conditions, I would work as a nurse until the age of 60. (I: In other words, if you had a 52-hour working week?). Yes.

What was a typical day like? Well, we used to start working at 6:30 or 6:45. First we had breakfast. Officially, breakfast was supposed to be until 7:00 I think but everybody ran off and had breakfast as quickly as they could and then went straight up to the ward. And then we got a certain amount of time off over lunchtime and in the evening (...) I can't remember exactly. We had different shifts. One of two nurses a

unit left at 7:00 and the other nurses finished up by 8:00. The nurse on night duty came shortly before 8:00 and listened to the report. But sometimes it got later.

207/41

Yes, we started working at 7:00 P.M. and worked until 7:00 A.M., so (...) (I: And how many weeks in a row were you on night duty?) Three weeks and then I got two weeks off. (:And you didn't have any days off for three weeks at a time?). No. (I: So straight through?) Straight through (I: 21 days in a row). Yes, it used to be different. (I: How many patients did you take care of there?) That is hard to say (...) well, I'd say around 35. Full house, but it was nice work. We were completely alone with the patients.

Place of work, field of work, function: They just do with you what they like!

Place of work, field of work and function were assigned – often against the nurses' will or not according to their interests. This corresponds to the way the mother-house system works on an institutional level. The institutions express their needs to the heads of the institutions who had been contracted.

The following quotations illustrate the dimensions this system could have in the nurses' lives.

0703/14-20

And then I was sent to the operating room in W (...).

But that was terrible for me (...) I'll never forget that shock. What happened to me when I heard that I had to go work in the operating room. That was the worst thing that could have happened to me.

I wanted to become a nurse so that I could take care of people. I wanted to be able to work with people. That's why I wanted to work as a nurse.

And then after having worked there for three years they assigned me to the operating room without asking me or anything. They just decided about our own fate! (...)

And I remember I had to go to introduce myself to Prof. S. in W., say hello and whatever. Then he asked me if I wanted to work in the operating room. I said I didn't. That I had been forced to do so. "You don't say!" he remarked. Then I said "You see, I trained to be a nurse because I wanted to take care of people and not to work in the operating room". Then he said that I should try it out once and see.

And then I worked there for two years, giving anaesthesia, working with instruments and so on (...).

And then I wasn't myself anymore. When I had seen or heard certain things or experienced the whole operating room atmosphere I couldn't say a single word for days on end. And then I became ill. (...) And then I said that if I had to keep on working in the operating room I would resign from the Red Cross and would leave W. as well. And that seemingly had an effect as far away as in the headquarters in Z.

Salary, Social Insurance

The salaries were low and were kept that way. The fact that nurses lived on premises allowed hospitals to deduct food and lodging from their income which turned out to be a better deal for hospitals than for nurses.

An essential aspect in this context is the moral aspect of the salary of a nurse. In an article of 1911 on the ethics of the nurses, the professional nurses are

positively separated from those who worked for the salary only, the *Lohnwärterinnen,* since the latter were thought to be working only for money's sake and thereby lowered their profession to the level of paid services. Professional nurses were thought to be working because of an inclination and because of compassion and would only accept money because there was no other way. The other group could never "feel the deep satisfaction caused by work which is well and conscientiously done" (Vasangiacomo 1991: 85-86). In my own experience, salary was a taboo subject until shorltly before the new millenium.

Another money-saving method that had great potential was the concept of women's wages. Male nurses earned more than their female counterparts even though their income was very meagre to support a family with. One other method of saving money was not to offer jobs to students once they had graduated from nursing school.

Social insurance was also precarious, in particular at the time the mother house system was abandoned in the 1970s. On the whole, employers also adopted minimalist solutions. Many nurses fared poorly as to their pensions and health insurance unless they were able to get personal guidance and advice.

In the 1970s – a time when there was a shortage of personnel when the economy boomed – there was a relatively sudden raise in wages that was too late in coming for the respondents yet greatly improved young nurses' lives.

0202/11

(I: What did you earn when you lived in Basel?) Oh, Fr. 120 a month. (I: And how much did you have to deduct from your salary for food and lodging?) That was all included in the amount I earned. That was how it was arranged in the contract. (I. If you compare your income to another occupation which one would you say it was equivalent to? That's hard to say. Which other job? The position that nurses had was more or less comparable to the position of domestics before WW II. And there were some few cases of male nurses who were in high-ranking positions and were married. But they also got paid so poorly that they could just barely manage to survive. Yes, that was the way it used to be. (I: So wages were very low?) Very low wages. Yes, like servants'. That's the way it used to be. We didn't know anything else. And we worked too. We had very long days (...) we used to work 10 or 12 hours a day and always had to be on call. That was normal. That's the way things went and we accepted them the way they were.

0305/39

(I: And did it work the same way with your salary?) Male nurses used to earn more but nurses were paid very poorly when I was young. Questionable! And if you think that our supervisor earned less than the cook in L. Hospital. It took quite a while until the nurses joined forces and turned to the management demanding a higher salary for their head nurse. And that helped a bit. It must be mentioned that understanding for the salary question was only to emerge later on. In the L. with Mr. G. and in the I. Hospital with Mr. K. There were a few open-minded hospital directors who simply realized that salary adjustments had to be made.

0502/31

Even as head nurse I was still a mother house nurse. Everybody got paid Fr. 80.- a month regardless of what your position was. (...). And we also got food and board and the white aprons were paid for. At that time we still had to wear uniforms. We also had a grey skirt.

Uniform

The uniform was a particularly important issue. There was a uniform for workdays and one for Sundays that went with a bonnet. Each school had its own uniforms. The uniform was the working clothes in the first place and in the second place it was meant to distinguish the nurses from the rest of the hospital staff. The nurses regarded their uniforms as an expression of their professional status. For a long time, private and public hospitals as well as cultural institutions gave nurses reductions. Although uniforms were expensive, they only had to be purchased once. Nurses could not have afforded other clothes. Nowadays some people say that they were better dressed then than nurses are in this day and age. Uniforms represent so to speak all the aspects of the conditions under which the interviewees lived.

0207/35

Well, we went out quite often in our uniforms. We didn't have the money to buy ourselves anything. (I: What kind of reactions did you get when you wore your uniform when you went to town?). None at that time. I used to go out in my uniform for a long time, for instance when I went to a concert in the cathedral or to one of my godchildren's confirmations. (I: So you had a special uniform for Sunday for a long time?) Yes. (I: What did a Sunday uniform look like?) (she goes to get something).

Well, this is the psychiatry pin, like a deaconess we had a black cape over our dresses and a veil. (I: So the veil went over your bonnet?) The veil fell down our backs over the bonnet. It looked pretty, I must say. So we nurses were well-dressed. Nowadays when I go to visit the hospital I sometimes can't help laughing (she laughs). Whatever, this is a photo of my graduation.

2. I was in charge of the whole ward with 11 patients all by myself

(…) ich hatte diesen Saal alleine, elf Patienten ohne jede Hilfe (0503/17)

Work content

In the following section there will be greater focus on the content of work - i.e. what the work actually involved.

The following topics are addressed the most frequently: Tasks, organisation, division of labour, education, attending and cleaning ('dirty work'), collaboration, gender, material, deficits, professional self-image: holistic approach, the new nurse supervisors

The section on *working conditions* has provided the picture of an occupational group structured in such a way as to demand the utmost from the individual nurse, physically as well as psychologically. Improvements seem to simply occur, rather than being worked toward or demanded. They appear more as occurrences which also made life easier rather than developmental steps actively taken on the path toward professionalisation. The question arises whether the following analysis of the content of work will arrive at the same conclusion.

It is not possible to do justice to the diversity of the tasks that the nurses carried out.

Without a doubt it was the patients – their cure and their care – who were the central focus of their activities. If any regrets have remained for the nurses, they are related to the well-being of the patients and to certain ethical aspects. Medical and caring treatments were much more intricate than today, as a result of the state of medical and technical development at that time.

Nursing techniques and the philosophy of care, indeed the totality of the nursing domain were dependent on the nurses themselves. This becomes apparent when the nurses describe their work.

Tasks

As a whole, the nurses' domain included the tasks and duties of a housewife in charge of the overall appropriate care and support of the family members in all its physical, psychological and social aspects; this also involved organisation and coordination. In the case of nurses, it also involved specialised jobs such as anaesthesia and surgical nursing. To the structures as worked out above, however, another analogy may be more adequate, the analogy of a *mould*. The nurses' *mould* was composed of medicine with the consultant as head of the institution, administrators and the mother-house, or the particular matron. All of them, together as well as separately, were superiors of the ward nurses. What nurses had to do was defined by this *mould* and constituted the very diverse 'bundle of tasks' (Hughes 1958) of the nursing occupation.

In practice, the nursing staff was simultaneously embedded in several functional frames of reference. One system was the '*Mutterhaus'*, or rather, the matron and the school. It was here that professional doctrine was defined and qualifications were formulated, but it was also where placements of student nurses and qualified nurses were arranged (e.g. which nurses would work in operating theatres). In principle, this system has remained valid up to the present day. However, it is only still true of student nurses. In the educational system, we speak of 'the principle of the place of schooling' and sites for field work.

The field of *medicine* represents a second functional frame. Nurses were the doctors' closest associates. Physicians were the top authority as well as the nurses' immediate superiors in the care of patients. At the same time, nurses saw themselves as the equivalent of a professional counterbalance to the doctors, because their constant presence and their closeness to the patients allowed them to observe aspects which inevitably escaped the doctors' notice. From that time until today, the nursing staff has laid great store by establishing working relationships with doctors that could be termed friendly cooperation as partners, which does not necessarily affect their subordinate position within the hierarchy within the field of medicine (Dätwyler et al. 1999, Dätwyler and Baillod 1995).

The third frame of reference is the *administration*. It was of dual significance for the nursing staff. On the one hand, it was responsible for material as well as for human resources, which was central in importance for the work of nurses,

as has been seen in many examples (bedpans, cleaning women). On the other hand, the administration was responsible for determining working conditions together with the '*Mutterhäuser',* which made 'their' nurses available by contract. That was why the nurses were often paid by their 'mother-house' and not by the institutions in which they were actually working.

The nurses' tasks covered came from all the different fields: from the 'mother-house' the knowledge, norms and rules of general nursing, from medicine the special tasks such as anaesthesia, supervision of operations and nursing in the special fields, as part of the house management cleaning and maintenance work as well. Auxiliary tasks had not been systematically introduced yet; either the nurses did everything themselves or the wards were staffed in great part by unskilled hands, which put an inordinate burden on the nurses, both ethically as well as professionally.

To a large extent, Dingwall's (1983) concept of 'fusion' corresponds to my notion of the *mould* into which professional nursing was 'poured'. In a certain way, Abbott's (1988) concept of settlement may also apply. However, the various categories of settlement are taken as the basis of jurisdictional claims, i.e. active civic politics. What we will see is that the category 'workplace' is an audience among others in the development of nursing. But medicine from the beginning took precautions against a possible attempt by the nurses.

Again, a few statements shall serve as an illustration.

0503/78/80-83

In SG we still had to do our wards ourselves. You had to clean and sterilise all the syringes – sterilisation was done in each department. They had to prepare the medications. But there were a lot of extra jobs, too. All the bandages and dressings; you had to make all the swabs yourself and prepare all the gauze dressings. You were responsible for waste disposal, too. You were responsible for everything that was handed out//distributed; central sterilisation and so on. I am not so worried that they did anything wrong (...).

It was much more the impersonal treatment of the critically ill patients – that frustrated more, a lot more. To the point that I had to say later that was nothing at all.

(I: If I may interrupt here for a moment, in what ways was the treatment of the critically ill patients not personal? Was it a lack of time or what?) I would say so (...) I don't like it at all when people say, "I have no time". Well with us everyone had a ward with eleven patients -or nurses on the other. And then we had some small rooms and in there they had the patients who were dying and the old people.

In the medical department we had eleven young ones- or younger ones, as they would say today – up to the age of 50. Today there are eleven people on a ward and three seriously ill patients outside. At that time we had one double room and one single room. We had to do those in addition to the other eleven patients. So we did them all together. In the morning they got taken care of much later, and that was the right thing to do. And you had to see (that there was time for it) besides doing the big jobs in critical care there was such a lot to do on a ward like that; you had to take an unspeakably enormous amount of blood, there were a lot of different therapies we had to do because all the acute cases were in the medical department. And also when I

worked in the surgical department I had to do all the bandaging and dressing, and that took two hours in the morning.

So you hardly had any time left for the single room where the most critical cases, the terminal patients and the alcoholics in delirium tremens were lying. I know that we sometimes said of those patients in their deathbeds who finally passed away, “My God, thank God he died”, only because you did not keep them company. We did not see them as patients who were dying. They died as Mrs. XY without our knowing anything about their lives or how they felt while they were dying.

0602/7-11

The apprenticeship was tough. You didn’t really know beforehand what was in store for you. So you were all the more surprised to discover everything that nursing did entail at that time. At any rate we had to do a whole lot of cleaning jobs because they were saving money on housekeepers. And once we went to the boss and asked if we couldn’t get at least one cleaning lady. Then we were told, “Well, we have no money for that sort of thing”.

We started work at that time around 5:30, depending, once we had finished getting the children ready and they had eaten, we were allowed to go to breakfast. And then afterwards you had to clean your ward or the room and do the washing-up, and after that it was time for the doctors to do their rounds so everything had to be spick-and-span.

And you had to do the dusting, otherwise the boss would come and see it, and then he’d go, “Who cleaned up here?”

0502/28

(I: If you think back on the work you did, what it involved, the routine jobs and diseases you treated at that time, what are the most important things that come to mind? Well, I was in the surgical department for a very long time – or at least for a relatively long time. (It was) a surgical-urological department where you could work quite independently with the patients. Of course we had non-resident specialists, who aren't there all the time, and so obviously you could take over a lot of responsibility and really get something done. But about nursing care (...) we did try very hard to see that the patients were comfortable in bed and feeling all right. That was really so important for us. We had to move the patients a lot to get them in the right position**.** Depending on the operation you had to have the patients lying for a long time; after kidney operations up to three weeks. And so of course there were also more complications, and at that time there wasn't so much in the way of drips. You did do a couple of subcutaneous infusions, but that was quite painful and you only did that if the patient couldn't drink or something. But they were certainly very frequent vascular diseases, in other words embolisms or phlebitis or a lack of exercise and certainly, in part, some dehydration. And then we had to get the patients with phlebitis into the right position, which is a real art, so the patients really stay put in the right position and feel comfortable. Those were things that were important. Sometimes I practised doing that. In my free hour I would go to an experienced nurse who I knew and told her she had to show me how to make a patient with phlebitis feel comfortable in bed so I could show it to the students. That's how we worked it over there. But anyway, it probably did give the patients the feeling that you were there for them and for the treatment they needed. (I: So it was more primary care and some therapeutic care.) Yes. Naturally you also gave injections- but otherwise not much more. Well, actually, yes: while I was becoming a departmental sister we were suddenly allowed to start giving intravenous injections. We had not learnt how to do this - not at school and not

afterwards, either. Up till then we were not supposed to because that was what the doctors did. And afterwards there was penicillin and other things which you should have been administered more often, sometimes at night. At that time they still gave penicillin and other drugs every six hours or so. And then you had to get up in the middle of the night, and so that made it more difficult for the doctors and so from then on we were allowed to take over a bit. At first each nurse got up for her patients, and after a while we noticed that basically one qualified nurse was going around giving penicillin shots in the whole house. You see, there were only student nurses doing night shift.

Organisation, division of labour

In the organisational structure at that time, ward nurses and qualified nurses ran the departments together with student nurses and nursing staff without formal qualifications (nuns or lay nurses). Ward sisters or matrons were their superiors. As we shall see below, some ward sisters began to redefine their role by introducing system and structure into nursing care. An example of this was documenting systems and reporting, both of which were relatively unknown at the time. We will see that this process of the structuring and organising nursing work represent a crucial step toward professionalisation. Because nursing ceases to just execute but adopts an active role within the hospital organization.

0201/48/49/78

And I had the impression that the atmosphere at work was very old-fashioned and that they had a less systematic style of working. For instance, I still have this notebook that we got in the first year of nursing school where we used to have to keep exact records

of everything – point by point – which really helped you to remember all the details and understand the wider implication of situations we had to deal with.

Well, we didn't have that sort of thing on this particular ward in B. called '*the Lindenhof*'. They used to write down their reports on the back of an old diet menu or on an order slip. And every nurse had to figure out herself how she wanted to divide up her time at work. So naturally the risk of forgetting things was considerably larger. And it took a lot more time to do something like that.

And there was not much turnover among the house officers (...). They were more or less members of the nursing team (Interviewer: Could you explain why?). We used to have tea on the ward. We didn't have a cafeteria in the house. And the junior doctors were there as well. We used to sometimes talk about work-related issues. At that time we didn't have regular meetings with the doctors about problem cases. We consulted them when necessary. Everything was pretty laid back and uncomplicated. I don't think that a lot went unnoticed.

There was a severe shortage of nurses. Nursing students had to do whatever full-time nurses did. The interviewees still remember how much pressure they were under on the one hand and the tremendous responsibility they had when they were full-fledged nurses on the other hand.

But besides being difficult, the relationship between qualified nurses, student nurses / ancillary staff was also often critical because it was often practically impossible to distinguish between their respective areas of authority. Many of the interviewees will never forget their fears.

0305/8

(...) At least at the beginning of the second year (...) – we were left completely to our own devices. We had to study an awful lot. We also had to help whenever a woman gave birth. The midwife only came towards the end of the ordeal. Before she was called we just had to manage ourselves (...) And they didn't want to wait longer than 15 to 20 minutes until the baby was born. Otherwise the midwife would get angry. And then they just did something (...) I sometimes thought that the responsibility was tremendously difficult to bear (...). But we survived. And I was glad that I learned to scrub up and lay out the instruments at the end of that year and I knew my rank. I replaced the only theatre nurse who was there at that time when she was on holiday and had quite a lot of responsibility at the hospital already then.

0602/15/16

(I: Besides the head doctor, were there also nurses who gave you instructions?) Oh, yes. There were the departmental sisters. But there was a shortage of nurses because I worked at a private hospital which didn't have a lot of money.

And we had to pay tuition and we didn't earn anything while we were at nursing school. (I: Nothing.) No, nothing.

0305/10

There were only three or four nursing students. The other two were studying to become theatre nurses and how to fit out instruments, so we just muddled our way through, that's really what we did.

0703/8

(...) We worked very independently and a lot was expected of us. (I: And where were you sent to for your second half-year?) In the second half-year I was in Z. and they

made us do whatever full-fledged nurses do. I still remember the first time I was supposed to give an injection. I was on night duty. I was supposed to administer an injection to a child. I hardly managed to. I was so afraid of hurting him that I actually dropped the syringe on the floor after I gave him the shot. But we eventually learnt how to give injections. We learnt a great deal. And I learnt most of all when I was allowed to take over the full responsibility. So we were on duty day and night and we did replacements. We did all kinds of things. We even had to work on a maternity ward and in casualty in a district hospital. I remember how pregnant women used to come to hospital in the middle of the night with the midwives and sometimes with their husbands. They would ring the doorbell. And then I looked round the corner to see how many faces there were. If I saw two women's faces I assumed that one of them was the midwife. But when the doorbell rang at the other end of the house, I knew it was an emergency. My heart used to almost stop beating. So I had to sit down for a minute until I had plucked up enough courage to go downstairs and open up. (I: So you were alone in the hospital when you were a student nurse?) Yes, I was all alone. All by my lonesome self. There was a midwife around though and she used to tell me that I could call here if I needed anything. And the ward sister was old and hard of hearing. You couldn't call her. And that's how I got through those 6 months – pretty well but there were so many things that scared me a lot.

0603/99

But there were old nursing auxiliaries who used to do whatever they liked. They used to do things like neglect patients who had had a heart attack or not let them move. So it was terrible. And then one of the nurses' aides felt sorry for one of the patients so when we removed the handle from his bed she made a contraption out of a bandage so he could pull himself up. When we came the patient had struggled just as much to sit up as if the handle had been there.

0503/17

In the first year I had to do everything myself. I was in charge of the whole ward with 11 patients all by myself. I just had one woman who helped me make the beds and that was it.

0207/37

(...) And that's what we did. I stayed there for seven years until I was a nervous wreck. I was the only qualified nurse there and I had 80 patients to care for. Besides me there were only nursing auxiliaries who were very kind to the patients but not capable of performing difficult tasks. And that's why even though I was given time off, I had to stay around in case anything happened (...).And then after seven years I said that I just couldn't keep that up anymore. I was simply too tired. My boss understood my situation.

Education

It was the prevailing opinion that a nurse had to do all kinds of work, including the menial tasks such as transporting and cleaning instruments, rooms and beds which used to be put out-of-doors.

On the one hand, doing the menial work prevented nurses from becoming haughty and taught them to subordinate their wishes to those of their superiors. On the other hand, it made them aware of the importance of knowing how to do a task from scratch.

A further aspect of education involved the practice of changing a student's name. Stemming from the religious orders, this happened when two people in

the same class had the same name. It meant that personality was of secondary importance.

0603/11

First I was placed in the operating theatre. And the theatre nurse said to me on the first day “I’ll show you how we clean here. But don’t think I won’t be keeping an eye on you. I am going to get down on my knees every day and check if there isn’t a drop of water behind the wash basin”.

0502/13/14

My name was G. Sch. and there was another nurse by the name of Nurse Ge. who had been working at the hospital for a long time. She had already been called by so many different names. So they called me Gisela. And a very tall heavy-set nurse was called Gritli. And then the two of us exchanged names.

I never used to think that I would once want to become a senior nursing officer. The atmosphere there was very unpleasant. Nobody dared to call me Sister G. And then they started calling me Sister M. and all sorts of other names. They just never called me by my right name.

0306/20

That’s why it was so hard to always take that all into account as long as the nursing students had to work the way they used to (I: Did you feel like a workhand?) Yes, absolutely. (I: And did you have to do a lot of cleaning?). Yes, we did. We had to clean the lavatories. I used to sing Schumann or Schubert songs while I cleaned until they told me not to. But I used to think that I should at least have something that was good for my soul while cleaning. And naturally, nobody bothered to give us any sort of introduction. I mean, the first day when you arrived at the L. School you were

simply handed an apron and your name was changed if there were two people who went by the name in the house. So they called me A. and I felt like I was on stage: everything was new: and different to what I had been used to: my clothes – I felt like I was dressed up in a costume –, my name, and my surroundings. Then I made up my mind that I would just act the role (...). For a long time I had the feeling that I was disguised as A., the one who took care of the old people (...) But I felt more like I was observing myself from the outside. A was not really an integral part of me.

Menial work ('dirty work')

Although ideological and pedagogic-didactic reasons were given why menial tasks that were not directly related to the domain of nursing care were delegated to nurses, the main reasons were probably related to economic factors. In an effort to cut down on spending, the nurses' pleas for extra outside help were disregarded.

In the interviews, the physical proximity or the excreta etc. are not mentioned as menial, this seems to go without saying, disgust is not a topic. Nursing as such was never felt to be menial work. But cleaning work is referred to – and that could already be linked with degradation. But then again it is primarily the pupils and the general caretakers who had to clean.

According to Hughes (1958), occupations are characterised by a specific set of tasks and roles ('bundle of tasks'). Within this set, there are tasks which are regarded as honourable and respectable, and others that are considered as 'dirty work'. This is an important concept in Hughes' writings and represents one element within the process of permanent change within the division of labour.

The way occupations manage their ‘dirty work’ (concealment, delegation, integration) illuminates the specific claim of occupational boundaries.

In the sociology of the professions often nursing as an occupation is used as typical case for this step of the professionalisation of medicine.

Abbott describes this process as degradation: “Degradation of work is perhaps more familiar, from cases like nursing, librarianship and teaching. The move of medical care from home to hospital destroyed the former independence of he private-duty nurse and placed her in a subordinated division of labour” (Abbott 1988: 127)

As we have already seen, the new nursing profession included more than what medicine delegates as supposedly ‘dirty work’. In addition to the tasks of medical assistance which was highlighted so much, there was the share of ‘*Hausfrau- und Mutterarbeit’* (housewife´s and mother´s job), which was after all so extensive and intense that the organisational form of the convent seemed to be adequate or necessary. We will see in the course of the following chapter that the nurses adopted the whole parcel resulting from the *mould* they were assigned to and tried to bundle it into a whole.

If the concept of ‘dirty work’ were right, then nursing would have been established but as medical assistance. Therefore we need an extended concept in order to explain the specific ‘bundle of tasks’ of the nursing occupation since it’s beginning. Certainly, the concept of ‘fusion’ relative to ‘fission’ is

more adequate. I agree with Dingwall that it is meaningful to understand occupations correctly:

"If we need to create several million jobs in the next decade, then an understanding of occupational life-cycles might actually help us to identify and nurture prospective sources of employment in a much more sophisticated fashion than the blunderbuss approach of many labour economists. A detailed investigation of the subjective and informal economies may have much more to comment it than the use of public sector employment as a vast programme of outdoor relief. What is needed perhaps is a restatement of the truism that occupations have careers just as much as individuals" (Dingwall 1983:621).

The significance of this statement will become even clearer in the chapter on the reform of the education system.

Whether and how the profession of nursing itself will define 'dirty work' remains an open question at this stage.

Let us continue with the nurses' statements.

I have here assigned 'dirty work' to the category of education since this is how I understood the statements.

0603/39

(...) We didn't have anyone on night duty, and the first thing we got was a nursing assistant in charge of four floors. And she helped us as much as she could. But she also had a lot on her hands. But the girls distributed the food or (...). And then after a while we said that we had to get up so often at night. We had patients with the worst

cases of thoracic haemorrhaging, some of these cases were even fatal, and we had to stay up all night. The evening nurse was on duty until 1:00 A.m. and the night nurse was on until the morning. And we had to work all day long. And then (...) we couldn't take it anymore. And then we said that we'd prefer having a night nurse rather than an auxiliary so we could at least get some rest at night. But it had to be a nurse.

0602/7

(...) -we always had to do a lot of cleaning because they wanted to save on the maintenance workers. Once we went to our boss and we asked him if we couldn't have a charwoman. And then he told us that there was no money for that sort of thing.

0206/40

The worst thing was when we had to powder gloves. That took a great deal of time. Or when we had to powder the rubber gloves (I: Were they sterilised afterwards?) Yes. (I: And then what did you have to do first?). First you had to (...) I don't know if they still do that today. We had to powder them so that it would be easier for the doctor to slip them on. (I: So you first had to wash them. Then you to put powder into them and check that they weren't torn). Yes, that's right. Or we had to check whether they had a hole in them (...) (I: So there was always extra work to be taken care of). Yes, yes. Then we also had to dust everything. (I: You didn't have a cleaning lady yet.) We had to do the dusting but we didn't have to clean outside or to wash the floors.

Collaboration

While the nurses interviewed primarily described their relationships to the doctors at work, when interviewed on the topic of collaboration they tended to describe their relationships to fellow nurses in more general terms, referring to them as good and friendly. On the other hand, neither the administration nor

other services were frequently mentioned. And if so, it was usually a question of difficulties or of a particularly nice person. When analysing the statements made in relationship to the aspect of conflicts, the doctors are once again in the foreground.

Collaboration among nurses

In contrast to the results summarised in the foregoing section, the 31 rank and file nurses who were interviewed about their relationships at work primarily talked about collaboration among nurses which they mainly described as being good. They prefer senior nursing officers who are lenient and supportive rather than strict ones. Sometimes an officer was referred to as a 'dragon' ('a witch').

These results are in line with the results of interviews conducted with the senior nursing officers who sometimes had to confront opposition and preconceived notions about new developments. They talked about the necessity of educating and addressing the question of what was meaningful and what was right. Besides conflicts that arose between different positions in the hierarchy and different generations, there are also some examples of cases of injustice.

0603/76

I liked my job in the hospital a great deal. Teamwork was good there. We just made it our business to work well with each other. What used to trouble me most was when Sister M. was on holiday and a midwife replaced her who had angina pectoris and once she had to go and lie down at work (...) But we had thousands of fears.

0502/28/29

(...) I educated the nurses quite strictly. Nowadays you would say I had been very strict. They just had to do as they were told. I guess I couldn't be as authoritarian as I had been then. (..). Naturally, we worked well with each other. They said that they appreciated knowing what was expected of them. At least with me they knew what was supposed to be done and what wasn't.

Yes. I became a senior nursing officer when I was 30. I was pretty young for that job. Obviously, the old sisters didn't think very highly of that. But at that time we were still the '*Mutterhaus'* and they couldn't just leave. They had to stay. And in the course of time they got used to me.

0703/38/40

(...)You know, we used to have our morning snack and our afternoon tea in the offices. I used to go to the office and sit down on a stool and ask if I could have a cup of tea or whatever, too (...) I managed to worm my way in. The older sisters realised that they had misjudged the situation. And so time passed.

There were tensions and just imagine the queens eventually had (...) Oh, I wanted to also tell you that shortly after I became senior nursing officer I wanted to introduce a night duty report – something that we had not had before. (...) And after a while it became a routine procedure. And at that point I once assigned a night duty to the queens. And suddenly they discovered that being on night duty was just great because it wasn't as hectic as working during the day. And after a while they started to ask, "Sister M., when can I be on night duty again?"

0207/23

So we had to be very obedient. I still remember – maybe I shouldn't be telling you this but all the people involved are dead and gone now. Nothing can happen to them anymore. Once over Easter – you know what it was like – the youngest sisters used to sit at the foot of the table in the old dining-room, Mother E. sat at the head, and all the other nurses were seated in between according to age, and then, young and silly as we were we complained. And then an elderly sister (...) said as we were leaving the dining hall that we should for Heaven's sake at least for once because it was Easter be a little quiet at dinner. And then I saw red and I talked back to her and told her to watch her 'foul mouth' for a change for Heaven's sake. Oh no, I thought. Now you've gone and done something wrong. And sure enough, the next thing that happened was that she went straight to Mr. M. I was called into his office (...) "You know", he said, "you really have to pull yourself together. Your behaviour towards an elderly sister is unacceptable". Then I said to him "Yes, but all same I think that the older sister should also pull herself together when she talks to us". But the time just wasn't ripe enough for that sort of thing, that's the way I would put it.

Collaboration with doctors

Rank and file nurses and nurse managers focus on the same aspects when describing and appraising the relationships they had with doctors at work (Dätwyler et al. 1999). On the other hand, the nurse managers tend to refer mainly to the consultants in this connection whereas the high-ranking nurses tend to talk about doctors at all levels of authority.

The following two elements proved to be of particular importance in their overall appraisal of collaboration with doctors: First, the doctor's competence

in his field of specialisation and secondly his social skills (i.e. communicative skills) which influenced both the way he treated his patients and the way he interacted with the nurses. The interviewees' comments show how circumstances have changed over the years, on the one hand insofar as cooperation between nurses and doctors was not always taken for granted, and, on the other hand, as far as the division of labour is concerned: in the course of time doctors delegated certain areas to nurses and they did so depending on the amount of time they saved and the extent to which their working conditions improved in the process.

The reports of the nurses correspond with Abbott's description of the workplace as one of the arenas where jurisdictional changes and contests become manifest. Abbott points out that, in the institutions, inter-professional division of labour is often replaced by intra-organisational division of labour. Thus professional boundaries, even when formalised in job descriptions, are blurred in reality. The complexity of professional work has its effects at the workplace – which remains at stays in contrast to the other two arenas, i. e. the legal and the public. Abbott (1988: 66) "There is a profound contradiction between the two some what formal arenas of jurisdictional claims, legal and public, and the informal arena, the workplace. If the public knew the extent of workplace assimilation, it would profoundly suspect professional's claims of comprehensive jurisdiction."

According to the theory, this should lead to problems. The doctors would have to actively defend their boundary against the nurses, since, following Abbott,

professionals must reconcile the sharp contrasts. If they did not fight for active maintenance, the public picture would be eclipsed. Professions have to use methods to reemphasise the public picture at the workplace. Physicians invoke their clear public relations, nurses emphasise, vis-à-vis physicians, the functions and knowledge that both groups share: public clarity is directed downwards, workplace assimilation is directed upwards.

Although, in the interviews, the nurses mention problems with doctors, these are assigned to the respective persons and not to the medical profession as a whole.

The topic of the doctors' boundaries against the trained nurses appears to be in the focus in written sources. Thus for instance we find in the journal *Blätter für die Krankenpflege* published by the Red Cross an article dealing with the fear of the medical profession that, in view of the new, trained nurses

"through the above described thorough education a class of *Wärterinnen* (female wardens) are being raised who, trusting superficial knowledge, high-handedly interfere in the treatment and are unwilling to submit to the doctor. That this danger really exists is not to be denied, and from England and America sometimes complaints can be heard that the 'trained nurse', who insisting on her book learning, becomes bothersome to the doctor (...). Yet these complaints definitely are to a major part related to the fact that in those countries a woman assumes quite a different position vis-à-vis a man than is the case here and that she is not used to submit to him" (*Blätter für die Krankenpflege* 1909:90/91, in: Dätwyler and Lädrach 1987:103).

There were already at the time high-handed nurses, particularly among those who were least trained. “A well-trained warden is the doctor’s best ally” (ibid.). The author goes on to stress that special training was only one side of the coin. That it was just as important to realise that nursing was more of an art than a science – but that this awareness was perhaps missing in the English training. A nurse was required to be discreet, tactful and have a the kind of manners enabling her to fit in. Furthermore, she was to be willing to help, even when the duty was seemingly unworthy and posses

“that modesty of needs which is a sign of true education. We demand a strict discipline and the kind of ‘intelligent obedience’ which endures even in difficult situation, like in the military troops grace under fire. We must not forget that the profession of the nurse requires a much greater degree of devotion than that of the doctor” (ibid)

Or, as Dr. med. Carl Ischer, the successor of Walter Sahli, co-ordinating secretary of the Swiss Red Cross, Director at the ‘Lindenhof Red Cross Nurses’ School in Bern’ and President of the ‘Nursing Association KPB (*Schweizerischer Krankenpflegebund*) as well as editor of the nursing magazine *Blätter für die Krankenpflege* in 1925 wrote in a long article on the nursing education at nursing schools:

“2. Theoretical classes, within reasonable limits, is a strict requirement for schools which do not want to turn the nurses into machines but into under-standing assistance of the physician. For a long time now, nursing has no longer been a trade but a scientific profession (...). We generally follow the

principle: an efficient nurse should be better educated in medical respects than her average patients. If the lessons are given in such a way, one does not have the fear of breeding arrogance or even self-aggrandisement through a so-called smattering of knowledge. The danger of self-aggrandisement is in inverse proportion to the amount of knowledge. The more openly we allow the pupils an insight into the science, the more readily they are to realise the gaps they are bound to have in their knowledge and the more they will pay attention to the difference between them and a scientifically trained physician (...)" (*Blätter für die Krankenpflege*, 1925: 99-102, in: Dätwyler and Lädrach 1987:111/112).

Abbott states that "it is difficult to judge the long run relation of the two major spheres of jurisdictional claims. Dominant professions seem to be successful in hiding from the public the excessive assimilation of professional knowledge at the workplace" (1988:68).

In actual fact, the problem the doctors were afraid of did not arise for the nurses interviewed. By and large, they seem to have developed means and ways of operating which made it possible for them to experience their collaboration with doctors as satisfying. What has been referred to as diplomacy otherwise is described as the doctor-nurse game in the literature (cf. Dätwyler 1989). What becomes manifest in the above statements is the strong genderedness of the physician's image of their 'best ally'.

On the whole, the relationship between nurses and doctors is assessed by most respondents as positive.

0207/49/50

(I (...) How did nurses and doctors get along with each other?) Well, at first we were very submissive like nurses used to be. We had to accept whatever the doctors said. We didn't allow ourselves to speak up - especially not when we were nursing students – and later on – all right, when I used to be on night duty I sometimes had to speak up and say things like "Doctor, don't you see (...) we should (...) and so on."

If I think about the surgery at the hospital and the specialist registrar I had there when I worked in the department for tumour after-care, he was always very polite and nice (...) Well, yes, yes. Or the former associate specialist, Professor T., who now works in C. Hospital, he was really a fantastic boss (...)

0305/28

(...) (I: So you provided more primary care and some therapeutic care). Yes. Yes, of course we gave injections - but that was about it. But when I was departmental sister we were suddenly allowed to give intravenous injections. We had never actually been taught how to, neither at school nor at a later point in our careers. And besides, we weren't supposed to give injections anyway. That was the doctors' business not ours. And then penicillin and other substances came along which had to be administered more frequently, sometimes at night as well. Penicillin used to be given about every six hours or so. And we used to have to get up at night and that made it more difficult for the doctors and from then on we used to be allowed to sometimes take over. At first each nurse got up for her own patients and after a while we realised that one nurse could be in charge of giving all the penicillin injections for the whole house.

0502/44

(...) He was very good-natured as opposed to Sch. who was of a very strict nature. And I tried the whole time to stick to the old rules so that he thought he was the boss. It

called for a great deal of tact and diplomacy on my part, but on the whole it worked. You just had to be diplomatic, that's all.

'I wasn't popular among the doctors. I always did my utmost for the patients.' This statement is representative of a series of nurse managers who were deeply committed to the patients' well-being, even if their lives became difficult by so doing. On the other hand, there were some consultants and ward and departmental sisters/senior nurses who had a special relationship of mutual trust, which was experienced as a relief at work.

0502/44

(...) But I wasn't popular with the doctors. My prime concern were the patients, then came my fellow nurses and last of all the doctors. (...) There were quite a number of struggles and it wasn't easy for the doctors. So I reported things to the consultant that shouldn't have happened.

0603/50

For instance, I could call the consultant directly if there was a problem with somebody who had been operated on. I didn't have to go over the house officer, even at night. Yes, always, he said for example I won't be here on Sunday but you can call me back home if anything's wrong. The senior physician on duty doesn't know so much about lung surgery. And once I really did call him up myself and he came right away. It's actually a wonder that the doctors didn't become jealous of each other, isn't it, because we really weren't going through the official channels.

0703/24

(...) I know, I used to have a specialist registrar. I got along very well with him but not with the associate specialist because of things I had seen in theatre. But whenever

there was a serious emergency he used to say “We’ll fight alongside each other M., won’t we! And then we sometimes actually fought for these people. And that really filled us with great satisfaction. Within a year and a half I had 83 patients who passed away. But we were always there when it happened. And it was the surgical department.

0207/49

(...) But I never actually quarrelled with anybody. Oh yes, once I had a fight with a junior doctor in neurology. He forgot a scrap of paper on which he had jotted down the names of all the pubs he would be at on Saturday evening and I brought it to him. Then I called there and they said that the doctor was already gone. Then I called at another place and yet another place and they kept on telling me the same thing. And finally I got him at the fifth or sixth place I called and he said- yes, do I have to come now. Then I said you don’t have to come at all, Doctor. I’ll call the consultant. He’ll come immediately. No problem. Then on Monday when we were having our conference he said that the night nurse, she said she’d call the consultant if he didn’t show up.

Collaboration with other services

As mentioned in an earlier passage, the interviewees rarely commented on the hospital administration and other services. On the whole, decisions concerning the nurses were usually within the authority either of the doctors who were their direct superiors or the consultants and/or administrators. The latter were in charge of the area of remuneration (salary, board and lodgings).

0603/118/119

(...) Then we tried to formulate the objectives of nursing and succeeded in doing so. We tried doing so together with the head consultant and with the director of administration (...) we travelled to the Emmental (region of Switzerland about 40 km from Bern), the matron and me and another colleague (...). We travelled there and thought a lot about the goals of the hospital, but nothing occurred to us (...) nothing really came of it. We (at least) had some good discussions.

Things can get out of hand (for nurses) at a hospital if neither the consultant nor the director of administration has any management training or any idea about nursing services.

0702/90

And then the head of housekeeping said that we – the new nurses, the modern ones – were using too many linens. And then the consultant said that he didn't care about that. The main thing was that the patients were clean and were lying in clean beds. We should just keep on cleaning in that hospital.

Gender

In the foregoing sections we saw that there were major differences between the working conditions of male and female nurses because male nurses were married or were allowed to be married whereas their female counterparts were not. At the same time, even if men had a degree in nursing, their professional status was lower than their female counterparts.

0305/38

No. No, male nurses were on the very bottom of the career ladder. While I was at nursing school in B., there were male nurses who used to help us bathe, lift and wheel the patients around. But we never really considered them as full-fledged nurses. They usually had little or no formal training. I guess though that once they had gotten their degree in nursing, they were eventually granted full recognition and employed as full-fledged nurses.

0603/24

And there were male nurses (...) they were orderlies, they were called orderlies, and some of them were homosexuals. And some of them committed suicide. (I: Didn't the orderlies get any training?) No, at that time there were no training programmes for men as there are nowadays. They only came into being a lot later on, I believe only in connection with the enforcement of a normal contract or as a ensuing result.

0202/40

(I: Did the male nurses do different work than their female counterparts or did they do exactly the same things?) Yes, I only worked on the men's ward. Today it's completely different. That's at least what you would think. (I: Yes, or did you have other duties that female nurses didn't have, or did the women have duties that you weren't delegated?) Above all, we had to deal with the corpses. The men were in charge of transporting the corpses. In M. I was also responsible for the autopsies. I had to get the corpses from the mortuaries, prepare or dissect them for the post-mortem. The male nurse had to take care of all those things. (So you had to help when there was an autopsy?) Yes, yes, I had to be there. I had to get everything ready and stitch the corpse back up and put it back into the coffin where it had been buried or sometimes even transfer it to another coffin.

Material (Equipment)

The interviewees reported that the material they had at their disposal was an important element influencing their work experience. The poor quality of the equipment they had seems to have been experienced as an unreasonable situation. Physical exertion was caused by a variety of factors including the hygiene that had to be maintained for the patients and the psychological effect it had on the nurses.

0603/13/20/21/89/90/91/92

And after that I stayed there for a long time as a night nurse on the isolation ward. We had full-blown infectious diseases – typhoid, paratyphoid, diphtheria, scarlet fever and most of all, a lot of patients with tuberculosis. And we were not protected against tuberculosis yet and the patients used to simply spit into a paper cup or into a little glass jug and out in the hall we used to have to clean the sinks and rinse the sputum out. And nobody told us anything about disinfection. The TB patients used to die there very often. They came straight from the sanatoriums to the isolation ward. There were rats in the house.

They also didn't have enough material or ambulances. For instance, they had too few bedpans for the patients. And the ones they had were old and beaten up. And one day the sisters decided that they had had it. And then one of them went to the bridge that crosses over the Aare River – the Aare runs through O. – and threw all the bedpans into the water and they floated down the river. And she just wanted new pans. Well, there was another bridge somewhat further down the Aare and just as the hospital administrator happened to be crossing that bridge, the bedpans came floating by. And naturally we got into trouble (laughs).

The field of nursing was also relatively backward at that time. So, for instance, we had to go out to the loo to give the men an enema before they were operated on. We had to lock ourselves in there with these men. And laundry was collected in the anteroom in cloth laundry bags that had a lot of mice in them.

It was pretty hard work trying to modernise things a bit that winter. The whole method of sterilisation used in the house. They used to, for instance, boil the instruments to sterilise them. And we used to make packages of bandages. Everything had to be changed, including the atmosphere in the house. A new school was being planned with completely new requirements. And so we did whatever we could. And then the commission hired a housepainter who has been with us ever since and he started renovating all the rooms. And the commission agreed to a large budget so that we could afford to buy new beds. And so from that winter on we successively modernised according to our budgetary constraints.

And I also had a bit of resistance from our village's main Protestant pastor. He wasn't terribly happy about us – we were too free. The teaching sisters probably criticised us pretty strongly so to put us in a bad light in his eyes (I: Were you overly self-confident?). We were more self-assured (than they would have liked us to be).

And the equipment was awful. So the dead had to be carried down two flights of stairs. We didn't have a lift. But there was a dumb waiter which was used to send food up to the ward. Next to the dumb waiter there stood the gardener's mouse poison. And I had to kick up a terrible fuss until that was changed.

Professional self-image: Holistic approach to nursing care

The professional self-image conveyed by the nurses in the interviews will not be described in great depth. All the same, it is of significance for the category

of work because it is a basic element of the holistic concept of nursing. Based on their professional self-image, nurses engaged themselves in providing their patients with nursing care to the best of their ability round the clock. They do not glorify this. They simply lived with the patient. This has to do with the living situation and the life style of those providing the care. The claim that this holistic aspect was the big difference from medicine and other health professions comes into it later. (I will come back to this in the next chapter.)

0602/44/31

(...) I still am in touch with the oldest patient I ever had. I cared for her in 1935. She's now a mother of 3 grown children. She was 5 years old when she came to us as when she was severely ill. Then she came down with scarlet fever and our boss didn't want to send her away. They discovered a room up in the attic. Then they ordered me to take care of the child up there. And so I wasn't allowed to be with any of the other patients throughout December and January. The two of us were upstairs. We slept in the same room. Then she got periostitis of the leg and afterwards she had a grumbling appendix and I had to make compresses for her at night and to change them every hour, night and day. I did that for three whole days. I had to set the alarm to ten minutes to the hour and had to warm up some camomile (...). That lasted for three days until the boss said "You took care of her at night too, did you?" And he had been the one who had originally ordered me to do so. He had forgotten what he had told me to do. Then once I asked him and he said, "So, the two of you should once get a good night's sleep (laughs). Yes, I did appreciate that very much. (I: Yes, and then we celebrated Christmas together.) Yes, yes, of course. We were given a small Christmas tree. Naturally, her parents were sad too but they saw that we got along well with each other and that their child wasn't unhappy.

And once I also had to take care of children who had serious cases of whooping cough. One of them was a 9-month old baby and another one was a 3-year old. And I sometimes had to get up up to 18 times a night for the 9-month old. He couldn't help himself when he had a coughing attack. At times like those we were rather worn out**.** But it was nice when the sick children got better**.**

Ethical aspects

In the interviews, the nurses often conveyed the underlying feeling that they felt very badly about their inhumanity towards their patients. The inhumane treatment of their patients was primarily due to the time constraints they had to work within, which, in turn, forced them to neglect the patients, in particular those who were seriously or terminally ill. Another factor that also weighed on their consciences was the inhumane and inconsiderate medical practices in medicine itself. For me, the biggest questions arose in this report since I have known the nursing occupation. On the one hand, I felt situations such as they are described by the nurses in the following to be 'dirty work' in the sense of Hughes, namely delegated 'from above and from outside', by medicine and by the regulatory framework of the institutions. On the other hand, I always found the attitude and the commitment of the nurses to their patients in such situations or constellations always extremely independent. When Freidson in 'the third logic' (2001) writes about the soul of a profession, this is where I primarily locate it in the nursing profession. I equally belief, in respect to Dingwall´s position, that, in modern societies, professions have often taken on parts of the sacred (for instance 1987, 1996, 1999, 2004), that, from the perspective of the patients, the actual professional contribution of nursing

consists in living up, physically as well as humanly, to what medicine promises therapeutically. The nurses appear to deduce from this a monopoly on the psychological caretaking of the patients. Within the nursing profession, this is a lasting field of tension between the licence and the mandate of nursing (cf. Dingwall 2000).

0305/5/6

Even though I was transferred to a ward afterwards, it was a men's ward, I was in charge of up to 24 patients. (I. Surgical patients?) Yes, and medical ones. We had patients with pneumonia (...). I had the feeling that I simply couldn't look after them properly. In a separate room I had a man who had a severe case of pneumonia, we had to be prepared for the worst. But I never had time (...) he was constantly covered with sweat. At that time we didn't have the medications we have today. And then I thought, "If this man dies, it'll be your fault. You just cannot care for him properly". I was at the end of my tether in many respects. And then once help came from the L. Hospital. They had too many patients themselves and they asked for extra help which they then sent on to my department. And from then on I started being better able to cope with things. But there was always a lot of turmoil.

0503/73/74

Another dark chapter in a cantonal hospital was the treatment of terminally ill patients on their death beds. They died relatively faster, often of dehydration. We – but also the sisters – used to just bring them the oil (for the last rites) instead of bringing them water, or the priest came and prayed with them to ease their lot. But there was no such thing as patient support or family support. In any case, families weren't given support anyway.

Research was not a small issue among the doctors at that time, in particular research about sulphonamides was a big thing and sometimes probably not very humane. For instance, we were doing the rounds with a dying woman. She was obviously going to die within the next 2-3 hours. We nurses didn't know anything. The doctor left – half an hour later the house officer came from the research department with a lot of little flasks and took blood samples. The patient's relatives were in the room, full of hope that the woman could be saved with these blood samples. The doctor did not tell them or us anything. We only found out later that everything was done for the sake of research. Afterwards they tested to see how the patient's blood sample took to the antibiotics and what their effects were. It was necessary and it didn't harm the patient. But nothing was explained and it was inhumane not because it was painful – she only felt a little prick. It was inhumane treatment towards the patient's relatives nor was it very fair towards the nurses involved. I suffered a little because of the importance that was assigned to research at that time. The boss we used to have later became professor and really did a lot for the field of medicine. But despite the fact that he was very human in the way he dealt with the patients when he was doing his rounds and the way he treated us nurses, he never seemed human when he was conducting research. Of course he had his junior doctors. They were research doctors. We tried to bring out our human side as much as possible. We were the 'good nurses', 'the good sisters'. But nobody tried to teach us to be that way. That's not how it was.

0703/41

Something that has really bothered me over the years was the direction surgery developed in, those attempts to resuscitate people rather than to let them die. That really got me down until I told myself that if I go along with something, I am implicated as well. I saw things that I wanted to contest but they were bound to turn it

down. And then I said, “I’ve been here for 10 years. Now I’ve had my fill”. And I gave notice after working there for 10 years.

3. And I was the first senior nurse officer who actually worked on the ward

Und ich war die erste Oberschwester, die wirklich auf der Abteilung war (0502 21)

The new senior nurse officers

Analysing the category we named ‘function’ proved to be surprisingly useful. The statements in this category resulted in information which was new to me although I knew the interviews very well. They revealed a surprising turning point in the development of nursing.

The duties delegated to nurse managers – which are extremely diverse in nature – were very much in the foreground of the interviews conducted with senior nurse officers. What is surprising – after one had been given the impression that the prevailing conditions had been accepted without resistance – is the new dynamic tone of their statements: the interviews reflect an extremely active, at times even aggressive, self-image of their activities. They were often delegated the position of senior nursing officer or head sister against their own will. They set about dealing with the tasks at hand with all their energy (at times over-exerting themselves). They started to organise nursing care from within – often with opposition from the nurses, the doctors and the administrators.

In my opinion, here the nursing project in the sense of an active shaping of the profession starts. It is almost exclusively focussed on content, not on structures. The issue is the improvement of the organisation and quality of work. From where the impetus comes is not easy to deduce from the interviews. More than primarily from a new step in the development of medicine (cf. Dingwall and Allen 2001) it seems to me to have to do with a new type of nurse.

In Abbott's model, at this point we would notice processes of internal differentiation which would have consequences for the whole profession.

0502/20

And then (...) they wanted me as head sister. And first I didn't want to because I never wanted to become head sister at all. I realised that it was like changing to another job. I became a nurse because I wanted to care for patients.

0703/28

And then she got her training as a senior nurse officer and then I had to replace her for three months and I had to go. (...) and I ran high and low and even went to Sister M. W. to see whether she couldn't change anything. (I: you mean about the position of head sister?) Yes, because I knew that it would mean my having to leave the nursing career.

Being a nurse supervisor involved more than fulfilling a nurse's duties; it involved the tasks delegated to almost the entire range of hospital workers. As regards nursing skills, a sister was supposed to master all disciplines because she had to help out in the theatre, anaesthesiology, obstetrics and in direct

nursing care. In the area of management she was in charge of the nurses (departmental nurses, qualified nurses, students, nursing auxiliaries). Besides being responsible for all of these areas, she was also supposed to ensure 'that business ran smoothly' as a nurse supervisor has described in the following words:

0602/51

Yes, we were in charge of the department sisters and student nurses and in the housekeeping department there was a cook, a laundry-woman and two other women, a woman who did the ironing and a charwoman. Yes, but once I had to cook for 2 weeks in a row for guests when the cook got ill and we couldn't find a replacement for her. I once also had to do the laundry and washed the diapers. We had a washing machine but there was so much laundry to be done. Yes, we didn't have any other choice if we wanted things to run smoothly.

Despite the fact that it seems reasonable to assume that nursing supervisors were exploited physically, mentally as well as financially when replacing doctors and hospital administrators who were on holiday, the interviewer herself never would have broached this topic with the interviewees – even though it certainly could have been in this day and age.

0603/69-74

But I had to (...) he used to go off on holiday and we didn't have an anaesthesiologist, we didn't have a specialist at that time...And I had never learnt anything about anaesthetics, I began to learn about it from a work-mate who I was not very close to. She used to say to me, "Come on. This is how you give it". At the beginning she

stayed with me – we had a German scrub nurse and after a while Sister M. just wasn't around so I had to give the anaesthetic.

So I used to tremble because I was afraid. And afterwards too (...) but the surgeon took full responsibility. He always said, "I'm completely liable". And we really had (...) nothing ever happened.

And in addition to all that, I had to learn how to take X-rays. Because the doctors – we used to have free choice of physicians in this house and they sent us patients who needed x-rays of their extremities or their lungs, smaller x-rays in comparison to what larger hospitals have to do today but all the same. And we had to tell them whether something had been fractured or not. And then we had to phone the doctor and tell him our diagnosis.. (I: Is that right?). Yes.

And then I had to learn how to do office-work. At the beginning our administrator used to work on a voluntary basis and the nursing supervisor took care of the paperwork, including all the . She sometimes used to work until 2:30 in the morning. At 11:00 p.m. she had Nescafe. At 2:30 a.m. she went to bed and was up again at 5:30 a.m. And I had to learn how to do all the book-keeping because when she went on holiday, I had to be able to take over for her.

Another thing I had to learn was how to dispense medications at the hospital's chemist's. Because we had that as well. We didn't have to write prescript but we had to purchase whatever the chemist's needed.

And in addition to all that, I was also the official housekeeper there. So I had to order the meat, make sure that everybody got fed every day, and devise the menus with the cook. Sister M. used to go down to the kitchen and make deserts for the patients to relieve the cook. Even though I didn't do that anymore, I did help with the cleaning.

So I helped clean out the attic, and took down all the heavy shudders, cleaned them and then put them back up again. I used to be in charge of all that. But I was also in charge of all the shopping for food and materials and everything we needed, even furniture. (I: So you actually managed the house?). Yes, we managed the house.

This anecdote gives us a vivid description of the tasks and duties of a nursing supervisor. The following quotation also assesses the work she did:

0502/52

One of the nicest things were the Christmas parties. I was in charge of organising everything for the whole hospital. I was responsible for so many different things (...) I was always present.

Set against this background, the interpretation of the objective of management is very interesting. The nursing supervisors, who obviously had immense knowledge and know-how and an equally large sense of duty – presumably the reason why they had been designated that function by their mother-houses - mixed in with the nursing care being provided. This was a completely new policy of nursing that called for courage and perseverance, and provoked protest on the part of doctors and nurses. What was new was the following:

0502/21-23

And I was the first nursing supervisor who was really on the ward.

My predecessor was also in charge of a policlinic. And the policlinic used to be called ‘Social welfare for wandering journeymen’. (...)

So the nursing supervisor had no time. Things were supposed to get better with the position I had. But the registrar didn't accept me at all, (...). It went so far that the only thing they let me do was to go on the rounds with the doctors. And then a real fight broke out about the job I never wanted in the first place.

So the doctors were first not used to nursing supervisors who wanted to know the illnesses that had been diagnosed and the treatments that had been prescribed so that they could supervise the nursing care being provided.

0703/40

Or I could work on the wards. That was freedom. We used to be able to talk with one another. I didn't complain about them but after a while the registrar didn't have anything to complain about. I just wanted to have law and order and as few conflicts as possible. You know, doing the rounds with some 12 doctors or more, that's a bit of an explosive thing. And how many registrars there are – I saw that myself – who really dislike doing the rounds. It's a fact that a registrar is a completely different person when you're alone with him or if there is a line of doctors trailing after him. After a while everything went well.

Already established nurses were banished from 'their kingdoms' in which they used to rule the patients to the best of their knowledge.

0703/36

And so I said that I had had the chance to observe everything and to work under these conditions for 3 months and I just wanted to say that I had assumed that my job would be different than it turned out to be. Because the nursing supervisor came at about 8:30 in the morning, then somebody brought her breakfast and she used to have large books and so on. And at that time everything used to go over the office. And

occasionally we used to see them in the halls. But I told the nurses that I was also a nurse and that I knew our hospital (...) Then I said that I also wanted to work with the patients, not that I would care for them but that I would like to have contact to them. I have had to do the rounds with the registrar twice a week. That way I've gotten to see what goes on. And I see what kind of work the nurses do and I've been doing this for 3 months now. I'd like to have the freedom to go in and out of the wards all by myself. And then one of the sisters said "Listen, if you want to (...) but that's not really necessary. If you do your office work properly, you have enough to do". (I: Don't you dare poach on my territory...!) Yes, exactly. And that's just what I did. Things didn't go the way I wanted them to. (...) and then I went along on the rounds with the registrar twice a week and I sometimes saw the conflicts that arose. If the boss wasn't in a good mood he criticised all sorts of things that weren't even important about the patient charts. And then I just had to exclaim "For God's sake, do you really have to do this!" I can tell you it took four years until I was accepted by those queens. The nursing students accepted me though. And that's just how I did things.

The 'new' nursing supervisors set out to structure, to systemise and to document the duties and tasks to be delegated to nurses by various measures including the introduction of report and documentation systems. The established nurses felt that such measures were related to a loss of power and control which they initially rebelled against. In one instance the registrar was turned into an allied enemy of the nursing supervisor.

0703/42

And I think we could talk to the doctors. I used to have not exactly fights with the registrar but certain tensions because he also thought (...).He always used to call me Head Sister. He must have worked in Catholic hospitals at some earlier point of time.

Until one day I said to him “Listen, Professor, I won’t take that from you”. (...) And if he had anything to complain about? (...) No, he had (...) there used to be nurses who used to think that they always got the bad end of things, and never got the jobs they wanted. And then one day after the rounds he held a large sermon. Afterwards I told him how the situation had come about and explained everything to him (...). So, that’s how it sounded on your end. Then he wanted to tell them (...) I’ve been making sure that this business has been running for almost ten years now and it is running. (...) Yes, yes, I had a lot of courage.

It took the nursing supervisors a number of years until the ward nurses understood the meaning and the purpose of this new professional self-image.

0703/42

Luckily the nurse who first wanted to lock horns with me when I said that I wanted to be with the patients too became one of my closest staff members. We had a very good relationship and have been very good friends until today. But she simply had to realise that it’s possible to work that way as well.

In addition, in retrospect the price for the changes that have been achieved seems to be high.

0703/67

Another funny thing I realised afterwards. If you think of the four years I wasn’t accepted. I had to be glad that people greeted me or that I experienced anything nice. Or I used to have to say to myself “Thank God that there’s a night in-between two days”. (I: And when was that?) In the first four years. (I: The first four years as a nurse?). No, that was in the Cantonal Hospital, when I wasn’t accepted by the queens. Later on I basically had to realise that it had never occurred to me once in those four

years, I could just leave. Not once! (I: That's interesting.) Not once. I remember that it once went through my mind on my way home and I just had to laugh and shake my head. Not once did that occur to me. So I just stayed on. (I: Even if it went against your will). Yes. Or I think there would have been certain occasions in Tessin (...) But I never would have gone there either. You simply stuck it out. (I: I'm really impressed by the fact that the idea didn't even occur to you) Yes. And you know, I didn't even turn bitter. I'm not bitter. I'm still the same person I used to be. (I: That's nice) I was always fun to be with and was always cheerful. (I: But I guess you had a strong character...) I'd say that was my path and I was given the attributes to be able to follow this path.

4. Discussion

At the beginning of this chapter, I asked the question of how the nurses themselves experienced their profession, whether they had a professional project in mind and, if so, what it looked like.

We started with the knowledge that a reform was under way in nursing. This was to turn nursing into an official profession satisfying the demands of modern medicine. The milestones on the way to this goal were that the training was standardised and regulated, that the practice of the profession was tied to a licence, and that the working conditions were regulated. New schools were founded and those already existing were officially recognised. Since the 1920s, the *Sanitätsdirektorat* of the Red Cross above all controlled the processes. Only physicians worked there. To answer the questions, there were interviews with nurses who had been working between 1940 and 1980.

I divided the statements into the three main fields of *working conditions*, *work content* and *function* although they inseparably belong together from the aspect of the nurses' work. That was the reason why I did not individually comment the statements.

If we try now to incorporate all the aspects brought up in the interviews into one whole picture, certain salient features become noticeable.

First, the categories of working conditions and nurses' description what their work entails are inextricably interconnected. The aspect of working conditions dealing with remuneration and right to privacy is also shown to be precarious. The nurses seem to give the impression of living and working in a microcosm that is isolated from the outside world. The ongoing reform was not an explicit topic.

Second, the discrepancy between the high level of commitment to excellence in professional work and the relatively passive acceptance of poor working conditions.

Third, as a new medical profession nursing is put into the *mould* of the medical institutions. This implies that the nurses are positioned in different hierarchical systems, different domains of activity and at different intellectual levels.

Fourth, the large diversity of activities which might fall into two or three main categories: patient care which consists of medical adjunct activities (curing) and basic and psycho-social care (caring) on the one hand, and activities to ensure the infrastructure of the institution on the other.

Fifth, the nurse supervisors are beginning to systematise their set of tasks. They adopt the set of tasks and begin to conceptualise it as a unique professional body, as 'the "glue' which holds everything together" which is much more than a collection of tasks (Clarc 1997).

Supply approach – demand approach

What the nurses show in their statements is the practical, actual side of reform in nursing which was medically desired and controlled and implemented by the state and the corporations (cf. confer chapter one and four). I did not find as a political programme the professional nursing project I was looking for.

Nursing's mould – 'bundle of tasks' – settlement

The analysis of the interview data suggests that we have to account precisely for the way the duties of nursing were initially shaped. Because it is basically this shape that has constituted what first was adopted and later conceptualised by the nurses as the core and the body of knowledge of nursing as an occupation or a profession respectively.

In order to highlight the specific way of the formation of Swiss nursing as an occupation, the image of a *mould* seems to me to apply. For at the beginning of the last century nursing was cast into a pre-existing structure. It is important to understand this structure which represented three different systems, the medical profession, the hospital organisation, and the nursing school, the *'mother-house'*. Consequently, the casting thus resulted in a big diversity of duties delegated to the nurses.

Nurses were embedded in three fundamentally different systems: the medical profession, the organisation of the hospital, and the organisation and philosophy of their nursing school or their '*mother-house*', respectively. This implied that they were an integral part of different functional and hierarchical systems, had different domains of activity and had to function at different intellectual levels. In a figurative sense, we visualise them as being able to fit into a variety of different moulds as needed.

Nursing schools were to provide training in two divergent areas. One of them was the field of modern *medicine*. Doctors who worked as teachers and supervisors in nursing schools and as superiors on the ward were primarily interested in providing nurses with reliable assistance in implementing therapy plans and in monitoring and providing patient care. The official objective of nursing training was the acquisition of medical knowledge and know-how.

Besides providing medical expertise, nursing schools provided training in *housekeeping, work organisation and caring*. A Swiss nurse at that time could have been and was actually compared to a middle-class housewife who was head of the household and responsible for fulfilling her family's daily and emotional needs. This part of the training – although crucial in the curricula – represents a *tacit part in nursing*. It evolved from or even merged with a moral codex of serving. It was under the jurisdiction of the nursing schools *Mutterhäuser* or the matrons and their training staff. Training nurses to have the 'right' attitude towards their job has to a great extent been delegated to these authorities.

There was yet a third system besides the medical field and nursing schools that also played a key role in the evolution of nursing, namely the working conditions where student nurses and full-fledged nurses were embedded. Analysis of the interviews cited in this thesis has revealed that the *occupational setting* has been paid too little attention in reflections on the development of nursing in Switzerland to date. On the whole, nurses' working conditions are discussed from the perspective of women's work – that is, synonymous with poorly-paid work – and from related areas such as trade unions and gender studies. The specific working conditions (convent model with corresponding rules and norms, including the interpretation of salary as pocket-money), however, have had a different relevance because they represented an integral part of the nursing profession. This part has also been integrated by the conceptualisation, as I mentioned above.

Thus the specific organisational setting in which nursing schools referred contingents of student nurses and full-fledged nurses under conditions which had been agreed upon by nursing school directors and hospital administrators, has played a key role in the evolution of nursing as an occupation.

The nursing settlements had three main effects. First, they provided doctors with medically trained assistants who were capable of caring for patients who had e.g. undergone operations or required complicated treatments. Second, they provided hospitals with staff that could take over housekeeping chores and were also on call around the clock. Third, the settlements provided the nurses with a job they loved yet one that put them under enormous physical and

emotional strain as a result of precarious working conditions (working hours, free time, accommodation, food, and wages).

The *nursing mould* represents a customised and cost-effective solution for the health system, that is state and private hospitals. To nursing, it represents a great diversity of tasks, whereby even though foremost the medical assistance was visible, it was the tacit part as well the nurses understood as constituting their profession. It is interesting that the nurses are hardly aware of this. They fill in the *mould* they have been assigned, or rather the functions resulting from it. We cannot talk of a *professional project* in the sense of Larson's model. But the nurses are starting to take their *bundle of tasks* (cf. for instance Hughes in Dingwall & Allen 2001) or *set of tasks* (e.g. Abbott 1988, Freidson 1986, Larson 1977) into their own hands.

There were 3 different components to the duties nurses had.

1) Work that had been delegated to them by doctors

0502/28

Yes. Of course we gave injections – but that was about all we were allowed to do. But when I was head nurse we suddenly were allowed to give intravenous injections. We hadn't actually learnt how to, neither at school nor later on. They used to say we weren't supposed to give them. That was up to the doctors. And then such medications as penicillin were invented which should have been given more frequently, sometimes at night. At that time you used to have to give penicillin every six hours or so. And you had to get up at night and that made it more difficult for the doctors. So from then on we were allowed to help out sometimes. At first everybody got up for her own

patients and after a while we noticed that a certified nurse was giving all the penicillin injections everywhere in the hospital.

2) Nursing Care

Despite the fact that nurses showed great interest in medical activities, their prime concern was always providing patients with full care.

0502/28

(...) That is how we worked there. But anyway, maybe the patients did actually get the feeling that we were there to take care of them and to offer them the measures they needed.

3) Infrastructure: household chores and material

This seems to have been the most controversial aspect of their work: nurses felt that they had to devote too much of their energy – which should rather have been invested in improving the patients' well-being – to housekeeping. Despite the fact that they overextended themselves with household chores, their demands for replacement or assistance for these chores were rarely ever met. Institutions used to save money at the nurses' expense.

'Motherhouse' principle – subordination and 'professional soul'

An important element in the structural-organisational setting of professional nursing appears to me to be the system of the *Mutterhaus*. It was not only economically relevant but it also ensured the subordination, which some of the

doctors considered to be threatened as a consequence of the medical training of the nurses.

In 1942 – the time the nurses who had been interviewed started working – 54 per cent of all nurses were nuns (Schenkel 1970:19). At that time, however, there was general agreement that the medical profession were the top authorities. The nuns, and the nurse supervisors and school nurses – as the teachers used to be called then – tried to train the nurses so that they would fulfil both roles simultaneously: the role of the qualified medical assistant and the nurse who provides care and does the housework. The combination of the *'bundle of tasks'* nurses were expected to carry out and the high ideals of these leaders might explain why the interviewees often mentioned placements that had been arranged against their will and the enormous workloads they had.

Sahli as well as Heer set their sights on bourgeois women as *'free'* nurses. As has been shown in the preceding chapter, the doctors with their reform wanted to deprive the church of its leading role in nursing. All the same, they appeared to be orienting themselves quite naturally on the *Mutterhaussystem.* In this system, the nurses were subordinated in several ways: to medicine, their 'mother-house' and to the institution.

Then again, in this particular system may lie the approach to professional independence. On the one hand, a 'convent' philosophy and culture was communicated by the schools. On the other hand, life in the institution promoted solidarity and a common identity.

In the interviews, it is expressed that the nurses did not approve of their working conditions but, in the end, accepted them without bitterness. They did, however, suffer from the ethic dilemmas with which they were confronted for instance due to the shortage of personnel or medical mistakes. The commitment to the patients was fundamentally in the centre of their concept of the profession. And here in the nursing profession an aspect may appear of what Dingwall sees as a characteristic element of professions:

"Professions are not only the bearers of scientific knowledge, they are also, in effect, the secular guardians of the sacred, the priesthood of the modern world, but a priesthood which acknowledges the ultimate unknowability of things, deals in uncertainties, and recognises the openness of the world to change. The professional system is the regulating system of the modern society, whose function is to accommodate society to this reality" (Dingwall and King 1995:18-19 in Dingwall 1996).

Pointing to the normative aspect of professional ethics, Freidson (2001) speaks of the soul of professionalism.

The concept of caring, or holistic emotional work, will later be derived at least partly from this ethical part of nursing work.

'Dirty work'

According to Hughes, occupations are characterised by a specific set of tasks and roles. Within this set there are tasks which are regarded as honourable and respectable, and others that are considered as 'dirty work'. This is an important

concept in Hughes' writings and represents one element within the process of permanent change within the division of labour. The way occupations manage their 'dirty work' (concealment, delegation, integration) illustrates the specific claim of occupational boundaries. The setting of professional nursing in Switzerland and the tasks connected with it shows that nursing cannot only be seen as a delegated medical auxiliary function. The result of Dingwall's (1983) analysis of the emergence of health visiting helps to understand the occupational constitution of nursing in Switzerland: both the concept of 'fusion' and 'capture' seem to be adequate insofar medical assistance, caretaking and *convent* together constitute the occupation of nursing. The image of the *mould* combines both: 'fusion', because from all three fields super ordinate to nursing activities were derived and assigned to the nurses´ bundle of tasks: tasks of medical assistance, housekeeping and the moral/ethic guidelines of the mother-house. Abbott terms this process amalgamation. The concept of 'occupational capture' also fits, since nursing by members of religious orders was absorbed by the new professional nursing. While parts of the nursing tasks can be derived from medicine, other parts came from what Freidson (1978) calls the subjective or informal market, mainly tasks that all members of society are able to perform. Freidson (1990) locates nursing professionalism within the limits of both medicine and administration. Dingwall (2000) states that nursing's bundle of tasks has remained remarkably stable in its basic features. Abbott (1988) pointed out that the legal jurisdiction is the most durable.

The nurses on their part give account of their efforts to delegate cleaning and other household activities in favour of gaining time for the caring of patients. They only succeeded with this at the time of the crucial lack of nurses in the sixties.

Gender

The interviews give the strong impression that the nurses lived in a world of their own in the world of the hospital. Davies (1995) focuses in *Gender and the Professional Predicament* in nursing on this particular aspect: nursing care is an integral and subordinate part of a system. It is as autonomous as the system in which it is embedded allows it. She perceives an emphasis on gender in the organisation of this system. She suggests that by first looking at the framework in which nursing practice actually takes place we will realise that the concept of the profession only applies to jobs commonly delegated to men and thus would either have to be refuted or modified accordingly (Davies 1996a, 1996b).

It applies to the nurses´ interviews that they felt themselves to be autonomous in *their* world. Even though the nurses were part of a complicated hierarchical system as described above, it does not exclude autonomy as an element of nurses' work in their view.

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(...)A surgical-urological department where nurses acted very autonomously. We have doctors who are not here all the time. That is why we were able to take over quite a lot of responsibility and really achieve something. But as far as the nursing care we

provided was concerned (...) we tried very hard to make sure that the patients were bedded down comfortably. We considered that to be a central part of our jobs. We had to bed patients very often. (...) Vein diseases like embolisms or phlebitis or lack of physical activity and of course to some extent a lack of fluids. And then we had to bed patients who had phlebitis. Bedding them properly and making them feel comfortable is quite an art. Those were the things that were important. I sometimes practised how to bed those patients. When I was off duty, I used to sometimes go to a nurse I knew who had a lot of experience and ask her to show me how to do a good job of making a patient with phlebitis feel comfortable in bed so that I in turn could show the apprentices how it was done.

Savage and Witz (1992) are also convinced about the importance of including aspects of gender in theories about professionalisation "because organisations do not exist in some abstract sense and power is not due to the stratification system, but rather has to do with human agents and their relations".

Witz states that the model of the male career rests upon another assumption, namely the existence of the person – the wife – who is at her husband's service. This is of far-reaching importance for organising and dividing the work: "Many organisations imposed marriage bars on their female work force, forcing them to retire on marriage, and so become full-time housewives. Male workers, on the other hand, were expected to be able to draw upon full-time domestic service-givers so that they could work long hours, get work done by their wives, and so forth. Modern bureaucratic hierarchies both helped to construct the idea of the dependent housewife and drew upon this for their own advantage" (Witz and Savage, in: Savage and Witz 1992:12).

Therefore professions should be considered as professional projects, in order to gender the agents.

The closest co-workers of the nurses, the doctors, represent this concept of profession in two ways. On the one hand in the private domestic support, on the other hand in the professional support by the nurses. In other words, the professional status of medicine rests upon the private and professional support of women. This constellation is described as characteristic in the gender discourse on professions. For this reason a number of authors fundamentally question the concept of profession (Davies 1999, Thornley 1996, Rafferty 1996, 1997).

It is obvious that this analysis confirms the claim that the institutions in which the nurses of the study worked were deeply 'gendered'.

But the nurses did not feel themselves to be oppressed or dependent on medicine, but to practise a full profession with a great deal of autonomy (cf. Dätwyler et al. 1999). They developed strategies to reach their own goals in the given settlement. The evaluation of the co-operation with the doctors shows positive results (cf. Dätwyler et al. 1999, Dätwyler & Baillod 1995; doctor-nurse game, Stein 1968:101-105).

Control over work: jurisdictional audiences – workplace –settlement

The concept of profession implies the professionals defining the terms, conditions and goals of their work, in Abbott's terms this means full jurisdiction. In Freidson's, it represents the pure professional model. In reality,

professional groups do rarely reach this state and are never stable; on the contrary, they are constantly contested. Within the system of professions, jurisdiction represents the key concept concerning the claim to processional status. Abbott defines jurisdiction as both cultural and social structures; thus the analysis of professional claims means understanding their target (public), their general forms (settlements) and their social structure (internal structure) (Abbott 1988:59).

In order to understand the nurses´ world in the super ordinate world, Abbott's concept of the system of the professions is helpful. In this system, the issue is power and the status of the professions. That is what the fight is about. The system is constantly in motion. Two of Abbott's main categories of audiences seem to be especially relevant for the development of Swiss nursing.

Settlement

Even though I have already pointed to the position of nursing by the concept of the *mould* I suggest focusing now on the *dynamic* within this system.

The question of where and on which terms the nursing staff – i.e. student nurses and qualified nurses – was called into action was the object of negotiation between the '*Mutterhäuser'* , or nursing schools, and the hospitals or homes and institutions.

The '*Mutterhäuser*' were usually schools which worked in association with a hospital. The matrons were headmistresses of the nursing school and were also in charge of organising nursing care. Training mainly consisted of practical

work on so-called school wards which, wherever possible, were run by nurses who had graduated from the same school. There were teaching wards in the hospitals connected to the nursing schools but also in other hospital or homes; these were called outposts. Together with the school board, the matrons decided which tasks and functions the student nurses and the qualified nurses would carry out, and they were also in charge of planning when and where students and qualified nurses would be on duty. In this way, the nursing schools were able to safeguard the *unité de doctrine* (i.e. their control of the field). The hospitals were dependent on contingents of staff from the nursing schools.

Freidson (1990) argues that the power of allocation of resources is critical for professional work. It is interesting to note that, on the one hand, the heads of schools had the say as to, for instance, how many nurses or which ones in particular were allocated to a certain hospital, decisions about the wider job plan were taken by the administration on the other.

The administrators of each contractual partner laid down the financial terms of employment, or they drew up contracts concerning compensation for room and board and settlement of wages to be paid to the nurses. The administrators were the direct superiors of the matrons and the ward sisters in outposts (cf. Fritschi 1990, Schenkel 1970).

The hospital board of directors was above the administration in the hierarchy, and members of the board generally were medical doctors. In the clinical field, nurses were subordinate to medical doctors in the direct line of command.

The organisational and hierarchical structures are complicated for nurses – more so than for any of their colleagues at work.

Seen from the physicans' perspective, hospitals were supposed to render services to their profession. Significant developments in medicine made it necessary for doctors to have well-trained assistants who would help them care for their hospital patients and nurses were expected to primarily carry out this function. As a result, the development of nursing as a profession in Switzerland was a project run by doctors (cf. chapter five). According to Abbott, this project would concur with one of the various forms of settlements.

Abbott (1988: 71) himself interprets the subordinate position of nursing as another form of settlement: subordination as a public and legal settlement often results from a failed attempt at full jurisdiction, as had been the case with Florence Nightingale who had aimed at making nurses equal to doctors as regards their administrative and custodial duties. However, due to the fact that the division of labour was already controlled by the medical profession, a movement similar to Florence Nightingale's failed. As described above, physicians were the ones who from the very beginning systematically defined the concept of nursing as a profession: In the first place, a nurse was to be an informed adjunct of the physicians and in the second place she was supposed to be a housekeeper at the hospital (Dätwyler and Lädrach 1987, Fritschi 1990).

Yet neither the household work they did nor their working and living conditions were brought to the physicians' attention. In other words, these duties remained a tacit part of nursing.

The ward sisters supervised both of these areas of nursing. Throughout history, patient care and housekeeping have been associated with nursing for longer than the function of a medical assistant. As described in chapter three, Catholic and Protestant religious orders were largely in charge of the nursing care provided in hospitals even up to the 20th century. When modern medicine began using hospitals for its own professional purposes, real power struggles broke out as to who was to be in charge of nursing.

Seen from today's perspective, another aspect that remained a tacit part of nursing at that time, neglected by those in leading positions, is the question of pay and working conditions.

The interviewees gave detailed descriptions of the poor working conditions and the huge workloads they had, which was an additional stress factor. Set against this background, it is astounding that the administration was hardly mentioned, neither by the nurses nor in the literature on the sociology of professions. The administrators were familiar with the working conditions of all parties involved. They were in direct contact with everyone. They were in charge of the nurses' working conditions. None of the statements of the interviewees give us any information on the extent to which the medical authorities took part in negotiations about working conditions. Nor was there any evidence that the nurses' supervisors had fought for any improvements in the nurses' working conditions[11].

[11] From my own experience as a teacher in a school of nursing from 1972 to 1995 I know that there used to be tough arguments about the nurses' working conditions between the nursing

The administrator focussed his attention on the hospital, which was subordinate to the medical doctors. When viewed from this perspective, the high demands on the nurses remained tacit or obscure.

The analysis of the settlement of the interviewees reveals – what I have already stated concerning the concept of the nursing's structural *mould* and the corresponding content of work – that Swiss nursing cannot be referred exclusively to medicine. Yet despite the fact that physicians were the top authorities in facilities providing health care, nurses' work consisted only partly of medical duties. The '*mother-houses'*[12] represented the entirety of the nurses' activities – curing, caring and housekeeping. They were in charge of training and qualifying student nurses and of placing and taking them back if necessary. This position of power was until recently an element in the complicated contractual settlement governing nursing. The mother-houses/nursing schools, as well as administrations of institutions, played a more important role in the question of the jurisdiction of nursing than has generally been assumed.

According to Abbott's concept of settlement, the settlement of subordination would be the most appropriate. Abbott also addresses caring in this context. Abbott states that subordinate groups are often directly created as a result of the division of labour below dominant professions. In the field of medicine,

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leaders and the head of the administration in which the doctors used to be on the side of the administration.

[12] Nowadays the term 'mother house' is being used informally and describes the school of origin of a nurse.

Hughes differentiates between downward delegation, which applies to the paramedical professions, and segmentalisation, with dentistry as an example. Downward delegation proves to be only partly correct in the case of the nurses in my study since functions of medical assistance were only one part of their work and since the nurses were not only subordinated to the doctors but also to their mother-house and to the hospital administration.

Workplace

Abbott shows that in institutions the inter-professional boundaries are blurred because the task of the institution is in the foreground and the functions can be obscured. In the case of medicine and nursing, workplace assimilation is a natural thing. I have shown above how the doctors took action against the undesired independence of nursing.

The social mobility project

We have seen that the categories of working conditions and nurses' descriptions of what the work entails are inextricably interconnected and that working conditions dealing with remuneration and right to privacy were precarious. We have also found a discrepancy between a high level of commitment to excellence in professional work and a relatively passive acceptance of poor working conditions.

The concept of profession "represents a more than ordinary *commitment* to performing a particular kind of activity – an avowal of a special sort of devotion or dedication" (Freidson 1990). To a very large degree, this was true

for the nurses at the time. But if Larson (Larson 1977) states that professional work cannot be detached from the rest of life, she does not understand it to this literal extent, namely that life and work become the same.

Professional work is described as a two-sided concept (cf. Evetts 2001, Abbott 1988, Freidson 1986. 1990, 1994, 2001): besides being of benefit to consumers, professional work also represents a means of economic gain. On this score the nursing profession does not fit the definition of profession in the time period of which the nurses tell.

The fact that the work implied living at the place of work was seen to be an attribute of the occupation. Giving up one's right to a private life was a sacrifice which nurses were aware of before starting their training. They chose this career. It goes beyond the scope of this study to explore what lies behind the choice of career (e.g. career opportunities for women, the choice between marriage and career, connotations of the nursing profession as a medical career for women, cf. Dätwyler et al. 1999, Dätwyler and Baillod 1995).

The wages of nurses consisted of pocket money. The rationale for this was that the institutions were covering the cost of room and board as well as providing for illness and old age. The descriptions given by the nursing staff leave no one in doubt that this system of payment worked against the nurses in every way, and only benefited the institutions (some examples: a charwoman cost more than having the nurses do the cleaning; nurses had to file an application to ask for permission to get married).

Although the nurses in our interviews were aware that the pay system was unfair, they did not engage in political campaigns to fight for better conditions. If wages were mentioned at all during the interviews, it was only in the context of comparing different work places.

The topic of women's wages cannot be examined here in more detail. However, it is important to stress that nurses – then as now – do not see pecuniary reward as a crucial factor in determining their professional interests (e.g. VAP Study: Moser et al. 2001; Strub and Künzi 2001). Their feeling of having status does not come from the payment they receive but from their activities as a nurse.

The dialectical relationship between exceedingly high commitment and extremely poor remuneration, each on opposite poles, gives rise to some questions.

To the extent that status or social mobility is connected to income, power and influence according to the theory of Larson, Freidson and Abbott, this concept does not apply to the case of nurses. The question would have to be asked whether social mobility might not be redefined also as choosing a – even poorly – paying job as an alternative to choosing the career of housewife, and making the former rather than the latter one's vocation. Gaining independence from a 'family career' has always played an important role in the biography of nurses. Nursing as a profession is appraised as interesting, versatile and is seen as a socially meaningful activity. In the past, many nurses had to struggle

against the will of their families in order to pursue their career (cf. Dätwyler and Baillod 1995, Dätwyler et al. 1999).

Seen from this perspective, the term social mobility, when applied to women, could be used perhaps to refer to the act of stepping out of the world of the family and into the career world. However, this professional world is fundamentally different from the male career world, in that the female world is conceived to be an alternative to a private life and the founding of a family. It is not my intention to take up the topic of the dual standard in relation to gender[13]. Yet the consequences of this professional pattern for nursing must be stressed, because the duties and functions of nursing are devised to fit this *mould*. To date, nurses' role and function within the health care institutions as well as the diversity of their tasks are comprehensible only against this background. (Dingwall and Allen 2001) and state that the bundle of tasks, although fluid because of nursing's licence (Hughes 1971), have remained remarkably stable. I shall return to this point later.

The nurses' professional project

We have seen that, on the one side, nurses were involved in complicated hierarchical structures and their work became the result of a specific historical structure of the institutions with three focuses: curing, caring and

[13] For male nurses, this aspect shows different indications insofar as at that time the male nurses took on functions as house servants combined with some nursing duties. They represented a small minority. Nevertheless, the administration did not like to see them getting married.

housekeeping. We have seen too, that together with this bundle of tasks goes a considerable amount of autonomy.

The interviews have not only made the *mould* manifest but also shown that at a certain point in time leading nurses took the development and organisation of nursing into their own hands. They made nursing into their project, meaning that they conceptually brought together the bundle of tasks which had been delegated by medicine, the administration and the mother-houses. We have seen that nursing has in part entered the official market via the subjective. Freidson suggests that these are tasks which may be both the cradle and the grave of professions. "As they are translated into the market, their organization into occupations depends upon assembling the skills into intellectually or practically defensible units" (in Dingwall 1983).

We now see that a professional project is indeed developing from the work. The nurses feel forced to structure their work, to rationalise, to conceptualise. The nurses begin to design, to shape, to arrange, to conceptualise the activities (for instance documentation, administration, night duties, co-operation with the doctors etc.) which were not only situated in different domains but also at different intellectual levels. Starting in 1950, this development also took place on a theoretical and pedagogic level at the *Kaderschule* in Aarau.

As already mentioned, the analysis of the interviews does not reveal what I had looked for, namely a professional project corresponding to the demanding theory. Instead, we see how the market (medicine, hospitals) and the corporate state (Swiss Red Cross) organise the support for modern medicine. Over time,

this newly moulded professional group develops a growing dynamic within this *bundle of tasks*. We will track this development in the next chapter.

Chapter Six: The Professional Project in Nursing

Conceptualizing the 'bundle of tasks'

Maybe it is time now to briefly recall our goal and the stages of our voyage so far.

It is the goal of this voyage to obtain a picture of the professional project of Swiss nursing. In a first stage, we noted that, in the 19th century, the Swiss nation adopted a liberal, strongly de-centralised structure. Only tasks of national significance were handled centrally. An example is the national monopoly of medicine around 1900. We have noted that licensing was not only the result of a successful policy of lobbying but just as much in the interest of the government (social question). From this, I deduced that, as a theory, the supply approach would be appropriate to this case. We have furthermore seen that, within medicine, the process of a division of labour by downward delegating (delegating of 'dirty work') was probably the impetus to establish 'free' nursing – corresponding to the description by Hughes (1958) and other writers on the sociology of the professions. The physicians demanded qualified assistants.

In the second stage, we have observed how this demand was put into practice starting around 1900. The process can be described as a corporative project by the nation state which ensured the national interests (low costs, prevention of epidemics, and medical are in times of war) and the interests of medicine. Two

Swiss charitable organisations headed by strong personalities conceived the re-organisation of nursing and started to implement it step by step. The schools were organised following the model of the *Mutterhaus* which was not only economically advantageous but also allowed the integration of the religiously organised nurses of the time. Thus three superior structures formed the *mould*, into which the new kind of nursing was put: medicine, administration and the *Mutterhaus.* Thus we can see professional nursing in accordance with Johnson (1995) as a development parallel to the state. However, the concept was not only about the delegated 'dirty work*'* of medicine as Hughes (1958) describes it, but the result of a 'fusion*'* of different elements following Dingwall's theory (1983). Also, the position of the nursing profession remains subordinate in a medically dominated division of labour, which is said to characterise the particular status of nursing as a profession (cf. for instance Abbott 1988, Freidson 1990b, Dingwall 2000).

In the third stage, the preceding chapter, we have seen how work and life went on in the above-described *mould*. The working conditions, which were organisationally as well as ideologically influenced by the 'mother-house' system, can be put into Freidson's (1978) categories he described in his contribution to *Official Construction of Occupations: an Essay on the Practical Epistemology of Work*. The nursing profession at the time when our interview partners were working is a mixture between official and informal, even subjective occupations. 'Official' in the sense that the profession officially existed, 'informal' since salary and working hours were not regulated like they were in official occupations, 'subjective' since it was frowned upon to

work for money and not out of an inner impulse. In connection with the informal character of nursing, the gender aspect is also expressed. Without exception, there was a bourgeois ideal of women where charity work, particularly caring work, was seen as the fulfilment of nature (cf. for instance Dätwyler and Lädrach 1987: 107). Another aspect of the features of the nursing professions based on charity and gender-ideology is probably the culture of the religious orders which – as has been mentioned – was strongly represented in nursing, from the beginning in the new training as well (cf. Dätwyler and Lädrach 1987:102). In this context, I raised the question of whether the roots of the caring concept could be based on this. Freidson (1990) also takes up this question but in relation to the status of the nursing profession: "Is it possible that an emphasis on nursing's caring role can change the position of nursing?"

As mentioned above, so far I could not detect a professional project corresponding to the theoretical model. With few exceptions, the nurses themselves were far from politically active, neither regarding the politics of their profession nor, even less so, regarding the politics concerning their status. I call to mind the fact that the professional association (*Krankenpflegebund*) was founded and directed (until 1935) by medical doctors. But there were certainly first signs of a professional project.

In this part, I argue that the *mould*, i.e. the whole bundle of duties, was assembled and integrated by the nurses in order to construct a whole. This process resulted in the nurses' claim to have their work regarded as a profession. The implementation, however, could be difficult.

In the following, I would like to follow the way of the professional project. Taking as an example the *Kaderschule für die Krankenpflege*, I focus on the question of whether and how the carers were able to politically be successful with their attempt at professionalisation. The Red Cross *Kaderschule* demonstrates the developmental process nursing underwent with regard to the content of nursing work as well as to political structures.

Here as well, I am able to rely on interviews with leading figures. They all contributed to the development of the school.

The subsequent *phase of professionalisation (1950-1992)* was characterised by leaders both in the practice and in the training who integrated the many-facetted set of tasks involved in nursing by conceptualising it as a unique professional profile: the 'glue which holds everything together' that is more than a mere collection of separate tasks. The integrated concept of nursing has cast light on the tacit aspects of the profession by including in the concept of caring more than medical assistance. The elaboration of theoretical models of nursing as a professional field has been an ongoing process since the *Kaderschule* (Management School) was founded in 1950.

The impetus to introduce further education for nursing officers came from the following parties: head nurses in the health-service system (cf. chapter five), the 'Association of Nurses' (SVDK, later SBK), and the Red Cross, that is to say the 'Commission for Nursing' founded in 1944 (President: Dr Hans Martz, MD). Outstanding personalities played just as crucial a role in shaping the school of further education as during the constituting phase of the nursing

profession. After five years of planning, the *Fortbildungsschule für Krankenschwestern* (School for further training of nurses) was founded in 1950. “Over the course of time, the initially vague and sometimes differing ideas had – partly quickly and directly, partly via various intermediate stages – taken definite shape” (Bourcart N., in: Valsangiacomo 1991:305). Likewise, the relationships between the organisations were corporate during this phase: the vice president of the commission was President of the ‘Nurses’ Association’ and nursing senior officer of the *Kaderschule,* all at the same time (Monika Wuest). The Red Cross wanted to create a Swiss school rather than copy models from abroad. From the very beginning, the authorities assured everyone that the school would never become an elite school (Valsangiacomo1991:314). Monika Wuest underlined that the school should never strive to be a university, unlike the situation in other countries (Valsangiacomo 1991:315). For pedagogical reasons, the male directors wanted the school to be a boarding school – against what the female directors wanted.

In the issue how the school inspectors were to be integrated into the hierarchy of the Red Cross demonstrates how the *Kaderschule* was aiming at autonomy. There was a lot of conflict in the relationship between the *Kaderschule* and the Red Cross. In the 1960s, the controversy was primarily about the costs and the financing of the *Kaderschule*. “In several instances, candidates for traineeships had to suffer financial losses if they accepted a place in the *Kaderschule*.” (Valsangiacomo 1991:334). In the Duvillard expert’s report (1973-1773), it was recommended to reconsider the maintenance of the *Kaderschule*. It was

noted “that the claim of the Swiss Red Cross, to be in charge of nursing and nurses’ further training, was not on principle accepted. In 1973 and 1974 it was far from unrealistic to think of the state taking over the *Kaderschule* for nursing” (Valsangiacomo 1991: 337).

Two bills were voted on by the people, both were rejected. For the Red Cross it was clear that it wanted to keep its authority; even if the bills had been accepted, the organisation had counted on getting a mandate. The nurses on their part had hoped to be free of the Red Cross.

PN04

At the beginning of the seventies, there was hope – it was a purely Swiss vote – that the training in health professions would also be made part of the BIGA (*Bundesamt für Industrie Gewerbe und Arbeit*, BD). We were fighting for that. We wanted to be independent from the Red Cross. We had a teacher who was in the National Council who had to submit and support this. Then the vote came and it was denied. So we stayed with the Red Cross. (*BD: So you fought because you thought that the Red Cross was more of a hindrance than a help?)* Yes, because of the restricted finances, the Red Cross had to beg from the cantons, from the directors of the medical service, and not every one of these directors understood why this was important. There were also cantons which were a bit behind the times and did not see it like that, Zurich and some others of the large cantons were the exceptions. After all, it was something odd that these professional trainings were not under the auspices of the BIGA but were such a special case and controlled by the Red Cross. We wanted to change that but were unable to.

In 1976, there was a solution at the level of the cantons. In the SDK-SRK Cantonal Agreement, the duties assigned to the Red Cross are explicitly specified. The most important effect of that agreement was that the cantons took over a substantial part of the costs and were put in charge of the explicit task of providing management training to people in the nursing professions. In 1988 the status of the *Kaderschule* within the Red Cross changed considerably when a new executive-level position was created. Strong debates were connected with this. The female representatives of the *Kaderschule* resisted since there was little professional competence in the new structures of the organisation now superior to the *Kaderschule*. They felt that the Red Cross wanted to put someone above them at any price (cf. Interview PN03).

PN03

I saw that, if the Kaderschule was so to speak connected with the department for professional training that (and now I am saying something very bad): When I was still a very young woman – before I went to the Kaderschule – I was myself in the department of professional training, and there were M.C., R.S. … They were women! Later, there was N.F. (…) and then there were (…) people who I felt had no idea about the whole thing. And even today, there are in the department only very few people who know what they are doing; the (…) were never interested in conditions outside Switzerland. That was the reason why I was so much against our school becoming part of the department (…). The reason was that one wanted to put someone above us who had no idea and the nurses would then be below that person.

The re-structuring was carried out and the above-mentioned personnel appointed. As a consequence, a number of leading persons left the *Kader-schule*. As a result, the school lost its special significance for nursing.

PN06

(BD: Why did you leave the Kaderschule?) That is censured! Well, no, my reason was (…). At that point in time, nursing knowledge was of little importance at the Kaderschule as far as the Red Cross was concerned, only pedagogic and management. (*BD: And you noticed that?)* On the one hand, it became manifests in the number of hours nursing was taught as against the teachers and in management and, on the other hand – at the time I attended, it was required that there was one hour of preparation time for one lesson in school.

PN04

There was definitely a break since – who had put pressure on as at the time? – I believe the directors of the medical service and the Red Cross. Then the Canton of Aargau announced that it was interested in the school since the VESKA (Swiss Association of Hospitals, today H+) was also there, so it would be a centre. Then (…) She fell ill and she quit. (…) every year, we had a different female or male director. The first director was Mr (…), therefore someone without experience of the field, he was (…) and did not know much about the health system. That was all new to him. That caused things to "slow down" (…) Then he left again. Then there was (…) ad interim (…). Subsequently, (…) came, she was a professional. Now it is again someone without any experience of the field. (*BD*: *What is the explanation for that?)* Well, we thought it was a pity that it was no longer in the hands of our profession. (…) One relinquished it, I regretted that very much. I cannot say how it is now.

The considerable development in nursing at that time is what I have referred to as the *conceptualising phase*. In its first decade, the main subjects taught in the *Kaderschule* – which had been called the 'School for Head Nurses in Schools and Hospitals' up until 1971 – used to be general knowledge and physiology. Starting in the sixties, greater emphasis was gradually placed on nursing care, initially on the organisation of nursing services and later on theories of nursing. The seventies and the eighties were shaped by a 'paradigm shift' in nursing (PN05) which involved elaborating "nurses' own field of knowledge" (PN04), or further education in terms of 'advanced nursing knowledge' (PN03). This time it was a group of nurses who had worked and studied abroad who realised that Swiss nursing had a great deal to catch up with, and who took on teaching commitments at the *Kaderschule*.

PN05

Then, ten years later, I was a young teaching nurse, and there were steps from the dark ages to natural science and technology. I wrote my first book because of this, to record the knowledge. (…) then, another ten years later, I experienced how we got more technical and noticed that one overall bathing of the patient each day didn't work and then I made the step to the holistic approach.

PN04

In 1960, nursing was still very strongly medicine-oriented and we really didn't know anything about the theory of nursing, except Mrs Henderson. I had made her acquaintance in England. There were new concepts such as the care for the terminally ill in the hospice with Cisley Sanders, you know, whom I had also met in England. Then it suddenly dawned on me that this was going to be a field of its own in nursing

which has nothing to do with medicine. And it was like I had seen the light, that one could start with the needs of the patients instead of the diagnoses from the medical side. I still know (…) Later, I integrated that into the curriculum at the Kaderschule: (*BD: Then, when you went to America ...)* (…) Then of course I went to large libraries and we also had courses on theories of nursing. Then I saw even more lights! This knowledge I then brought back with me to Switzerland. I translated a lot into German (…). That was something completely new at the time. *(BD: At that time, there were already several of you, were there not?)* There was also (…). She simultaneously graduated with a Masters Degree for Adult Education in Great Britain. But then she did her job on the basis of theories of nursing, you know, like Travelbe and so on, and Rogers then came into fashion (…) She did a lot with patient-oriented talks, communication and so on, and I worked more in the direction of the planning of nursing, nursing processes etc.

Their ways of thinking and acting were substantially formed and shaped by their personal relationships to people who had made an active contribution to the development of nursing all over the world. One of these people is the sociologist Anselm Strauss of the University of California, who has been a friend and mentor to the Director and a guest lecturer at the *Kaderschule*.

PN03

When I came back to Switzerland, I was terribly disappointed and felt, oh, not like that! *(BD: Then there was another departure, again far away?)* Yes, then was another departure. It appeared to me to contribute in some way to changing the situation. But never, I don´t think I ever (…) but from time to time, I did have big goals! I have to say, already when I got to know Anselm Strauss and read what he had written, e.g. *Chronic Disease, Nursing of Chronically Ill Patients,* then I thought what we are

lacking in Swiss nursing is further training in special fields of nursing. Then soon after my studies I had the objective to contribute to developing the nursing knowledge in Switzerland. That was important to me, not my career, but that I could promote this. (...) Yes, above all (...) and I worked very hard towards it, (...) also joined. (...) We then had above all the goal to establish specialist training. That really concerned me (…) on the one hand as a didactics teacher (...) and I soon noticed that the female teachers lacked the knowledge of their profession. The training might have been still a quite good pedagogic-didactic training, but what about the knowledge! For instance I soon noticed – after I had been to England, Israel and America – that almost none of our pupils read the literature, the literature on nursing. I found that awful.

PN04

Well, at first I felt very much like I was fighting the battle on my own. But then came (…) – in England, she had also seen the light – then we fought together. And then – I believe it was in 1970 – it happened (…). Then we could work together well.

This group of nurses has not received a great deal of support either at the *Kaderschule* or from other institutions. They are even known to sometimes being ridiculed by social science teachers at the school.

PN04

In contrast, the pedagogic side of the Kaderschule, that always worried us, because of this nursing, especially when later men also joined, pedagogues, psychologists, sociologists. They always smiled at us. I can still feel that today, they always wanted to ridicule nursing somehow, also our enthusiasm about nursing. They thought this was a myth, the myth of nursing, and that we were full of missionary intentions. *(BD: Did (...) laugh about it as well?)* Yes, something also a little bit, well they always accused (…) and me (…) of having missionary intentions. We had to assert ourselves.

Then even more people entered nursing – and there was one time (…). There came (…) – well, they came more in the eighties. *(BD: But they were also smiled at, were they not?)* Yes, well, (…) in the eighties, they were then also very much in favour of nursing. So I found it great to work with them because we felt supported and worked together. Then they also studied. *(BD: Were there for you all – or for you in particular – other obstacles in the Kaderschule? (...)* Pedagogy simply carried more weight. The idea was that the basics of nursing or of theories of nursing also had to be integrated in the training of the female teachers, they had to be well-versed as well. In the middle of the seventies the curriculum of the Kaderschule was revised. Then there were learning modules in nursing. Everybody had to enrol for them, that was obligatory. Only then, in 1983, one was able to graduate from the so-called *Höhere Fachschule* in nursing, a college of special higher education. *(BD: That was then the centre where nursing was concerned?)* Yes, for nursing it was the absolute centre. (…) I must say that I had significant autonomy there. They didn't interfere with me there. (…) But nursing was in the centre. *(BD: To come back to this situation now: Do you think that it plays a role that nursing is a women's profession?)* There is no doubt that it played a role. Over and over again, also in the team at the Kaderschule, the issue of men versus women came up. We from nursing were women. The psychologists and the pedagogues were men. They were academics and we not yet. There were many discussions in the team about that. (…) The women were inferior. (…) We always had to – how shall I say – create an image for ourselves. You felt under pressure to create an image for yourself and prove yourself. I still remember the respect the men had when we published the book *Pflegeplanung* (Planning in nursing). (...) *(BD: That impressed them?)* Yes, that impressed them. *(BD: And they appreciated it?)* Yes. They probably thought we could not write a book.

Although there were a few situations in which the Nurses' Association, that had been linked by contract to the Red Cross until 1979 (the agreement dates back to 1962), did lend its full support to the development in question, but the support tended to be rather weak. Nursing schools seem to have had an ambivalent attitude to the development, primarily due to the fear that teachers would not be able to meet the higher demands they would be facing. Explicit opposition came from the cantons, i.e. from the 'Conference of Health Directors' (SDK) which dealt with the issue of the development of nursing first of all from the vantage point of staffing and financial constraints. In the Red Cross, respectively its 'Department for Professional Training', nursing expertise was scanty. Criticism voiced by the *Kaderschule,* that educational planning should be guided by clear professional concepts comparable to those adhered to in other countries and by the definition of criteria of selection rather than by haphazard market demands, for instance, led to the exclusion of critical staff members when the first guidelines were revised (*Richtlinienrevision*).

PN03

It was inopportune to get support to promote our profession. For the cantons and for the confederation, the Swiss Red Cross (…) was decisive for nursing. And the people they had! I often fought with (…). (…) I could not make the people who worked together with (…) understand that you have to start from one end. After all, I did not have elitist ideas, but it would have been my goal (…), that people who create the concept for an education in Switzerland understand something; that they are not simply people who listen to what this or that person wants and then come up with whatever. I believe that the current guidelines were formulated exactly like that. We were actually in the 'Commission for the Guidelines' *(Richtlinienkommission)*, (…)

and I together with (…). That was for the 1st revision of the guidelines, when a four-year training was planned, thus not yet the diploma-level I and II. We were excluded because we said that we cannot only consider what the cantons wanted. If we wanted to promote our profession for the future, it first had to be precisely decided what, on the one hand, was needed for this and, on the other hand, we had to have a goal. A goal would also be that we would be internationally exchangeable, within the WHO (World Health Organisation). There was a report by the WHO in 1985, *Rapport sur la Formation Supérieure des Infirmières*. It already stated that appropriately trained people were needed to assess the nursing needs in a country and to create an education concept. In Switzerland, one simply did not want to believe that. On this guideline commission, I already said at the time that we should not plan an education in Switzerland in isolation just because at the moment there was this requirement for nurses. (…) and I was dismissed from the commission.

The nurses realised that reaching their goal – to attain professional status – was only possible via politics, and that in other countries the political environment of nursing was different.

PN03

(BD: Which were the obstacles on the way to develop nursing in Switzerland?) There were other obstacles as well, they existed in the whole context in Switzerland. It started in 1979, when I attended the School of Nursing in San Francisco where I was not regarded as a foreign student but I could watch the dean, the female director, for three months, what she was doing, and work with her. She received support not only from the whole university – because the School of Nursing did a high-quality job just like the others – but also from outside, politically. One was proud of this school which had such a good name, and such good people as well. When I look where the people

of the School of Nursing in San Francisco from that time are today, I must say that they are all leading people all over the world. The current health minister of Korea, the current president of the Japanese nurses' association; they are all graduates of this School of Nursing. That was already noticeable at the time, the school was supported by the society. I then quite soon went to Zurich University, to (…), the vice-chancellor. I told him that I didn´t think that in the Swiss education system the basic training in nursing would have to be done at the university. We have a very good basic school and I believe that we as nurses in Switzerland can work with good women who are not academically trained. But a country like Switzerland needs at least one university where e.g. those who will work in the field of training can study; the people we need in the school. There still exists a letter in which Professor (…) wrote I had better look to it that the nurses would more gladly empty chamber pots again instead of thinking they had to attend a university. I am only telling you this to show you that we had not support from society and not from politics either. After all, politics here is mainly a thing for the men, there the image of the kind nurse is very strong, and that image has also been influenced by numerous physicians who basically resisted the development of this profession. That is what I felt very strongly in Switzerland, of course.

The nurses tried to get political influence through personal contacts as well.

PN03

Well. I invited the director of the medical services in Lucerne to the school. At the time, I was still in the EVP. I invited the EVP (Protestant People´s Party) politicians so they would talk a bit about us in the Federal Council or something. But, you know, that was so (…) like a needle in an enormous haystack! (…) I was probably not always successful. At the same time, nursing in the hospitals deteriorated.

Simultaneously, there was a shortage of staff. A large number of foreign nurses were employed, Philippinians etc. Everything happened at one. If I then told the director of the medical services in the Canton of Aargau that we had to have a new concept for the training in nursing, that we needed people who knew how to do that, and people who know how to do that first have to get a chance to study. He said to me that the nurses should better go and work so they didn't have to recruit people from the Philippines. The context was highly unfavourable.

Resistance against the project of this pioneering group came not only from politics but also from their own camp. The interviewees see the reason for this that the majority of the nurses were afraid of not being able to meet the requirements. The 'Swiss Association of Physicians' (FMH) did not support the nurses´ professional project although they appeared to be convinced when contacted personally.

PN03

This is also interesting: In personal talks with doctors, I experienced that they understood very quickly what we wanted. It was the same with doctors who had been abroad and had there worked with academically trained nurses. They understood that we didn´t want a 'mini-medicine' but qualified nursing. I never had the impression that they wanted to keep me ignorant. But the problem was that we couldn´t reach those who had the power.

It was clear to the protagonists of the professional project, that the Red Cross, their most direct and most fervent antagonist, was caught in a web of dependencies since, after all, it was a charitable organisation.

PN03

After all, the SRK is a Swiss institution and has to do justice to all the people all over Switzerland. The various sections have a strong influence. And these sections differ enormously, e.g. the Zurich section is dominated by doctors which the Glarus section is dominated by completely different people. Depending on who dominates, that is what the influence on the SRK also looks like. The SRK is also a genuinely dependent institution. During my studies, we often discussed this and noted how dependent nursing in Switzerland is from all these political commissions which, when all is said and done, have nothing at all to do with nursing. That was also one of the reasons why it would have been very important if we could have worked really well together with the professional association. After all, we did a lot for it. I was very glad then, when U.W. was in the union (…). I had always hoped that one day a professional association would be really decisive in Switzerland regarding what had to happen in nursing, as to the education as well as to the assessment of the quality in practice. Because of the fact that we still have the Red Cross which is a politically much more respected institution, the professional association never has the same 'power'. That is e.g. a difference from how it is in England. The professional association there is a political commission which at the same time is a union. That gives them more influence. With us, I have to admit, the professional association has over the past year gained a good voice of itself and now has excellent people, for instance C. P., who are really saying what nursing is and what is needed, U.W. as well. But, as I said, the professional association in Switzerland never has the 'power'. *(BD: The question is, could it be more political?)* I think it could well be more political but as long as the SRK has this function in Switzerland to, as it were, be commissioned by the cantons to decide about the training in nursing and thus also about the quality of nursing, the professional association cannot have this kind of power. *(BD: But when it goes to the EDK (*Federal Conference of the Directors of the Educational Boards of the Cantons)*,*

it will get even worse. That is what I am hearing now). Yes, then it will get worse. But if the power were given to the federation, it would become similar to how it is in England, then the government would have to get a person to talk to from the professional association. Until now, that person is still from the SRK. It is up to him, whether he wants to join the professional association. The difficulty is that the money goes to the SRK; there is no political-financial link with the professional association. That link only exists between the cantons and the SRK. In England, that is different. The Royal College of Nursing is financed by parliament.

The work of this group has had a lasting impact on nursing. Two textbooks deserve special mention: *Nursing* by Liliane Juchli written in 1973[14], now in its tenth edition, and *Nursing Care Planning* by Verena Fiechter and Martha Meier, originally published in 1981 and now in its tenth edition, too. Another undertaking that has had a formative impact on the field of nursing is a post-graduate nursing training course (HöFA I and II) which was initially conceived by Martha Meier in 1983. The long-term changes engineered by this group of nurses is, as we have seen above, a result of their personal contacts. Both the first Chair of Nursing in Basel (Annemarie Kesselring) and the Post-Graduate Programme in Nursing and the foundation of the Association of Nursing Experts (Silvia Käppeli) stem from the innovative work undertaken by the *Kaderschule* during the conceptualizing phase. However, as already mentioned, neither of these scholars would stay on with the Red Cross after the 1988 structure reform.

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[14] After the 8th edition, Liliane Juchli gives her publication to the Thieme-Verlag, where it continues to be published under the title of '*Thiemes Pflege:* entdecken - erleben - verstehen - professionell handeln', (2000, 9th edition, 2004, 10th edition) with a preface by L. Juchli.

In 1999 the ‘Association of Nurses’ (SBK) founded the ‘Institute of Nursing Sciences’ which Annemarie Kesselring headed until the ‘Institute of Nursing Sciences’ at the University of Basel was opened in 2000. At that time, the Institute of the ‘Association of Nurses’ (SBK) was integrated into the university. Today the ‘Association for the Advancement of Nursing Research’ (vfp), which had decisively contributed to the foundation of the institute, seems splitting off from the ‘Association of Nurses’ and establishing itself independently. The director of the ‘Zurich School for Nursing Specialists’ (HöFA) distanced herself from the ‘Association of Nurses’ (SBK) after a short period of collaboration.

The development of the *Kaderschule* shows, that the nursing occupation accepted its *mould* and was to determine the future structuring of its profession. That is to first define itself in terms of its contents so as to subsequently become politicised which was to help the structures of the profession to become more independent. While efforts to change the contents of nursing ushered in changes, the demands for structural and political autonomy did not. All parties involved from the Red Cross, the ‘Health Directors Conference’ (SDK), and the Swiss people (votes in 1973 and 1974) rejected the political claims of nursing. As in the case of the federal exam (see chapter four), the Red Cross strictly supervises the attempts by nursing to gain power and independence.

If, on the one hand, there were attempts to raise the significance of the training for nursing education, on the other hand, the opposite also existed: In response

to the shortage of nurses and the growing number of people afflicted with chronic illnesses, the VESKA (The Association of Swiss Public and Private Hospitals as well as Public Authorities which serves as the head office for data and information and keeps administrative and medical statistics), and the professional organisation (SVDK, today SBK) conducted 1959 a study on the situation of nursing. The 'Health Directors Conference' (SDK) commissioned the Red Cross to solve the problem by designing a new job profile – *assistant (auxiliary)* nurse (FASRe). The 'Conference of Senior Nurses' expressed concern that this measure would lead to two classes of nurses, the less-qualified ones who would care for old and chronic patients and the better trained ones who would be responsible for acute care (Valsangiacomo 1991:274). The interests of acute medicine and acute-care hospitals (VESKA) won, and the 'Nurses Association' and many nursing schools supported the development of this new job, partly against their conviction. In the 1980s it became evident that previous misgivings had been justified. In Great Britain, nursing struggled against this 'second portal' for about ten years (see Dingwall 1988).

As a further development in nursing, the 'New Education Regulations' (NAB) have to be listed, which was put into effect in 1992. Like the FASRK project, this project was a collective undertaking by the typical formation of political interest groups, led by the Red Cross. Although it was a compromise, its main achievement was the conception of the first non-medical but nursing-centred national curriculum. The 1992 'Education Regulations' are undoubtedly a

successful product of the specifically corporatist manner of the Swiss state system.

The 'New Education Regulations' (NAB 1992) reflect a concept of nursing that has been accepted and understood by wide audiences. In general, major parts of the people in nursing thought that the professionalisation process would likewise progress in the future.

The NAB had hardly been introduced when another educational reform began to reorganise this professional concept in the 1990s. The 'Project New Educational Systems' (NBS) is a purely state-run project. It was the beginning of what I call the *restructuring phase* or third phase in the evolution of Swiss nursing.

The development of nursing from the *Kaderschule* to the NAB shows Swiss nursing competing with what I have called the *nursing's mould* so far, i.e. with the state represented by the Swiss Red Cross. Nursing managed to undergo to a certain degree an independent development.

On the one hand, we recognise Abott's (1988) *System of Professions* with Swiss nursing now competing for a more independent jurisdiction, Freidson's wording. On the other hand, we also recognize what Davies (1995) calls the *professional predicament in nursing*. Furthermore, if we bear in mind the fact that women in Switzerland did not receive the right to vote until 1971 and that the 'Equal Opportunity Act' became a law in 1981, we think of Witz's (1992) statement of the *genderedness* of the professions.

Above all, we must note that a nursing professional project has definitely evolved. If we look at it more closely, it becomes obvious that primarily one side of the concept of professional project is pursued. Evetts (2001) points to the dual character of the professions that professionals and professions have a dual motive: "to provide service and to use their knowledge for economic gain". However, the nurses, at that time, fought primarily for their profession's sake and they fought almost exclusively within their own systems. Political efforts to improve nurses' professional status usually evolved from individual inititative. In retrospect many nursing leaders regret not having become involved in politics more vigorously (cf. Dätwyler et al. 1999). That the nurses as a professional group primarily focused on the content of their work and fought above all to improve conditions in nursing is a recurrent theme in the whole history of the profession (cf. for instance Moser et al. 2001, Dätwyler and Baillod 1995). As mentioned earlier, I can see here a part of what Freidson (2001) succinctly calls 'the soul' of the professions and Dingwall (2003) sees as the 'ethic of community'. During the first years of the Kaderschule, the attitude of the nurses came close to the definition of professionalism, which Evetts (2001) sums up as those aspects of work "which are in the best interests of customers, clients and patients as well as in the advice-giving, lobbying and sometimes oppositional aspects of professions' relation with states, legislative bodies, and regional and local administrative agencies". Just what the protagonists of the *Kaderschule* were trying to do.

On the basis of the concept of holistic nursing, as it was developed and now taught at the *Kaderschule*, a political movement emerged in the 1980s that

viewed nursing in light of prevalent (patriarchal) power structures and the concept of the gender roles (cf. for instance Bischoff 1994, Dätwyler and Lädrach 1985, 1987). With this, in addition to the content-related claims (jurisdiction by virtue of holistic care) the issues for the political agenda were now also income and status. The concept of professionalisation was picked up by the profession and has to date been the core of a main political programme of the profession[15]. Professionalisation is usually considered to be interchangeable with the word *Akademisierung*[16], thus professionalisation means becoming an academic profession. In this perspective, a professionalisation strategy has been successful as soon as a profession is taught at university and therefore professionals are academics. This also applies to the debate on nursing in Germany (cf. Kuhlmann 2002, 2003).

In the German-speaking sociology of the professions, the professionalisation discourse is guided by a fundamental criticism of the concept of profession which is primarily equated with the demanding or power approach. The notion of professional performance (*professionelle Leistung*) as an apparently measurable and manageable practical act in any field of work has been introduced as an alternative model to professions, in particular in educational circles (Mieg 2003, Oevermann 1996, Weidner 1995). The characteristics of professional performance are the same as those of professionalism (service,

[15] 1985 the annual conference of the professional association (SBK) addressed the theme of professionalisation

[16] Freidson (1986:34) states that in Germany a professional is called *Akademiker*. In1988, the author initiated the work group '*Universitäre Weiterbildung*' which in the end resulted in the establishment of the Institute for Nursing Sciences.

expertise, academic and economic gain) but professional performance is freed from a specific profession and can therefore be applied to any work. For me, this interpretation is insufficient insofar as central aspects of professionalism are dissolved, meaning the 'body and soul' to which professionalism refers (Freidson 2001), that is the body of knowledge, professional socialisation and a specific ethical code. But among other things this interpretation of professionalism makes us understand why the education reform, which has completely fragmented the professional body, met with relatively strong acceptance, while, at the same time, creating unbridgeable rifts in the professional group.

Today, the claim for full jurisdiction continues to be a political goal in Swiss Nursing, mainly in the circles of the teaching and management personnel. Academic education is seen as the solution and the end of the problem of the subordinate position of nursing. Interestingly, control over work, which is a definitional criterion of the term 'profession' in the sociology of the professions, seems to be irrelevant compared to academic status.

I stated before that I recognise in the clear focus at the beginning of the professional projects the 'soul' (Freidson 2001) of the profession as a strength like it already showed itself in chapter five and was later conceptualised as concept of caring.

The strength appears to be a weakness at the same time, or to contain the danger of cutting out reality, namely the prevailing conditions. Dingwall and Allen (2001) express their doubts regarding the mandate claim by virtue of the

concept of ‘holistic emotion work’, or as a basis for an autonomous professional licence respectively. They want the nurses to show “a bit more realism” and to re-think the relationship between the mandate and the license of the nursing professions. Let us think back to chapter two where I wrote about the significance of the ‘creation myths’.

“Golden Age myths, of course, really tell us much more about the present situation of a profession and the way in which its members try to use the past as a way of legitimating their current projects, whether toward change or toward conservatism (Gabriel 1993). They are an important means of making claims about the status of the occupation, about its relationship with its social, political and economic environment and about its proper tasks. As such, they constitute part of what Everett Hughes (1971), called the mandate of a profession, its assertions about its contribution to society. This, however, is also constrained by what Hughes called the profession’s licence, the actual terms of its contract with its host society, which specify what it is allowed to do that is distinctive from other occupations in return for money, prestige or other rewards. The distinction between mandate and licence is an important one. The analysis of mandates draws us toward the culture and ideals of the profession. The analysis of licences draws us toward its material base and the structural constraints of its work settings. An over-ambitious mandate may be the source of chronic dissatisfaction and poor morale as the profession’s dreams are broken on the wheel of its licence. An over-restrictive licence may deny the profession’s clients the benefits of its potential for creativity, innovation and normative self-control” (Dingwall 2003).

Freidson (1990), reflecting on nursing's claim to full jurisdiction, similarly points out the fact that nursing, in any case hospital nursing, is to a considerable part determined by structural conditions:

"When we look at the real world of the hospital in which the nurse must work for better or for worse, however, we see that the nurse's capacity to exercise discretionary judgment is limited not only by medical dominance, but also by the bureaucratic rules and procedures established by the hospital administration, and by the resources that are available for doing her work. The intake, staffing and other resource allocation policies of the administration, as well as what might be called the structure of governance of the institution itself, have a profound influence on how nursing can be practiced. They limit the possibilities for giving care in a caring way, and for practicing ethically. As Yarling and McElmurry put it, *'nurses are not often free to be moral.'* (Yarling and McElmurry 1986:63, italics in the original). The graphic anecdotes they recount in their article show clearly how the organization of power and authority in the hospital can frustrate and even punish efforts on the part of a concerned nurse to correct the most egregious treatment decisions. It is for this reason that we must agree with them that if the fundamental moral problem of nursing is a consequence of the structure and policies of the social institution in which nursing is, for the most part, practiced, then any ethic that seeks to address this problem must seek reform of the policies and structures of that institution. An ethic that is concerned with structures and policies of social institutions is a social ethic. Hence, a nursing ethic must be first and foremost a social ethic. (…)."

Set against the background of the institutional entanglement of the Swiss political system, it seems difficult to believe that nursing could achieve structural independence, control over its occupational work respectively. However, according to my primary theoretical perspective, my conclusion to this insight would have been that the nurses' political aims and strategies were invalid and basically insufficient to capture the state (Dingwall 2004) for getting a cartel. But I have to acknowledge that in my report so far it is the state and the market (in this case medicine in the widest sense) which put restrictions on nursing. If, in Abbott's 'long book', as he calls it himself, his system of the professions almost gives the impression of a universe of its own, he nevertheless states that "finally, the state limits the power of professions" (Abbott 1988:141). By the way, in the case of Switzerland a 'weak' kind of state which gives free reign to the Red Cross and to medicine as far as it is possible:

PN04

We were in Zurich, after all. But we could have been in Honolulu. The state did not care about us, neither the City nor the Canton of Zurich. That did not concern them since the Red Cross supervised the training, not the cantons.

Summarising this last piece of our journey, the nursing occupation so far has conceptualised its historical *bundle of tasks*, defined its professional project on a corresponding holistic basis, formulated its mandate, produced relevant textbooks, and established academic studies.

But both state and market (shortage of nurses) interfere and absorb the endeavours of the nurses, foremost the Red Cross. Under these circumstances the professional group is not capable of building a common strategy. Most of the leading figures had left the *Kaderschule* because of the inadequate personnel policy of the Red Cross and established themselves in single niches.

In the words of Freidson: "In sum, the state is the key force required for the creation, maintenance, and enforcement of ideal typical professionalism. Whether or not it does so depend upon its own organization and agenda, which varies in time and space" (Freidson 2001:128-129). "The state then becomes the critical arbiter of influence by choosing one rather than another to represent the interests of 'the' profession" (Freidson 2001:149).

Chapter Seven: The New Education System in Nursing

Seine Wort' und Werke[17]
merkt' ich, und den Brauch,
und mit Geistesstärke
tu ich Wunder auch.
…
Walle, walle …
Walle, walle …
…
Die ich rief, die Geister,
wird' ich nun nicht los.

Having memorized
what to say and do,
with my powers of will I can
do some witching, too!
…
Go, I say …
Go, I say …
…
From the spirits that I called
Sir, deliver me!

The Project 'New Education Systems' (NBS) is an exclusively state-run project. It was the beginning of what I call the *restructuring phase* or third phase in the evolution of Swiss nursing, because this reform, initiated by the federal state, fundamentally re-structures the nursing occupation.

At the start of the project, in the mid-nineties, no one could probably foresee the dimensions the reform was going to have. This is because in federal Switzerland, a national decision is always no more than a signpost. There are about 26 variants to implement the decision. In this case, there was the additional difficulty that the cantonal departments of education were to take on the responsibility for education structures for professions which had been implemented almost a century ago and with which they were not familiar.

Occupational control of work is understood as a central characteristic of the professions or professionalism implying advantages in market and bureaucracy

[17] *The Sorcerer's Apprentice* by Johann Wolfgang von Goethe. Translation by Brigitte Dubiel

(Freidson 2001). Following the *demand theories*, control over work results from successful competition of the occupational group. In Swiss nursing, the claim for professional status in the sense mentioned above only manifested itself as a political demand as well once academic training had been claimed. Up until the education reform, to some degree, nursing has been successful in achieving control over work, and academic education, if only for a small group of nurses. Thus the development regarding content, which I described in chapter six, brought about jurisdiction over what is conceived as the nursing process. The problem herewith is that the nursing process is neither institutionalised area-wide nor does it have legal authority. However, the education reform (*Neue Bildungssystematik NBS*) drastically demonstrates that the nursing occupation is – despite the achievements over the last years – far from being licensed to control its work. According to the theory of the professional project, this would mean that the professional group has failed. Indeed, among nursing insiders this is the most frequent interpretation of the current situation and thus exactly corresponds to the pattern of self-accusation which Davies identified in the nursing professions (1995).

The education reform in nursing takes our reflection beyond nursing professionalisation strategies. The approach of the professional project does not suffice to grasp the current situation of nursing as an occupation. At the latest at this point, I was forced to change perspective concerning the theory of the sociology of the professions. After a revision of my literature review I now understood exactly what Dingwall had said about the demand approach: "Having made this concession, however, she [Larson, BD] offers little analysis

of the state, tending to see this as a mere vehicle for the interests of capital" (Dingwall 1996:5).

Accordingly, the state and the market should not be seen as the targets. It could also be the other way round: The professions could be the targets of the state and the market.

The education reform goes back to the federal vote on a new law concerning the vocational training. The *Neues Berufsbildungsgesetz* (introduced in 2004) was to bring under the same law all non-academic occupations regulated by the 'Federal Department of the Economic Affairs' (FDEA), more precisely the 'Federal Office for Professional Education and Technology' (OPET).

The state responsibility for the regulation of the training and the practicing is extremely complicated – on the one hand, between the federal and the cantonal level, on the other hand, between government departments at both federal and cantonal level. I try to present those offices and laws which are of significance for nursing. First, it has to be stated that the transfer of the health professions from one to another department is linked with an incredible increase in complexity since particularly nursing in its present structure does not fit the traditional vocational training. The OPET is the federal government's competence centre for vocational education and training, universities of applied sciences (UAS) and innovation promotion. The Universities of applied sciences are regulated by a separate law (*Bundesgesetz über die Fachhochschulen,* 1995). However, both the federal and cantonal universities belong to the 'Federal Department of Home Affairs', or to two federal

secretariats respectively, the 'State Secretariat for Education and Research' SER and the ETH Board and the ETH Domain. The former is responsible for national and international issues relating to further and university education, research and space affairs. It ensures a coherent policy in the areas of science, research and universities and coordinates the Swiss university and research policy and promotes the cantonal universities, and it is responsible for Swiss school-leaving certificates, grants, European education programmes, international education cooperation, and research promotion. The latter, as an interconnected system of technical universities and research institutes, focuses on excellence in teaching and research. Swiss and cantonal universities have their own legislation. By the way, the 'Federal Department of Home Affairs' is also in charge of health affairs organised as Federal Office of Public Health FOPH.

Vocational training in all fields is regulated by the federal state which decrees and ratifies legislation pertaining to training and examinations. The 'Federal Government's Competence Centre for Vocational Education and Training' (OPET) is responsible for seeing to it that this legislation is enforced. It falls to the Cantons to organise the type of vocational training needed locally; as well as to supervise apprenticeships and set up the necessary colleges. Along with the Confederation, professional and economic organisations play an important role in this type of training. For nursing and other health professions, the new educational law brought a change of jurisdiction from the cantonal health departments, and the Swiss Red Cross, to the 'Federal Government's Competence Centre for Vocational Education and Training' and for the

implementation and supervision to the cantonal departments of education. This in fact means that the responsibility was assigned to the cantons while before it had been dealt with centrally by the SRK. This change signified a much more crucial cultural change than was expected. Before I examine the dimensions of this change, I would like to point out that the change in departmental responsibility coincided with changes in politics.

In the 1990s, politics in Switzerland were increasingly influenced by neo-liberal demands, with the same consequences as in other countries.

"The macro level of economic and social changes that have created new contexts for professions are profound and probably irreversible. Many Western states have experienced fiscal crises at least partly due to the rising costs in welfare states and social services professionalism. Remedial measures have been taken, often motivated by a New Right ideology and these have included cutbacks on funding the public sector and especially large areas such as health, education, social welfare and local governments; downsizing, flexible labour market strategies such as part-time work, externalizing, outsourcing and budgetary devolution; changing certain public service provisions into private enterprises; division into purchases and providers of services; quasi-markets, accountability and quality measures. As Hanlon (1999) has explained: 'In short, the state is engaged in trying to redefine professionalism so that it becomes more commercially aware, budget-focused, managerial, entrepre-neurial and so forth'" (Evetts 2001).

This dimension has shed a new light on the supply theory (Dingwall 1999, Johnson 1995, Halliday 1987, Freidson 1996, 2001). Freidson states that it was this political dimension that was the concern of the book *Professionalism, the Third Logic*. "For decades now, the popular watchwords driving policy formation have been 'competition' and 'efficiency', the first referring to competition in a free market, and the second to the benefits of the skilled management of firms" Freidson (2001:2).

The 'New Education Regulation' project (NBS) was primarily aimed at improving the attractiveness and the status of nursing. Instead, what happened was that it got caught in a whirlpool of financial constraints in the Swiss government and neo-liberal political developments mentioned above. The historical shape of the nursing occupation was completely fragmented by the reform to the extent to which the political developments contributed to this process is difficult to assess. All the more so, since the reform as such resulted in a change of roles for state and market where nursing was concerned.

In this context, Rafferty's (1996) historical reflections of nursing educations reforms illustrate that the Swiss reform must be understood in broader context. She argues that, concerning changes in nursing training, historians have tended to underestimate the role of government policy and instead have overestimated nurses as leaders. Reformers among nurses often adopted strategies pioneered by medical reformers (examples: registration debate and the campaign against Sarah Gamp).

"Consideration of government policy reveals not only the limited extent to which internal reform within nursing can be achieved without government support, but also that initiative does not necessarily reside with occupational leadership" (1996:184).

The mechanism of the reform

In order to assess the meaning of the reform for the nursing occupation, we need to understand its mechanism (cf. Appendix 7). The changes connected with the *Neues Berufsbildungsgesetz* affect the profession at several levels. The transfer from the Red Cross to the OPET, from the 'Swiss Conference of Cantonal Health Directors' GDK to the 'Federal Department of the Economic Affairs' has proved to have the most drastic impact. The OPET educational system differs from the traditional nursing education in that the basic vocational training is fixed to the secondary II level. The tertiary level corresponds to further education, as either higher vocational training (*Höhere Fachschule*) or applied university studies (*Fachhochschule*). The adaptation of nursing education to this systematic caused several to date unsolved problems.

First, one implication of the adaptation was the construction of a new occupation at the secondary II level (*Fachangestellte Gesundheit* FAGE) in order to position nursing at the tertiary level. Despite the reform designers' rhetoric efforts to dissociate the *Fachangestelle Gesundheit* from nursing, it is far unclear if the *Fachangestellte Gesundheit* is a nursing occupation or not. The fact is that the training – both theoretically and practically – is mostly located within nursing units of hospitals, nursing homes and community health

care. That is to say that the introduction of this new occupation, which is a purely theoretical construction, has had an immense impact on the field of nursing work, all the more so because of the associated ambiguity concerning the identity of the FAGE. The nurses' role, self-understanding, functions, tasks, and work division represent a permanent controversy since the FAGE have been in the working teams. Experienced rank-and-file nurses feel uncertain to a large degree.

Second, the transfer of nursing education to the tertiary level created systematic problems in that the diploma level in the French-speaking part of Switzerland is settled at an applied university level (*Fachhochschule*), whereas in the German-speaking and Italian-speaking part it is at higher vocational education level (*Höhere Fachschule*). The reasons for this differentiation can be explained with the decidedly lower value given to the dual professional training system – apprenticeship in a firm and training college for the education – in the French-speaking part of Switzerland since this region is more strongly oriented on the French education system where the education in school is in the foreground – as it is in most countries of Europe as well. However, we must also mention the financial fears of the German-speaking Cantons which preferred a higher percentage rate of qualified to a lower rate of graduate nurses. The consequences are status and career inequality among the nurses on the one hand, regulation of the education by different laws on the other hand (whereas the reform pretends to be a unification of the professions). To complicate the situation further, in order to compensate for the inequality problem, in the German-speaking Cantons applied university programs are

constituted for a small part of the student nurses (about 10 per cent). All three programmes lead to a diploma in nursing. Consequently, an unsolvable problem concerning the qualification of '*Höhere Fachschule'* and '*Fachhoch-schule'* consists in at the same time avoiding and defining differentiations. After all, nursing is also taught at university level, regulated by a different Federal Department and separate laws. Again, the question of equivalence between university and applied university qualification is open. In summary, the nursing occupation has been fragmented in almost every aspect possible: Between secondary and tertiary level, between tertiary programmes, and concerning legislation. The result is that the new functions of the various professional groups are to a large extent in practice unclear.

Third, a further unsolved problem in the OPET education systems is the implementation of the federal curricula. A nationally decreed curriculum can be conceptualised in 26 different ways, which is an actual tendency in the implementation process of the *Fachangestellte Gesundheit*: some Cantons or/and certain institutions clearly try to install the new occupation as cheaper nursing – against the *Bildungsverordnung* (Education Regulation). In contrast, the Red Cross regulation of nursing (and other health professions) operated at national level.

Fourth, as illustrated in chapter one, vocational training in Switzerland is characterised by its dualistic settlement in the free market economy and the state educational system. Traditionally, vocational training is a thoroughly corporate task of the market economy and the state. Following the

requirements of the industrial sectors, professional associations which are master's associations (foremost employers' associations), the OPET formulates and decrees the national educational curriculum of individual occupations. The training is performed and controlled at cantonal level by master craftsmen and in vocational schools. Thus this concept guarantees the occupations control over work to a large extent. For nursing (as well as the other health professions), however, the conceptualisation of what is the part of the associations in industrial occupations and what is now formalised as 'Organisations of the Working World' (*Organisationen der Arbeitswelt*, OdA) creates severe problems of representation. In the constitutional phase of this new institution on both levels, federal and cantonal, first of all associations of hospitals, nursing homes and community health care by virtue of their function as employers felt to be the legitimate representatives of the 'working world' and therefore in charge of telling the state the requirements for educational training. The professional associations which in health care occupations represent the profession's knowledge and expertise (equivalent to the master's associations of industrial occupations) have been either rejected or accepted only as a minority on the board. Paradoxically, what was constructed to assure control over work in traditional occupations has been perverted to withdraw this very control in the case of nursing (and the other health professions).

The response of the nursing occupation

The 'New Education System' (NBS) is a typical result of what we call the *green table,* namely a theoretical construct. A '*green table'* (literal translation

from German) in Switzerland refers to the situation that all approved interest groups sit down at the same table and come to a joint decision. The result is consensus which bears the most powerful group's handwriting. Nursing circles were involved in conceiving and putting the New Education System (NBS) into effect: professional organisations, nursing schools, nursing officers, and a wide range of individual nurses are called upon as experts. Concerning the construction of the new occupation of the *Fachangestellte Gesundheit* (FAGE), there has been, from the very beginning, a fierce controversy within the profession. Thus, the nursing profession as a whole does not have any clear-cut principles that could provide guidance in this debate that, admittedly, is enormously complex.

As a result, there are various trends with different strategies within the field of nursing. Nursing scientists represented by the 'Association for the Advancement of Nursing Research' (vfp) aspire to corporatism similar to the *Schweizerische Akademie der Medizinischen Wissenschaften* (SAMW) and, therefore, distance themselves from the 'Swiss Association of Nurses' (SBK). The 'Swiss Association for Head Nurses' (SVPL) and the 'Swiss Conference of Nursing Schools' (SKP) represent the political and professional interests of their respective constituencies. The 'Swiss Association of Nurses in Geriatrics, Rehabilitation and Chronic Care' (SBGRL) has placed its stakes on untrained workers, thereby playing the economic card.

Instead of following a common policy in order to compensate for the fragmentation of the professional field by the new educational system, the

associations contribute to the dissolution of the integral concept of nursing. The 'Association for the Interests of Health Care Professions of Central Switzerland' (ZIGG) which is an official 'Organisation of the Working World' (*Organisation der Arbeitswelt*, OdA) I have mentioned above, is an illustration of how crucially important it would be for professional organisations to have a common strategy. From a neo-liberal vantage point, health care institutions take the position of employers (irrespective of government subsidies) and claim the right to lead nursing training – explicitly excluding the professional associations. Not only can the health care system be called an economic market as long as it is primarily funded by the state, the ZIGG concept also does not apply with regard to the interpretation of its role. The principle of social partnership has been firmly anchored in the BBT to date. The professional organisations are under a great deal of pressure on this account.

The concept of the organisations of the working world (OdA), which is predominantly composed of subsidised employers in institutions, as a new formation for the health professions is only reluctantly understood and in whichever way implemented and this differently in every canton. Health policy does not understand the concept because the dual vocational system is new and does not really fit the health professions. Educational policy does not understand it since there the traditional concept of health professions was not known and thus the difference are not visible. The consequence is that the presently dominating political model is applied to the new structure referring to market and state ideologies corresponding to the traditional anchoring of professional training in the economy. Probably, we can understand the building

of this new institution OdA by using the concept of isomorphism (Dingwall 2004). This concept seems important to me since, although on the outside the OdA of the health professions pretend to be modelled on the classic OdAs of the market economy, however in fact is a state-controlled and state-financed institution which puts the management of the institutions in place of the professional associations.

"If we consider the pressures for isomorphism, the convergence of institutions on particular models that are regarded as legitimate, even if not necessarily efficient or effective, then we can see that only normative pressures might come form within an occupational group. The other types, coercive and mimetic, are both essentially environmental, requiring an institution to adopt a certain form because of the demands of state or market" (Dingwall 2004).

Under the motto of the standardisation and levelling of the health professions in the education system, the professions are deprived of the legitimisation and the structural basis for the control over education and work instead of – following the model – having it assigned.

An example of the ignorance of the new persons responsible for the professional training may be the statement by a young officer of the OdA that he could not understand how the nurses' professional association could give its views and demands concerning the nursing education and nursing job descriptions. As I have already mentioned, Dingwall (1983) points out that occupations have careers like individuals and that it would be useful for labour economists to develop an understanding of this for their work. Perhaps it would

be useful, if those newly responsible for the training would acquire knowledge on the development, culture and organisation of nursing.

Summary

If the educational reform has broken up the historic shape of nursing, the effects of the changing roles of both the state and the market concerning the work of nurses seems to be of even greater relevance. The impacts for nursing become manifest at two levels. First, education is now more split up concerning the federal state, the cantons, and legislation. Second, the attempt to copy the state-market corporatism of the OPET system produces divisions, distortions respectively because health care is a quasi-market. The constitution of the 'Organisations of the Working World' (OdA) is an example for this fact. The result of this is, that – against the principle – the profession is more or less excluded from control over education and work. Nursing is seriously threatened to be replaced by the new occupation of FAGE in some institutions or at least to be minimised to this professional group – with predictable consequences on the quality of nursing and caring in the institutions. The new confusing state of the nursing training – FAGE on the *Sekundarstufe II*, the discontinued (old) diploma trainings and the new trainings at the level of *Höhere Fachschulen* and *Fachhochschulen* – have the result that interested young people are made to feel unsure and thus give up on such an education. In practice as well, the nurses appear to feel insecure and no longer know who is responsible for what. Many of them appear to be overburdened and frustrated and are leaving the profession in increasing numbers.

In the professional group, the opinion probably predominates that the fact that there are university courses for nurses proves the professional status of nursing. This corresponds to the concept of professional performance in German-speaking Switzerland corresponding to the German approach to professionalism (see chapter six). The group of this camp claims the concept of professional nursing for itself. The other occupations working in nursing are cut off as to professional policy, the *Fachangestellte Gesundheit* for instance. Within the ‚Swiss Association of Nurses' (SBK), this camp strives for a corporatist form of the professional association (in Germany *Kammer*, in France *ordre*). This is connected with the '*academisation'* of the training mentioned in the preceding chapter. However, according to the *Neue Bildungssystematik* in German-speaking Switzerland this is only envisioned for 10 per cent of the trainees. The decision of the meeting of delegates of the SBK this year, that the association demands a bachelor´s degree for all those with a diploma, has been received with relative lack of understanding in politics and in the other camp of the nurses. When I talk about ignorance concerning the new education organisation, this also applies to the nurses. As an example, I would like to quote the statement of a representative of the International Council of Nurses (ICN) during this year's workshop on the strategy of the 'Professional Association' (SBK). First, she described the state of nursing in different countries as overall deteriorating concerning work conditions, shortage of nurses and such less quality of nursing. She referred in her concluding remarks to the plenary to my statement on the relationship between state and professions, namely "the state then becomes the critical arbiter of

influence by choosing one rather another to represent the interests of 'the' profession" (Freidson 2001:149). She appealed to the nursing community "to prevent the state to be the arbiter of nursing".

Nursing seems to fail to notice the reality. The education reform clearly shows that – in close connection with the market – the Swiss State solves its health care off its own bat. The structural environment of nursing is determined by interactions that the occupation cannot influence.

Thus both the ignorance of those newly responsible and the nurses´ insensitivity to environments let nursing appear to be an area of conflict. I believe that the educational reform could turn out to be like Goethe's sorcerer's apprentice by virtue of its unmanageable multitude of changes and building lots. As a result of long work of committees and working groups, the federal state, as usual, had endeavoured to make allowance for regional and cultural and cantonal differences and thus made possible the inequalities and incompatibilities that lead to major problems in the implementation. It seems to be clear, that the Swiss nurses' professional project could not oppose this very complex process of reconstruction. But one can but think that 'many cooks spoil the broth', for the Swiss state system, which is both federal and corporate, seems to be too big and too weak a platform as to promote a project like the implementation of the *Neue Bildungssystematik* in a goal-oriented, adequate way. Possibly also due to the fact that – in case of the reform of the health professions – a market ideology comes into effect which is not adequate to health care.

That means that the approach of the professional project is really not sufficient to explain the professional development in Swiss nursing, since the significance of state and market are here undervalued. The realisation that the supply approach does better justice to the development of professional nursing in Switzerland than the demand approach makes me consider the professional project of nursing in a different light, regarding the lack of a project in the first phases of the development as well as the failure of the later project. Johnson (1995) states that recent policy changes by government or basic alterations of the character of the state make it necessary to review the theoretical concepts of the sociology of the professions.

That is the reason why Freidson in *Third Logic* develops a plea for the concept of the professions as autonomous institutions. The impetus is to be found in the global neo-liberalism at the end of the 20th century.

"I will show in this book that monopoly is essential to professionalism, which directly opposes it to the logic of competition in a free market. Freedom of judgement or discretion in performing work is also intrinsic to professionalism, which directly contradicts the managerial notion that efficiency is gained by minimizing discretion" (Freidson 2001:3).

Pointing to the normative aspect of professional ethics he speaks of the soul of professionalism. "Thus, the most important problem for the future of professionalism is neither economic nor structural but cultural and ideological. The most important problem is its soul" (ibid. 213).

Freidson considers the professions to be a third (autonomous) power beside the market and the state. “The proponents of professionalism must necessarily exercise a strong, principled voice both in broad policy-making forums and in the communities where practice takes place” (ibid. 217).

We have taken note of the fact that the state and the market reject rather than adopt nursing following the model of the profession (holistic approach, academic formation). The current state reorganisation project focuses on tasks and rationalisation and does not recognise the emotional labour of nursing as something to be considered as work and paid for.

From my own experience and based on numerous reports on the experience of others, I know nursing’s professional spirit. In the preceding chapters, I have speculatively raised the question of whether the *‘soul’* of nursing has not entered modern nursing through the tradition and culture of religious orders. I wonder if it stands above the obsession of both the NBS sorcerer’s apprentices and Hughes’ nurses who ‘know what is best for the others’.

“My best years were when I already felt that I had the professional certainty, that I could judge a situation, and also the system at the time: I shared a few room with a student, I knew who were my patients and I was responsible for them. And that gave me satisfaction, that I liked” (in: Meier 1997).

Part III Swiss Nursing: Reflection of the State

Chapter Eight: Conclusion

The aim of this study was to explain the professionalisation of Swiss nursing on the basis of two main theoretical approaches of the sociology of professions, the demand approach and the supply approach. These approaches represent two opposing lines of argumentation within the sociology of the professions. The demand approach ascribes the status as a profession (monopolised autonomy by state licence, social standing) to successful political strategies of the professional group while in the supply approach, the professions are seen as institutions which can only be explained in their relationship to the state. Thus, in one line of thought of the supply approach, the constitution of the professions is viewed as a process parallel to the *modernisation of the state*. Another line of thought understands the professions also as *bearers of uncertainty* of both individuals and collectives. In the course of global neo-liberal politics, the ethic aspect of this approach has been condensed into the *soul of the professions* – as an antagonist to the soullessness of state and market.

Which approach applies to Swiss nursing?

At the beginning of my study I believed that the *demand approach* represented the adequate approach and the concept of the *professional project* by Larson (1977) offered the adequate frame for the analysis of the professionalisation

process of Swiss nursing. I expected that the analysis of nursing by the concept of the professional project would produce a specific kind of a professional project, and how far this was successful or failed. I hoped to contribute new aspects to the concept of the professional project. For instance to evaluate Davies' (1995, 1966a, 1996b) claim that the concept of profession was only applicable to men and not to a women's profession. Or to understand more about the genderedness of the professions (Witz 1992). Finally I hoped that the study would produce devices for a more successful professionalisation policy of Swiss nursing.

The reason why from the beginning I decided on using the demand approach lies in my previous work on nursing on the one hand. I was mainly concerned with two different focuses: First, the construction and implementation of professional nursing in Switzerland until 1925. Second, the nurses' view of their occupation at different times. I had learned that nurses are deeply committed to all the needs of their patients, even under inferior working conditions. At the same time, professional politics is of no interest to most of them. On the other hand, the discussion about the professionalisation of nursing concerned me. I assumed that nursing could have achieved a clearer and more prominent place in the health care system if it had acted in a unified and purposeful way.

Because the concept of the professional project is action-based and profession-centred it seemed to offer the approach which would apply to the professionalisation of Swiss nursing.

With the progress of the study based on the concept of the professional project, it became obvious that this approach in fact did display deep insights into the professional development of Swiss nursing. But it did not, however, produce a story of the professionalisation of nursing as I had expected. Rather, light was thrown on the state and the market. It seemed that I could explain a certain historical phase by the concept of professional project but not the development of nursing over the whole period of time I wanted to analyse.

For this reason I had to change the perspective in order to gain an encompassing understanding of the professional development of Swiss nursing from a more interactionist towards a more structuralist/functionalist perspective or from explaining professionalisation in terms of the organising efforts of professions to explaining it in terms of market demand or state interest. I had to focus on the conditions under which the development of nursing proceeded. Which institutions were decisively involved? Which role did the state play?

From the demand to the state approach

With the education reform, the Swiss state begins to play a similar role for nursing as it did traditionally for the service- and business professions. In principle, shaping professions falls to the economic market. This is where professions are defined. The state regulates according to the demands of the market. If today nursing is being transferred into this system, this is comparable to the changes in politics as they are discussed in the sociology of

the professions (e.g. Evetts 2001, Dingwall 1996, Freidson 2001, Halliday 1987).

Johnson claims that politics change professional jurisdiction.

"The point is that changing government objectives have had the effect of shifting the boundaries between what was regarded as contentious and what was accepted as neutral. To put it in another way, the arenas of professional neutrality and autonomy are transformed, not as a product of changing occupational strategies as Abbott would have it, not as an effect of technical change, as suggested by Freidson, but as a result of changing government objectives and policies" (Johnson 1985:20).

The distinct feature of a profession, control over its own work, is always contingent; in other words, what professions have won can be lost and removed (Johnson 1995; Dingwall 1996; Abbott 1988). This seems to apply exactly to Swiss nursing, although presumably not first and foremost because the policies have changed but because that is how the state structures are. The reason being that the Swiss state is profoundly built on liberal principles.

Consequently, the transfer of nursing into the market, pseudo-market respectively has for nursing the same effect as the attacks of neo-liberal policies on the professions as discussed in the recent literature of the sociology of the professions. The process of the education reform shows that the nursing occupation as it has been shaped through history does not fit into the new

system, and the continuation of the professional project is fundamentally challenged.

And thus nursing in Switzerland is faced with the same question debated in the sociology of the professions, namely what standing the professions will have in the future. Whether the position taken by Halliday (1987) is right that autonomous professions represent a necessary authority for the state (also supra-nationally) and the society since only like this the problems of uncertainty can be resolved with which every state is confronted. Or whether the professions would be divided between bureaucracy and commerce (for instance Evetts 2001, Freidson 2001, Evetts and Dingwall 2002) or fragmented in favour of more diverse skills as the German-speaking sociology has suggested with its concepts of professional behaviour or professional performance and which Evetts discusses in the international context.

Different roles of the state

After the example of the training reform in the health professions had shown so clearly that the role of the state is decisive for the formation of the professions, I wondered why this has not become manifest at an earlier stage of the study.

In order to answer this question we have to consider that the structures of the educational regulation system of the Swiss Red Cross were simpler than those of the regular state regulation system. In contrast to the regular system the Red Cross was not fragmented by federalist division of responsibilities between national and cantonal state as well as between economic and educational

system. To a certain degree, the Swiss Red Cross served for the health professions as what Freidson calls a 'shelter'. In this framework, the professional project was able to evolve. The SRK was committed to the development of the health professions. This also included the schools which, as *Mutterhäuser,* kept their distance and independence from the practice necessary to form a common identity which according to Freidson is central for a profession which has to act independently vis-à-vis the state and the market.

That means that, prior to the training reform for the health professions, the state played a different role than it does now, after the reform. The Red Cross as the regulating authority had been largely exempt from the federalist mechanisms since it was a corporatist institution. As an institution of the health system, it was rooted in the health department and not in the education department even though it regulated education. From this, two relevant consequences resulted: first, the Red Cross represented a shelter for nursing. Secondly, it was possible to develop nursing in a more uniform way, that is valid in all of Switzerland..

In view of nursing and its professional project, the state was more in the background than today. The Red Cross and nursing were together in a separate world: from this perspective, promoting the professionalisation of nursing meant that 'only'the Red Cross had to be convinced.

In this respect, the demand approach seemed to be adequate. And thus the question how good the strategies and the politics of the professional group are too defeat 'adversaries' and thereby gain autonomy. Only in the light of the knowledge from the last phase of the development did I understand that the

state behind the Swiss Red Cross played the decisive role for the development of nursing.

In the training reform, the state presented a different picture to nursing: 'soft' since uniformity in all of Switzerland was impossible to establish and 'hard' in implementing the training system which in the case of the nursing professions resulted in the deconstruction of existing professions, a temporary instability and rising costs for the health care of the population.

It became clear that the state determines the role and the position of the nursing profession. This happens in a specific way. In the case of the education reform, the state plays a different role in nursing than in the preceding phases when the Swiss Red Cross had taken over the regulating function. The argument that the form of the state is relevant for the shaping of the professions (Saks 1995, Freidson 2001) is in agreement with the Swiss case in nursing.

Thus, two theses of the sociology of the professions are confirmed. First, it depends on the state if a professional group is given and again deprived of a market shelter (e.g. Dingwall 1996). Second, the state can be both weak and strong (Johnson 1995, Freidson 2001).

If at the start I had been convinced of the *demand approach* and had almost successfully arrived at the end of the development of nursing, in the end, looking at the last phase of the development, I had to admit that the *demand approach* falls short because the role of the state and the market are underrated. The professionalisation of Swiss nursing and its professional project can only

be understood in their historic context. From this perspective, the period before the appearance of the nursing professional project no longer looks like an insignificant early phase but as central for the formation and the positioning of the profession. I discovered the image of a *mould,* shaped by medicine, the hospitals and the schools run following the Mutterhaussystem.

The 'mould' of nursing

Although in the end the *demand approach* turned out to be wrong, the use of the concept of professional project was very helpful all the same. The analysis of the interview data turned out to be extremely informative, foremost the statements which were assigned to the category 'work'. These statements show the fields of activity, the tasks of the nurses as well as the structure of the profession and thus how the *bundle of tasks* of nursing was constituted. In addition, the statements demonstrate in the temporal development how the members of the profession adopted this *bundle of tasks.* And they let us discover how and why the nursing *professional project* originated.

Work content and work conditions were inseparable at the time when the nurses interviewed were working. The nurses lived in their *Mutterhaus*, the hospital respectively. With her image of 'the house in the house', Davies (1995) has correctly portrayed the encapsulation of nursing. There are three quite different domains of work which evolved from the descriptions of the nurses, medical assistance, household and "house mistress" functions. The job of the nurse contained this whole setting. The specific *bundle of tasks* is part of it. More precise than Davies' image seems to be the idea of a *mould* to describe

the functions of the nurses as it emerges from the interviews: medicine and hospital administration 'pour' a new profession into their institutions. The resulting functions constitute the *bundle of tasks* of the new nursing profession.

In the course of the development, leading nurses began to improve the structures and the organisation of their work and to claim for further education. They started to conceptualise the nursing tasks which meant the consolidation of all of the three domains. The integration of these very diverse domains would be unimaginable without identification, without a binding professional ideal. Freidson points to the social psychology of occupational membership as a very important aspect of professionalism: only a long-term perspective allows members of the professions to identify themselves with their occupation (Freidson 1986). In the case of the nurses interviewed this was very much the case.

The conceptualisation of the *bundle of tasks* was derived from the practical work, from the *mould* shaped by the superordinated structures – this is perhaps the most important result of the analysis. The nurses identified themselves with their set of tasks; they felt responsible and to a large extent free in the organisation of their tasks. Thus they started their *professional project* on this historically based set of tasks.

In the 1970s the claim for academisation was raised; academisation in German-speaking countries is identical with professionalisation. With this the claim for professional status is connected. Professionalisation now became a political programme.

The professional project succeeded partly by the implementation of some university programmes, but after the education reform the profession is more far from the control of its work than before.

Only the nurses' description of their everyday professional life made me understand how important the knowledge about the emergence of a profession is. The *bundle of tasks* (Hughes 1971) of nursing did not originate by chance but it is the result of social and political processes (cf. Dingwall 1983). The *mould* into which nursing was poured at the beginning of the 20th century was shaped by the same corporate state which is today conducting the education reform. This explains why jurisdiction, settlement and bundle of tasks have in principle remained the same, similar to what Dingwall has also stated for Great Britain (2000).

Furthermore, the analysis of the interviews showed me that the core of the profession is their work and that the claim is correct to put 'work' in the focus of the analysis (e.g. Freidson 1986, 1994, 2001, Abbott 1988). Following Abbott, his theory should be an alternative in that it reverses the problematic assumptions of professionalisation theories – it begins by focusing on work, not on structure.

"The central phenomenon of professional life is thus the link between a profession and its work, a link I call jurisdiction. To analyse professional development is to analyse how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional

links between professions determines the history of the individual professions themselves" (1988:20).

In order to understand a profession, one has to know the various dimensions of the reality of that profession.

Finally, I also agree with Dingwall's (1983) claim that an occupation should not be analysed as a phenomenon *sui generis*, but in its environmental context. The reason being that only with knowledge of the historical context can the specific setting of nursing be explained.

Future perspectives

The professional project of Swiss nursing did not fail because of its insufficient politics. It could not succeed because the Swiss state is hardly engaged in a professional project in nursing and because it is the state which determines the position of the professions. However, the Red Cross as a corporate institution worked to a certain degree as a market shelter for nursing which means an internal development and a closed market. Within the mould which was created for it, nursing was able to develop with relative autonomy into a profession with 'body and soul' (Freidson 2001) and to a certain extent gain control over work. This would not have been possible in an education system controlled by a market economy. In other words, the shape of nursing seems to reflect the state and this in two versions of regulation, that of the Red Cross and that of the 'The Federal Office for Professional Education and Technology' (OPET), both in a different way.

For the sociology of the professions the results of this study support the following claims:

- Occupations can only be understood within their historical context
- To understand someone, one has to know his or her job
- With the emergence of a profession, its set of tasks is long-term determined. Therefore we should account precisely of the way the duties of an occupation are shaped at the beginning.

The results of this study are signficiant for nursing in Switzerland. If in the future the profession wants to play a leading role in providing the population with professional nursing, it will distance itself from its belief in professional-project-strategies in order to pursue policies adapted to the real conditions. The profession has to understand that the achievement of full professional status does not depend on neither theoretical nor political arguments but on the needs of the state.

This does not mean that nursing in Switzerland is not a profession or less of a profession than in other countries. It does not mean that it could not or should not perform the professions' distinct vital function in the society, namely to manage uncertainty by constituting trust into professional services, and bound in an interdependent relationship with the state by virtue of a contract.

Swiss nursing should put the 'academisation-strategy' into the background in favour of a broad national and international professional policy where the issue

is to defend the concept of the profession against economic attacks. Nursing professionals will resist to being transformed into neutral technical experts in the course of a neo-liberal ideology.

"Doubtless much of the change taking place in the organization and direction of professional work today is economically inspired and reflects the material interests of both private capital and the state. But it is politics that advances and protects such change, and in politics ideology is a critical factor" (Freidson 2001:198). Freidson points out that the professional ideology asserts commitment to the quality of work. With the example of managed care, Dingwall (2006) shows that physicians, by virtue of an ethic of human service, can "transcend the Fordist agenda of the managerialists and to treat patients as individuals, whose conditions necessarily require the conscientious and discretionary application of judgement based on the facts of the particular case, regardless of the evidence-based template that may be dictated, and to act as the patient's ally and advocate in the face of this routinisation" (Dingwall 2006:94).

With its historic foundation, the nursing profession has good prerequisites to pursue a policy in this sense of the concept of the profession. Whether we talk about peer esteem, professional spirit, the soul of the profession or the ethics of human service: the nurses in this study have based their work on this to a high degree since the beginning of nursing as an occupation. What Freidson demands of the professionals has been familiar to nursing from its beginnings. "Professional ethics must claim an independence from patron, state, and public

that is analogous to what is claimed by a religious congregation" (Freidson 2001: 221).

Dingwall reaches a similar conclusion with a different approach. In his writings, the professions are characterised by their exclusive role as managers of uncertainty for both the society and the individuals. He bases his answer to the question of the consequences the new capitalism had on the professions on the concept of Weber's 'iron cage' (stahlhartes Gehäuse) of capitalism in The Protestant Ethic. Dingwall (2003:86) states: "For Weber, bureaucracy was always a means to an end. (…) its creation and ultimate justification was the delivery of a service characterised by straightforward duty without regard to personal considerations". According to Dingwall, the question is whether people can be lured out of their ‚iron cage' (Baehr 2001) "by an ethic of community, an opportunity to serve the others in an organized and coherent way".

These are serious issues nowadays: how can profession maintain their ethics under the present political circumstances and thus ensure their responsibilities towards their clients? This applies to a large degree to nursing as well. In my opinion, the issue of the status as a full profession is secondary to these issues.

Maybe it is my own professional soul which believes in the correctness of the theory that professions represent a generic, socially necessary concept (Freidson) and have to be seen in large historic periods (Dingwall) since I cannot believe that any society would ever want to do without it. In this case, I refer to professionalism in nursing. Also in Switzerland.

Bibliography

Abbott, A. (1988). The System of Professions: An Essay on the Division of Expert Labour, *University of Chicago Press*: Chicago.

Abholz, H., Borgers, D., Engelhardt, D., Gaedt, C., Nemitz, B., Rosenbrock, R., & Schagen, U. (1982). *Pflege und Medizin im Streit*. Berlin: Argument-Verlag.

Ackermann, C. S., Walter (1981). *Historische Aspekte der Trennung und Verflechtung von Staat und Gesellschaft in der Schweiz* - Die Genese der Verschränkung. Zürich: Typoskript.

Allen, D. (1996). *The Shape of General Hospital Nursing: The Division of Labour at Work*, University of Nottingham.

Arnold, D. (1996). Krankenpflege und Macht: Anwendung sogenannter poststrukturalistischer Theorie auf die Analyse der Machtverhältnisse im Frauenberuf Krankenpflege, *Pflege*, 72-79.

Baehr, P. (2001). The “Iron Cage” and the “Shell as Hard as Steel”: Parsons, Weber, and the Stahlhartes Gehäuse Metaphor in The Protestant Ethic and the Spirit of Capitalism, *History & Theory*, 153.

Bischoff, C. (1994). *Frauen in der Krankenpflege. Zur Entwicklung von Frauenrolle und Frauenberufstätigkeit im 19. und 20. Jahrhundert*. Frankfurt and New York: Campus.

Bock-Rosenthal, E. (1996). Ein neues Verhältnis von Theorie und Praxis im Professionalisierungsprozess, *Pflegemanagement*, 19-24.

Borchert, J. (1996). Die professionelle Leistung und ihr Preis: Leistungswertung, Preisgestaltung und die Konstituierung des Verhältnisses zwischen Klienten und Professionellen. In H. Mieg & M. Pfadenbauer (Eds.), *Die Professionelle Leistung – Professional Performance*. Konstanz: UVK Verlagsgesellschaft mbH.

Bourcart, N. (1991). Die Schule für die Krankenpflege des Schweizerischen Roten Kreuzes. In E. Valsangiacomo (Ed.), *Zum Wohl des Kranken: Das Schweizerische Rote Kreuz und die Geschichte der Krankenpflege*. Basel: Schwabe &Co. AG.

Burau, V. (1996). The Comparative Analysis of Nursing – a Challange of Theories of Professions? *ISA Working Group 02 Conference*. Nottingham.

Burrage, M., Torstendahl, R. (eds) (1990). *Professions in Theory and History: Rethinking the Study of the Professions*. London: Sage.

Cheek, J. (1997). Policy Matters: Critical Policy Analysis and Nursing. *Journal of Advanced Nursing*, 668-672.

Cisneros-Puebla, C. A., Faux, R. & Mey, G. (2004, September). Qualitative Researchers–Stories Told, Stories Shared: The Storied Nature of Qualitative Research. An Introduction to the Special Issue: *FQS*

Interviews I. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* [On-line Journal], *5*(3), Art. 37. Available at: http://www.qualitative-research.net/fqs-texte/3-04/04-3-37-e.htm.

Clarc, J. (1997). The Unique function of the Nurse. *ICN 21st Quadrennial Congress*. Vancouver.

Dätwyler, B. (1989). Interprofessionalität: Plädoyer für die Abschaffung des Arzt-Krankenschwester-Spiels. In Peter Saladin, H. J. Schaufelberger & P. Schläppi (Eds.). "*Medizin" für die Medizin, Arzt und Ärztin zwischen Wissenschaft und Praxis. Festschrift für H.G. Pauli,*. Basel und Frankfurt am Main: Helbling und Lichtenhahn.

— (1990). Die veränderte Sicht in der Krankenpflege oder ethisch-politische Überlegungen im Hinblick auf das 21. Jahrhundert, *Pflege, Die wissenschaftliche Zeitschrift für Pflegeberufe*.

Dätwyler, B., & Baillod, J. (1995). *Mit-Leidenschaft, Krankenschwestern sprechen über ihren Beruf*. Bern, Göttingen, Toronto, Seattle: Huber.

Dätwyler, B., Egger, J., Lädrach, U., Pauli, H. G., & Schönbächler, G. (1995). Integrierte Medizin, *Schweizerische Ärztezeitung*.

Dätwyler, B., & Lädrach, U. (1985). Die Krankenpflege als bürgerlicher Frauenberuf., *Zeitschrift für Krankenpflege*.

— (1987). *Professionalisierung der Krankenpflege: Zur Entstehung der Berufskrankenpflege in der Schweiz*. Basel: Recom.

Dätwyler, B., Meier, M., Menzi-Kuhn, C., Lang-Studer, B., & Böheim, R. (1999). *Erlebte Geschichte der Pflege zwischen 1930 und 1970 in der Schweiz: ein Beitrag zur historischen Pflegeforschung*. Bern: Direktion Pflege, Medizinisch-technische und Medizinisch-therapeutische Bereiche, Inselspital.

Davies, C. (1976). Experience of Dependency and Control in Work: the Case of Nurses, *Journal of Advanced Nursing*, 273-282.

— (1995). *Gender and the Professional Predicament in Nursing*. Buckingham, Philadelphia: Open University Press.

— (1996a). Cloaked in tattered illusion, *Nursing Times*: Volume 92 NO45.

— (1996b). A new vision of professionalism, *Nursing Times*: Volume 92 NO46.

— (1996c). The Sociology of Professions and the Pofession of Gender, *Nursing Women's History and the Politics of Welfare, 18-21 September 1996*: Nottingham.

Denzin, N. K. & Lincoln Y. S. (Eds.). *Strategies of Qualitative Inquiry*. London, New Delhi: Sage Publications, Thousand Oaks.

Dingwall, R. (1983). In the Beginning was the Work…: Reflections on the Genesis of Occupations. *The Sociological Review*, 205-224.

— (1996). Professions and Social Order in a Global Society, *ISA Working Group 02 Conference*. Nottingham.

— (1999). Professions and Social order in a Global Society. *International Review of Sociology*, 131-140).

— (2004). Science: A Puzzling Profession. Nottingham: unpublished draft.

— (2006). The Enduring Relevance of the Professional Dominance. In Mirella Giannini, Charles Gadea (Eds.), *Eliot Freidson*. *Knowledge, Work & Socity – Savoir, Travail & Société*, 4, 2, 77-97.

Dingwall, R., & Allen, D. (2001). The Implications of Healthcare Reforms for the Profession of Nursing. *Nursing Inquiry*, 8, 64-74.

Dingwall, R., & Fenn, P. (1987). "A Respectable Profession"? Sociological and Economic Perspectives on the Regulation of Professional Services. *International Review of Law and Economics*, 7, 51-64.

Dingwall, R., & Kidd, K. (2003). After the Fall...: Capitulating to the Routine in Professional Work, *Penn State Law Review*.67-87

Dingwall, R., & King, M. D. (1995). Herbert Spencer and the Professions: Occupational Ecology Reconsidered, *Sociological Theory*, 14-24.

Dingwall, R., & Lewis, P. (1983). The Sociology of the Professions: Lawyers, Doctors and Others. London and Basingstoke: The Macmillan Press LTD.

Dingwall, R., Rafferty, A. M., & Charles, W. (1988). *An Introduction to the Social History of Nursing*. London: Routledge.

Dröge, & Kai (1996). Wissen – Ethos – Markt. Professionelles Handeln und das Leistungsprinzip. In H. Mieg & M. Pfadenbauer (Eds.), *Professionelle Leistung – Professional Performance*. Konstanz: UVK Verlagsgesellschaft mbH.

Dunlop, M. J. (1986). Is a Science of Caring Possible. *Journal of Advanced Nursing*, 661-670.

Elzinga, A. (1990). The Knowledge Aspect of Professionalisation: the Case of Science-based nursing Education in Sweden, In *R. Torstendahl, M. Burrage, M. (eds), The Formation of Professions: Knowledge, State and Strategy*. London: Sage

Evetts, J. (2001). Professionalisation and Professionalism: Explaining Professional Performing Initiatives, *Professional performance*. Zurich.

— (2003). Professionalisation and Professionalism: Explaining Professional Performance Initiatives. In H. P. Mieg, M. Pfadenbauer (Eds.), *Professionelle Leistung – Professional Performance*. Konstanz: UVK Verlagsgesellschaft mgH.

— (2004). From Professions to Professionalism: a Discourse of Occupational Change. *The First CSP Conference in the Studies of Professions*.Oslo

Evetts, J., & Dingwall, R. (2002). Professional Occupations in the UK and Europe: Legitimation and Governmentality, *International Revue of Sociology – Revue Internationale de Sociologie*, 160-171.

Flick, Uwe/ Kardorff, Ernst von/ Keupp, Heiner/ Rosenstiel, Lutz von/ Wolff, Stephan (Hg.): *Handbuch Qualitative Sozialforschung. Grundlagen, Konzepte, Methoden und Anwendung*. München (Psychologie Verlags Union) 1991.

Freidson, E. (1970a). *Profession of Medicine*: *A Study of the Sociology of Applied Konowledge.* New York: Dodd, Mead.

— (1970b). *Professional Dominance: The Social Structure of Medical Care*. New York: Atherton.

— (1972). Profession of Medicine: A Study of the Sociology of Applied Knowledge, *Dodd, Mead & Company*: New York.

— (1978). The Official Construction of Occupations: An Essay on the Epistemology of Work, *9th World Congress of Sociology*. Uppsala.

— (1986). *Professional Powers: A study of the Institutionalization of formal Knowledge*. Chicago ; London: University of Chicago Press.

— (1990a). Labors of Love in Theory and Practice: A Prospective. In K. Erikson & S. P. Vallas (Eds.), *The Nature of Work: Sociological Perspectives*. New Haven and London: Yale University Press.

— (1990b). Professionalism, Caring, and Nursing. The Park Ridge Center, Park Ridge, Illinois.

— (1994). *Professionalism Reborn: Theory, Prophecy, and Policy*. Cambridge: Polity.

— (1996). Theory of Professionalism: Method and Substance, *ISA Working Group 02 Conference*. Nottingham.

— (2001). *Professionalism : the Third Logic*. Cambridge: Polity.

Friedman, M. (1982). *Capitlism and Freedom*. Chicago: The University of Chicago Press.

Fritschi, A. (1990). *Schwesterntum: Zur Sozialgeschichte der weiblichen Berufskrankenpflege 1850-1930*. Zürich: Chronos.

Fulton, Y. (1997). Nurses' Views Empowerment: A Critical Social Theory perspective, *Journal of Advanced Nursing*, 529-536.

Gruner, E. (1956). *Die Wirtschaftsverbände in der Demokratie.* Zürich-Erlenbach: Rentschverlag.

Halliday, T. C. (1987). *Byond Monopoly: Lawyers, State Crises, and Professional Empowerment*. Chicago: The University of Chicago.

Hammersley, M., & Atkinson, P. (1983). *Ethnogaphy: Principles in Practice*. New York: Tavistock.

Hanlon, G. (1999). *Lawyers, the State and the Market: Professionalism Revisted*. Basingstoke: Macmillan.

Hellige, B. (2005). Professionalisierung der Pflege: Zum Verhältnis von Wissen und Macht in der Pflege, *Printernet*, 692-699.

Hughes, E. C. (1958). *Men and their work*. Glencoe: Free Press.

— (1971). *The Sociological Eye; Selected Papers*. Chicago: Aldine-Atherton.

Ivan, I. (1977). *Die Nemesis der Medizin: von den Grenzen des Gesundheitswesens*. Reinbek bei Hamburg: Rowohlt.

Johnson, T. J. (1972). *Professions and Power*. London: Macmillan.

— (1995). Governmentality and the Instiutionalization of Expertise. In T. J. Johnson, G. V. Larkin & M. Saks (Eds.), *Health Professions and the State in Europe*. London: Routledge.

Juchli, L. (1973). *Pflege*. Basel: Rocom.

Keogh, J. (1997). Professionalisation of Nursing: Development, Difficulties and Solutions, *Journal of Advanced Nursing*, 302-308.

Kissling, B. R., Bernhard; Achermann, Daniel (2003). Professor Dr. med. Hannes G. Pauli: zum Tod des visionären wissenschaftlichen Denkers und Förderer der Allgemeinmedizin, *PrimaryCare*, 801-803.

Kruse, A. P. (1987). *Berufskunde II: Die Krankenpflegeausbildung seit der Mitte de 19. Jahrhunders*. Stuttgart, Berlin, Mainz: Kohlhammer.

Kuhlmann, E. (2003). Traces of Doubt and Sources of Trust – Health Professions in an Uncertain Society, *6th Conference of the European Sociological Association* Murcia.

Kulmann, E. (2002). Transformations in the Health Care System – Assessing the Impact on Health and Gender Relations. *Biennal International Congress "Health and Society in Europe"*. Groningen.

Lambach, W., & Brosig, C. (1998). ‚Die ganze Zeit arbeiteten wir Hand in Hand': Eine vergleichende Studie über die Auswirkungen von Professionalisierung am Beispiel von deutschen und U.S. amerikanischen Pflegekräften, *Pflege,* 21-26.

Landenberger, M. (1996). Zur Arbeitsmarktentwicklung und Professionalisierungsdynamik im Berufsfeld Pflege. In S. Görres & D. Koch (Eds.), *Pflegewissenschaft in der Bundesrepublik Deutschland*. Bremen: Altera.

Larson, M. S. (1977). *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press.

Leemann, L. (1944). Enqête II über das Pflegepersonal in den Anstalten für körperlich Kranke der Schweiz, *VESK-Zeitschirft*.

Lindauer, J. (1928). *Die Frau in der schweizerischen Gesundheits- und Krankenpflege (Wochen- und Saäuglingspflege und Irrenpflege inbegriffen)*. Zürich und Leipzig: Orell Füssli Verlag.

Linder, W. (1983). Entwicklung, Strukturen und Funktionen des Wirtschafts- und Sozialstaats in der Schweiz. In A. Riklin (Ed.), *Handbuch Politisches System der Schweiz, Band 1: Grundlagen*. Bern und Stuttgart: Paul Haupt.

Macdonald, K. M. (1995). *The Sociology of the Professions*. London: Sage.

Mayring, Philipp, *Qualitative Inhaltsanalyse. Grundlagen und Techniken*. Weinheim: Beltz, 1983.

Meier, M. (1997). Das Pflege- und Berufsverständnis von Schweizer Krankenschwestern zwischen 1930 und 1970, *Dritter Internationaler Kongress zur Geschichte der Pflege*. Wien.

Meier, M., & Fiechter, V. (1981). *Pflegeplanung – Eine Anleitung für die Praxis*. Basel: Rocom.

Mieg, H., & Pfadenbauer, M. (eds.), (2003). *Professionelle Leistung – Professional Performance*. Konstanz: UVK Verlagsgesellschaft mbH.

Mitscherlich, A. & Mitscherlich, M. (1967). *Die Unfähigkeit zu trauern*. München: Piper.

Moser, M. S., Stamatiadis, M., & Baillod, J. (2001). Die Arbeitssituation im Pflegebereich im Kanton Bern. Untersuchung im Rahmen des Projekts "Verbesserung der Arbeitssituation im Pflegebereich" (VAP), *Mündliche Befragung der Pflegenden (Baustein 5)*. Bern: Gesundheits- und Fürsorgedirektion des Kantons Bern (GEF).

Murphy, E., Dingwall, R. (2003). *Qualitative Methods and Health Policy Research*. New York, Walter de Gruyter.

NVivo Online help, *What is Nvivo*? Copyright © 1999-2001 QSR International Pty Ltd.

Odendahl, T. (1994). Women's Power, Nonprofits, and the Future. In T. Odendahl & M. O'Neill (Eds.), *Women and Power in the Nonprofit Sector*. San Francisco: Jossey-Bass Publishers.

Oevermann, U. (1996). Theoretische Skizze einer revidierten Theorie professionalisierten Handelns. In A. H. Combe, W. Helster (Eds.), *Pädagogische Professionalität*. Frankfurt.

Pauli, H. G., White, K. R., & McWhinney, I. R. (2000). Medical education, research, and scientific thinking in the 21st Century, *Education for Health*, 15-25; 165-172; 173-186).

Rafferty, A. M. (1996). *The Politics of Nursing Knowledge*. London ; New York: Routledge.

Rafferty, A. M., Robinson, J., & Elkan, R. (1997). *Nursing History and the Politics of Welfare*. London: Routledge.

Rohde, J. J. (1962). *Soziologie des Krankenhauses: Zur Einführung in die. Soziologie der Medizin*. Stuttgart: Ferdinand Enke Verlag.

Saks, M. (1995). Professional Regulation and the State: the Response of the Medical Profession's Unorthodox Medicine in Briatain and the United States, *Annual conference of the Society for the Advancement of Socio-Economics*. Washington D.C.

Salvage, J. (1988). Professionalisation – or Struggle for Survival? A Consideration of Current Proposals for the Reform of Nursing in the United Kingdom, *Journal of Advanced Nursing*, 515-519.

Savage, M., & Witz, A. (1992). *Gender and Bureaucracy*: Oxford and Cambridge: Blackwell.

Schenkel, H. (1970). *Notwendigkeiten, Möglichkeiten und Grenzen der Arbeitszeitverkürzung im Krankenhaus*. Aarau: Veska Verlag.

Schmidbauer, W. (1977). *Die hilflosen Helfer: Über die seelische Problematik der helfenden Berufe*. Reinbek bei Hamburg: Rowohlt.

Schütz, F. (1996). Organisationszwänge und hoheitsstaatliche Rahmenbedingung im Sozialwesen: Ihre Auswirkungen auf die Paradoxien des professionellen Handelns. In W. Helper & C. Arno (Eds.), *Pädagogische Professionalität. Untersuchungen zum Typus pädagogischen Handelns*. Frankfurt a.M.: Suhrkamp.

Seldon, A. (1998). *The dilemma of democracy: the political economics of over-government*. London: The Insitute of Economic Affairs.

Siegrist, J. (1977). *Lehrbuch der medizinischen Soziologie*. München (u.a.): Urban und Schwarzenberg.

Stake, R. E. (1998) Case Studies. In: Denzin, N. K. & Lincoln Y. S. (Eds.). *Strategies of Qualitative Inquiry*. London, New Delhi: Sage Publications, Thousand Oaks.

Steiger, J. (2004a). In Memoriam: Prof. Dr. med. Hannes G. Pauli (1924-2003). Ein grosser Pionieer der Aerzteaubildung, *Schweizerische Aerztezeitung*, 107-108.

— (2004b). In Memoriam Hannes G. Pauli 1924-2003, *Education for Health*, 255-257.

Stein, L. (1968). The doctor-nurse game, *American Journal of Nursing*, 101-105.

Strub, S., & Künzi, K. (2001). Die Arbeitssituation im Pflegebereich im Kanton Bern. Untersuchung im Rahmen des Projekts "Verbesserung der Arbeitssituation im Pflegebereich" (VAP), *Auswertung von Routine-statistiken (Baustein 1)*. Bern: Gesundheits- und Fürsorgedirektion des Kantons Bern (GEF).

Taverna, E. (2001). Der lange Weg zur Reform, *Schweizerische Aerztezeitung*, 2425-2427.

Thornley, C. (1996). Segmentation and Inequality in the Nursing Workforce: Re-evaluating the Evaluation of Skills . In C. R, G. Duncan & K. Purcell

(Eds.), *Changing Forms of Employment: Organisations, Skills and Gender*. London: Routledge.

Torstendahl, R., Burrage, M. (eds), (1990). *The Formation of Professions: Knowledge, State and Strategy*, London: Sage

Valsangiacomo, E. (1991). *Zum Wohle der Kranken*. Basel: Schwabe.

Walby, S. (1986). *Patriarchy at work: Patriarchal and Capitalist Relations in Employment*. Minneapolis: University of Minnesota Press.

— (1988). *Gender Segregation at Work*. Milton: Open University Press

— (1990). *Theorizing Patriarchy*. Oxford, UK; Cambridge, MA, USA: Blackwell.

— (1994). *Medicine and nursing : Professions in a Changing Health Service*. London ; Thousand Oaks: Sage.

— (1997). Gender Tansformations, *Routledge*: London.

Weidner, F. (1995a). Professional nursing practice-selected results of a study based on an action oriented understanding of professionalisation. *Pflege*, 8, 49-58.

— (1995b). Professionelle Pflegepraxis: Ausgewählte Ergebnisse einer Untersuchung auf der Grundlage eines handlungsorientierten Professionalisierungsverständnisses. *Pflege*.

Whittaker, E. W., Oleson, V.L. (1964). The faces of Florence Nightingale; Functions of the Heroine Legend in an Occupational Sub-Culture, *Humane Organization*, 123-30.

Witz, A. (1992). *Professions and Patriarchy*. London; New York: Routledge.

— (1994). The Challenge of Nursing. In J. Gabe (Ed.), *Challenging Medicine*. London: Routledge.

Yarling, R., & McElmurry, B. J. (1998). The Moral Foundation of Nursing, *Advances in Nursing Schience*, 63-73.

Appendices

Appendix 1: Relations

Appendix 2: Schema professional project (Larson)

Appendix 3: Schema state and market approach (Johnson)

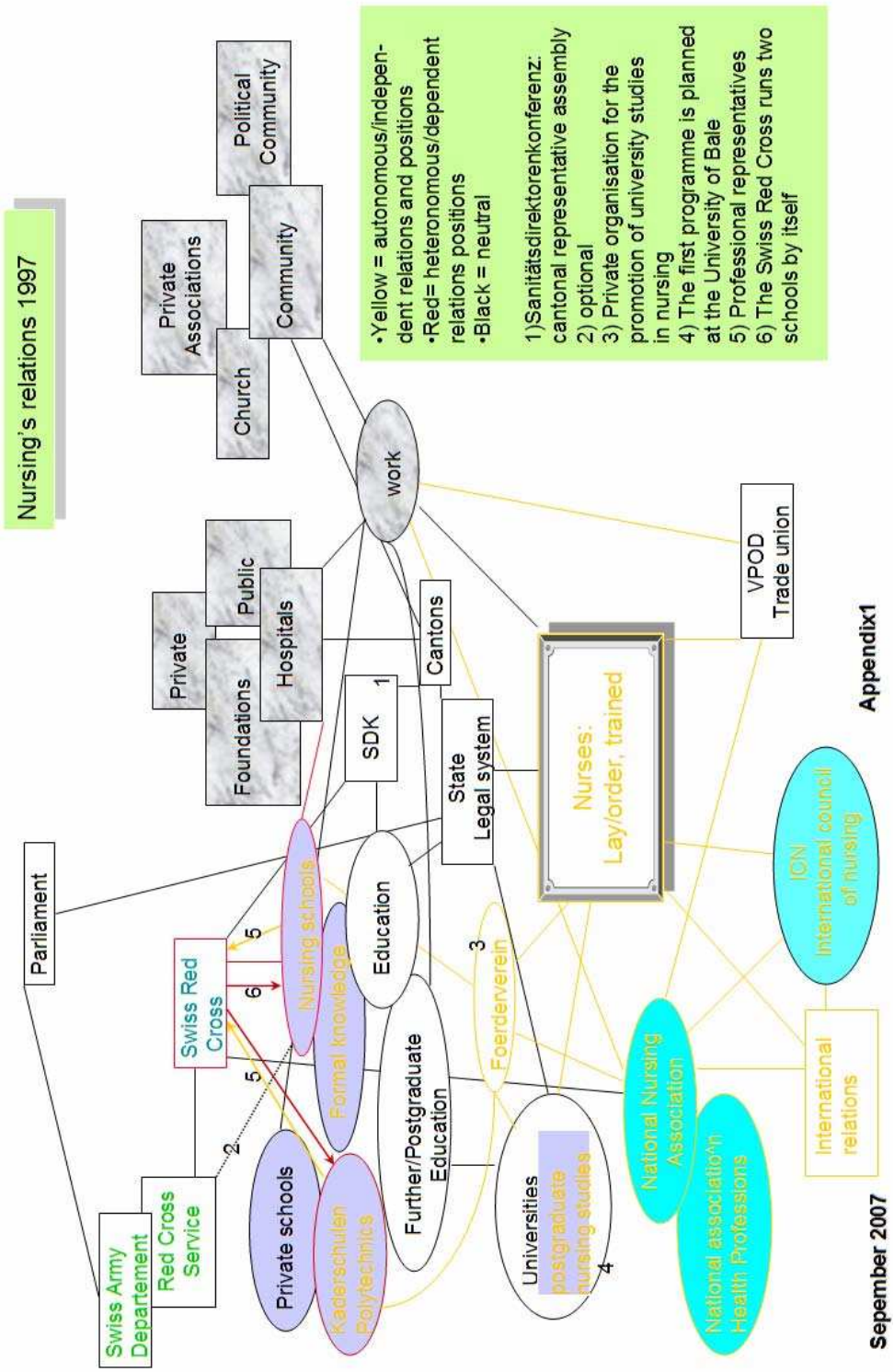
Appendix 4: Schema state and market approach (Freidson 01)

Appendix 5: Question guide one

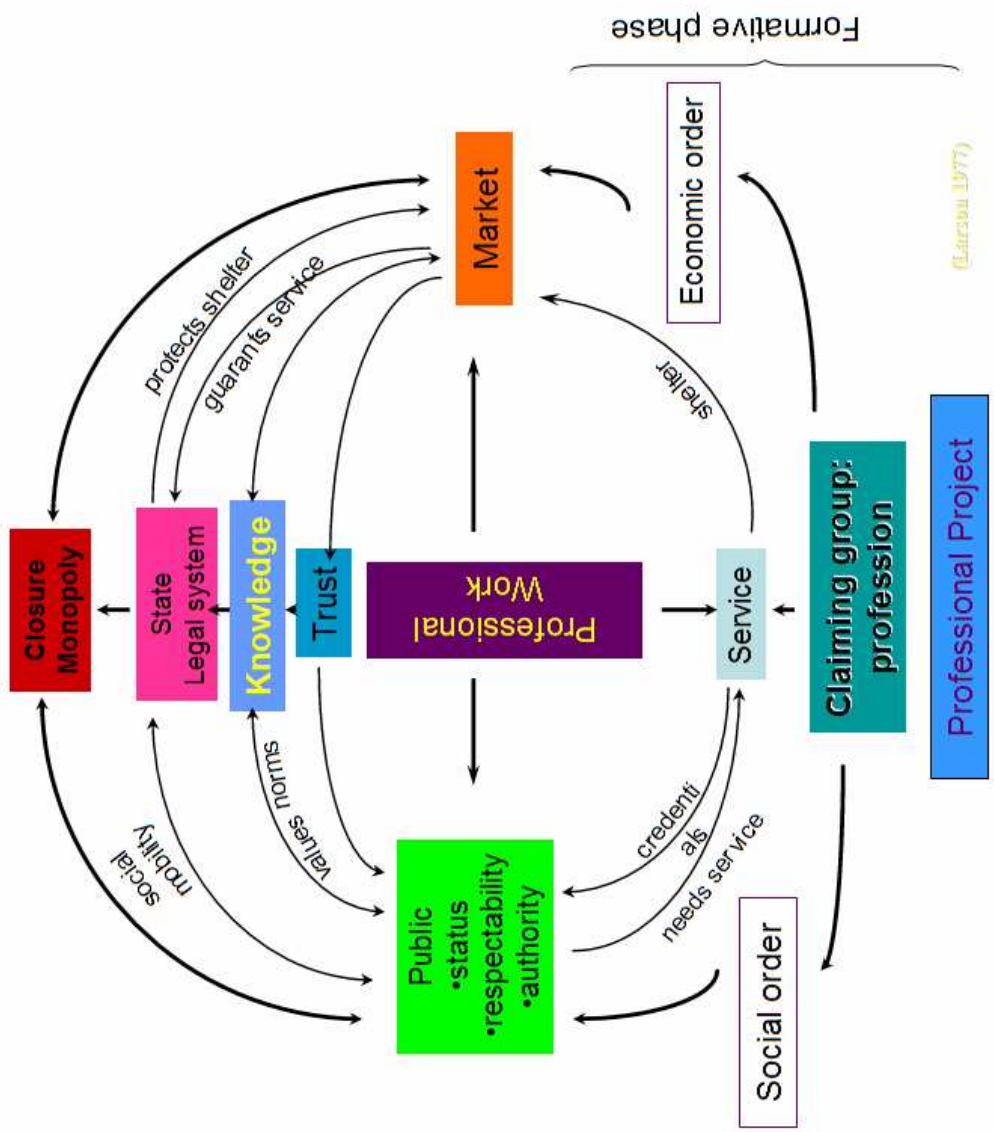
Appendix 6: Question guide two

Appendix 7: Systematics of Swiss occupational education

Appendix 1: Relations

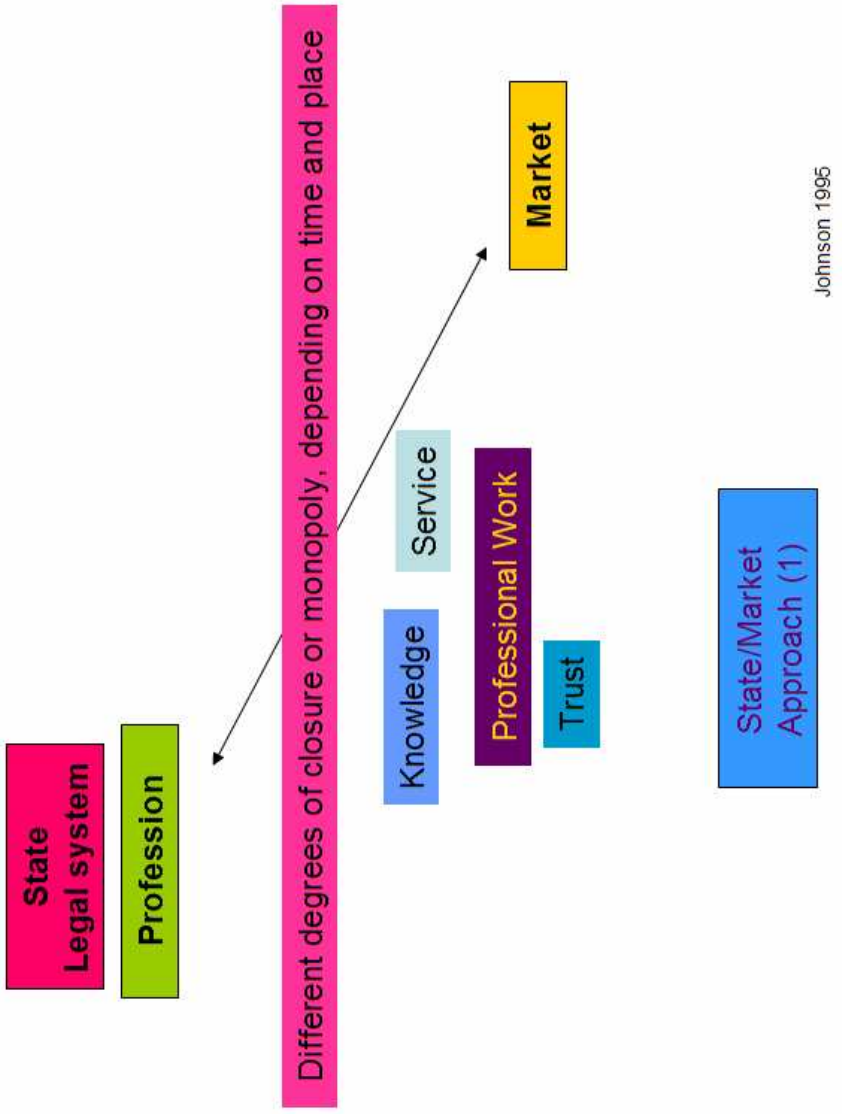


Appendix 2: Schema professional project (Larson)



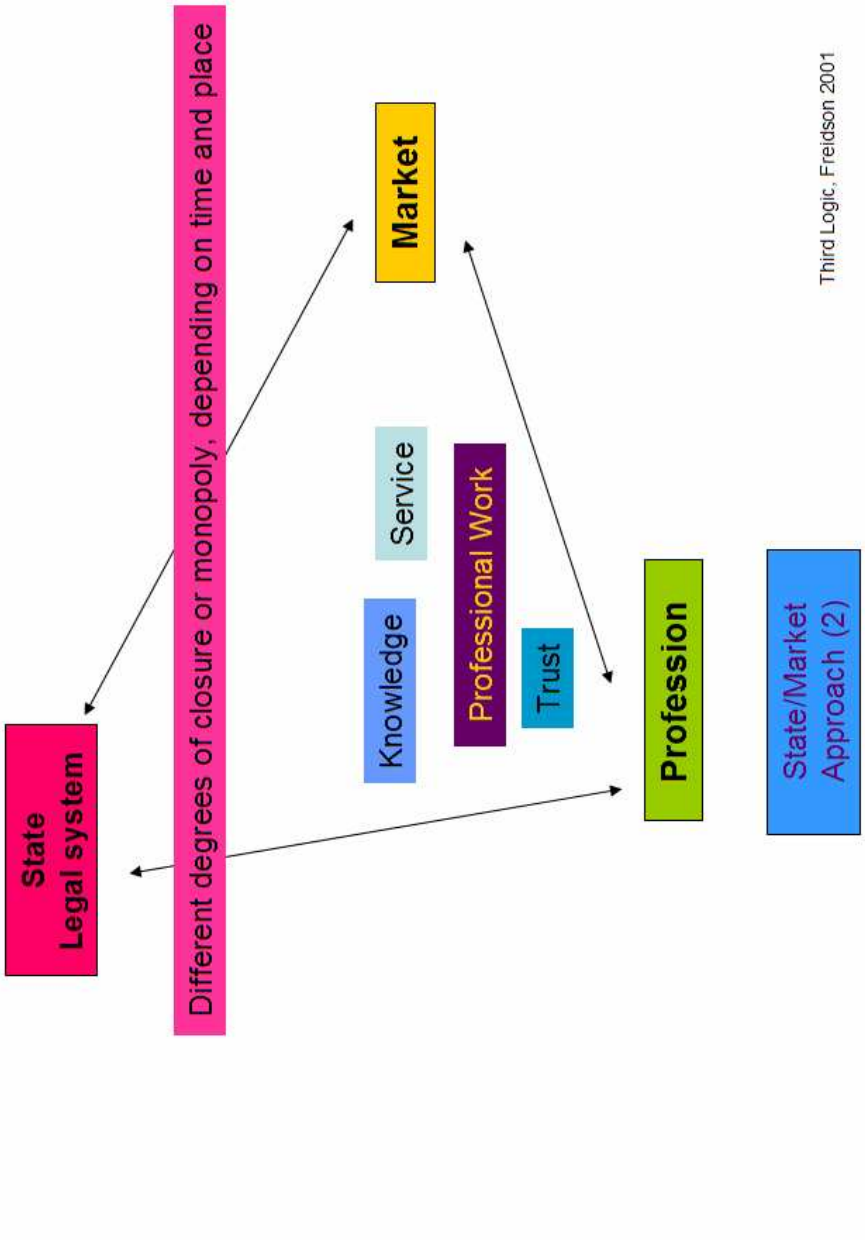
Appendix 3: Schema state and market approach

(Johnson)



Appendix 4: Schema state and market approach

(Freidson 01)



Appendix 5: Question guide one

Questionnaire: Interviews with 'old' officers

1) What was your motivation for becoming a nurse?

2) What do you think of your training oder education?

3) What was your first job after obtaining your nursing diploma? What was your motivation for choosing this option?

4) *In this question I would like to find out what were the professional stages of the person interviewed, either by way of a CV I asked for in advance or by asking at this point of the interview.*

   What were the stages of your career?

5) Could you tell me what you consider important at every stage and in what respect?

6) In the following part I am interested in looking more closely at certain aspects.

   Am I right in supposing that it is stage x in which you were professionally most involved?

7) What was your motivation for choosing that job?

a) Could you tell me, in a few words, what the state of nursing was like at that time?

b) What were your aims then?

c) What means did you use to reach these?

d) Did you struggle alone or did you have allies? If yes, who were they?

e) What were the obstacles to your attempts? Where did those come from?

f) Do you think that the fact that nursing is a women's profession was important? If yes, in what respect?

8) The following questions are aimed at locating your professional activities within the professional field of that time.

a) What was the attitude of institutions x towards the nursing practice like?

b) What was the relation to the international community of nursing like, to the international development of nursing respectively?

c) What was the attitude towards (or relation to) of institution x? medicine like?

d) What was the relation of institution XY to the state (to your Canton) like?

e) What was the relation of institution XY to the Swiss Red Cross like?

What was the attitude of institution XY towards the Swiss Red Cross like?

9) If you look back on that time, how do you assess the proportion of success and failure?

   What should have been done in a different way? And why?

   What role did the question of gender play?

10) What does the term professionalisation mean for you? And what do you understand by the professionalisation of nursing?

11) Can you name other key persons for the development or impediment of nursing in Switzerland?

Appendix 6: Question guide two

Questionnaire for the interviews with the persons who put their mark on the professionalisation starting in about 19970

1) What was your motivation for becoming a nurse?

2) What do you think of your training?

3) What was your first job after obtaining your nursing diploma?

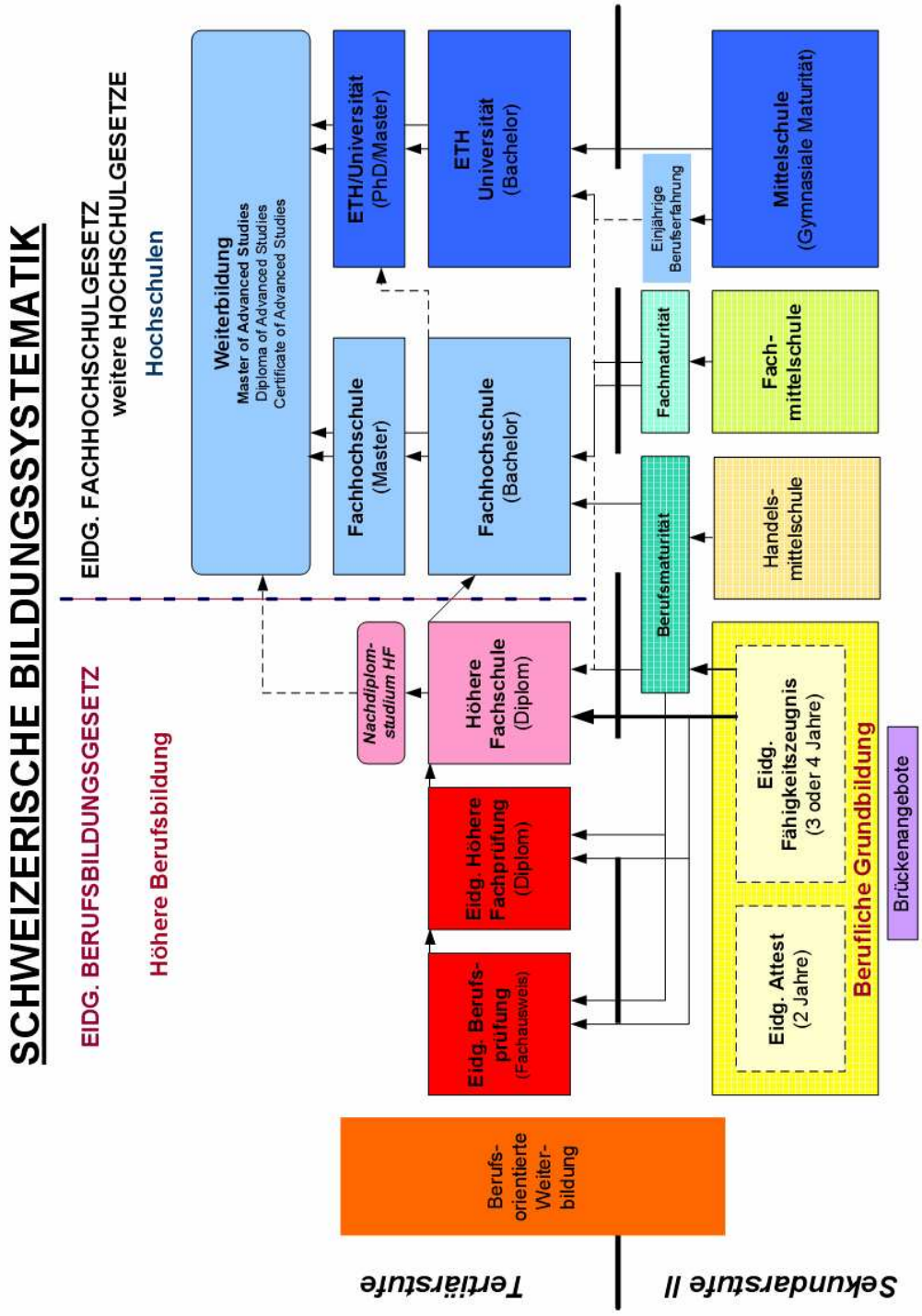
   What was your motivation for choosing this option?

4) With this question, I would like to find out what the professional stages of the questioned person were, either by a CV I asked for in advance or by asking at this point of the interview.

   What were the stages of your career?

5) Could you tell me what you consider important in every stage and in what respect?

6) In the following part, I want to look more closely at certain aspects.

   Am I right in supposing that it is stage ‘University Hospital XY’ in which you were professionally most involved?

Appendix 7: Systematics of Swiss occupational education