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THE PARADOX OF MEN WHO DO THE CARING:  
Re-thinking Sex Roles and Health Work

One Volume

Bryony Clare Elliott BA Gen Dur, RGN

*Thesis Submitted for Degree of PhD*

*University of Warwick*

*Department of Sociology*

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## SUMMARY

*This thesis sets out to attack beliefs that caring is women's work, to examine the reasons for the resistance to changing conventions about sex roles and health work and, in view of coming changes in British demographic and socio-economic structures, to urge people to consider the question, who cares for us?*

*The paradox of men caring makes its impact precisely because of the history and culture of women caring. The force of the image is as great as the contrast which makes it: men look like misfits in the caring role because women have been typecast for it. It is the extraordinary contrast of men carers and nurses talking about their caring feelings that forces the paradox. In this study, the men and women nurses and carers who were interviewed discuss their feelings as the very reason for their caring work, including emotion work and dirty work. The thesis argues that the men and women share the same caring values but their caring roles are conflicted by beliefs about sexual identity. Men's caring act is culturally constructed whereas women's caring act is directed by biological and cultural beliefs that help to perpetuate women's structured dependency in caring roles. The feminisation of caring designates the swamp of unthinking about women, feelings and bodies that breeds wrong beliefs about health work and sex roles and subverts the moral order of caring values.*

*This is feminist methodology, characterised by being reflexive, political and experimental. The resulting exploratory study combines qualitative fieldwork with theoretical inquiry. It is a deconstruction of sex roles and health work, exploring the feminisation of caring through the language of care and the history of nursing, the difficulties with current social theory that genders caring and ignores feelings, most importantly, the stories of men and women nurses and carers who talk about their caring feelings, their work and their beliefs about caring sex roles, and finally the context of caring in the UK today.*

*In conclusion, current beliefs about sex roles and health work undermine the moral order of caring values at a time when the task of caring for elderly people is increasing. What is required is the political will to begin the public debate on who should care for vulnerable kith and kin and who should pay for the work to be done?*

## INTRODUCTION

This small exploratory study of men caring takes a fresh look at thinking about sex roles and health work. Convention has it that caring is 'women's work'. However, given the rising tide of need among vulnerable members of society and the fact that most women today have a paid job, who is going to do the caring? The idea of men caring - be it men midwives, men nurses or sons caring for mothers - is still out of the ordinary. Why is this? The thesis argues that the paradox of men caring is explained by the feminisation of caring. In the research, men nurses and carers described their caring feelings and work and it is the contrast of their stories with the culture and history of women caring that encapsulates the paradox of men caring.

This chapter contains an overview of the thesis and its background. The coming chapters are summarised and the sequence of order of the chapters is explained. The thesis is written in the first person to represent the relationship between the researcher and the inquiry. Autobiographical details are included here and in Chapter Four and are intended to strengthen the meaningfulness of research by describing the events that gave my life meaning before and during the study.

### **Summary of the Chapters**

The thesis begins by exploring the likely historical origins of the paradox of men who do the caring and suggests that caring has been feminised in two ways at least. First: in the English language, care is conceptualised as feeling and not work, in a culture that typecasts women as feeling creatures. Second: the feminisation of caring may be linked to the growth of female sex roles in health work and the promotion of nursing for women as a role of virtue and feeling. Historically, caring has been feminised because of a conceptual absolutism that has reduced sex to characteristics that are biologically and culturally inescapable for men and women. According to this thinking, if women are the natural carers, men are the unnatural ones.

Throughout the study, beliefs and ideas that are spawned from biological determinism are challenged as wrong thinking. The technique of explicit political challenge to a logic that locks women into biological, cultural and structural dependencies is part of feminist standpoint theory and is discussed in Chapter Four. The aim is to improve the objectivity of research by repeated and explicit rehearsal of the methodological guidelines.

Chapter Three examines the main perspectives in social theory that have shaped ideas about caring and shows how these strategies helped to maintain the feminisation of care. This chapter begins by reviewing the British feminist literature on caring and points to two problems facing current thinking about care. First, the dominant feminist separatist critique of women caring was successful in addressing the marginalisation of women's issues in sociology and establishing feminist thinking in the discourse. Nevertheless the almost

exclusive study of white women carers had the unwelcome effect of rehearsing the same sort of sexual and racial inequalities the authors resisted (thereby making a feminist study of men caring appear controversial). Theories about gender relations and caring were unable to match determinist and essentialist explanations of women's social dependency with the way people make and maintain relationships because of their feelings.

Second, the elision of feelings in social science highlights the gaps in sociology's box of tools for comprehending the world of human relationships and emphasises the male dominated theoretical monopolies that keep the discipline in business. The inequalities of power in the ontological approaches of sociology, its systems of thought and research methods are more obvious when sociology tries to address the typically femininised spheres of caring feeling. Inequalities of power in the very construction of sociological knowledge make the attempted study of anyone's feelings problematic in a discourse that has neglected them. The lack of theoretical grip on feeling in sociology is addressed by reviewing existing theories and the epistemic status of feelings, finding considerable help in the work of Agnes Heller.

Chapter Four is the methodology chapter. It describes feminist standpoint theory and how its guidelines for good research have informed this project: explicit emphasis on the relationship between the researcher, the methodology and the participants; overt political challenge to false thinking that limits understanding of the social situation; and experimentation with research tools to find more robust and sensitive methods of investigation in the field of human relations that can synthesise lived experience with theory. There is

## *Introduction*

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more autobiography in this section that considers my life between 1988 and 1995 and how these events affected the inquiry. The irony is not lost on me that I spent several years of my life looking at the impact of illness on other people's lives without considering the effect of my own chronic illness on the inquiry - not least how long it took and the secondary effects (on myself and the thesis) of taking so much time. The final section in this chapter is about the research method. The research design, sampling, access to the interviewees, the interviews, data analysis and the ethical issues are described. The interview techniques - for example, those used to help participants explain their emotional performance and inner feelings - are described with reference to similar research. Finally, I share my doubts about the ethics of conducting an inquiry on people's private emotions in caring situations.

In Chapter Five, the research participants are introduced, with brief histories of their caring careers. It is hoped these cameos will acquaint the reader with the people whose stories of their caring experiences carry so much weight in this study. The sample consists of fourteen participants altogether - seven carers and seven nurses. Twelve are men and two women (a carer and a nurse). All the participants are white and their ages range from their early twenties to retirement. Some are just starting their caring careers and some nearing the end. Among the carers and the cared for, five men cared for their wives and the other two were looking after their parents. All the interviews were conducted in and around a place called Carrtown in the study and the chapter begins with a brief description of Carrtown where most of the participants lived and worked.

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Chapters Six and Seven are about the interviews. The men nurses and carers explain their caring feelings and their caring work. Their accounts challenge conventional beliefs about sex roles and health work as they describe invisible spaces that are part of a world of intimacies and connectedness generally explored through female relating in the literature.

The stories of the men's commitment to care show a weave of feelings, values, beliefs and acts that changes during their caring careers. Their testimonies reveal the continuum of feeling between love and duty, between feeling free to care and bound to care - a spectrum of human experience that is partially explored in the feminist literature on caring. The research points to an understanding of 'commitment to care' where fluctuating feelings towards the commitment mark its course.

Two aspects of caring work that have been explored through women's experience in the literature are emotion work and dirty work. The men tell of the effort to control emotion and accomplish dirty work that continues day to day regardless of the ebb and flow of commitment. Also, the excerpts show men's awareness of the complexities of the business of managing their emotions for the sake of others and also of coping with dirty work.

Chapter Eight seeks to explain why the issue of feminisation of caring is important today. Demographic and socio-economic forces have shaped the colossal task of caring that seems certain to impact on western societies in the new millennium. In this country, the potential costs to society have been re-cast by a decade and a half of politics that has legislated for individual

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in preference to collective solutions for health and welfare. In a society that is under increasing pressure to provide more care, wrong beliefs about female sex roles and health work could generate more tensions between the state and women income-earners. Will women who are juggling commitments to work and look after their families cope with expectations that they care for the chronic sick, elderly and handicapped as well? What is required is the political will to meet the social and economic costs of welfare by defeminising care so that men and women have equal opportunities and equal support to care for vulnerable others.

Chapter Nine concludes that the paradox of men makes its impact because of the history and culture of women caring. The force of the image is as great as the contrast which makes it: men look like misfits in the caring role because women were typecast for it. When men talk about their commitment to care, their feelings and the work they do, and what it's like performing a female role, the paradox is finally substantiated.

In so many ways, the feminisation of caring rehearses and confirms the false logic of biological destiny and prescribes the subordinate sexual identity of the caring role. The thesis concludes that while people believe caring is a biological given, society cannot be wholly responsible for its vulnerable members even though population and socio-economic trends are creating more need. Defeminising care and including men in caring roles is a necessary part of making 'a caring society'.



### **Autobiographical Details**

This is a thumbnail sketch of the background and circumstances surrounding my role as researcher. The inquiry is seen in the light of the main autobiographical events that marked its construction, a technique intended to strengthen the objectivity of the study. Consideration of how the relationship developed is part of Chapter Four.

For most of my life, I've been involved with caring - nursing others or others nursing me. I am white, British, middle-class, female and was university educated in the seventies by marxist/feminist minds. In 1983, and at the age of twenty seven, I did the general nurse training and worked for seven years as a nurse until my physical health deteriorated. A born crusader, I fought for issues with the health unions, people who supported complementary medicines and for local NHS campaigns. During that time, I decided I wanted a better theoretical grip of health matters and in 1987, I enrolled as a part-time student at the University of Warwick on the Sociological Research for Health Care Masters Degree.

This study grew from the time I was trying to put together a proposal for the dissertation in 1988. Its origins can be traced to two nagging doubts that concerned me. As a nurse, I was frustrated by what I thought was the professionalisation of caring by nursing, and as a sociology student, frustrated by its takeover by what I regarded as feminist separatism. Caring was subsumed by two different areas of knowledge, owned by predominantly white female groups with very different political aims, who seemingly wanted

to keep caring - the domestic reserve of unpaid labour and the underpaid welfare army - to themselves!

I could not find an interesting angle for investigation until one day, it struck me that little was known about men's views on caring (apart from Ungerson 1987). The original proposal was for a simple empirical study of men's views about their caring roles, interpreted in the light of existing social theory on caring. However, the common features of writing about care - the invisibility of work and the rhetoric of feeling - was also a feature of the first case studies in 1988. As Meg Stacey remarked, it was paradoxical that men talked more about their feelings than their work (when it is the norm for men to discuss their work and hide their feelings). This is how the inquiry was started.

My health gave way rapidly after the spring of 1989. By the end of the year, I was unfit to work. Nevertheless, I stayed at Warwick as a sick part-time doctoral student until 1991 when I was well enough to return to the NHS to do health research. My academic efforts have been hindered by recurrent and persistent ill health, my return to full time work in health research and the uncompromising and sometimes unreasonable demands of NHS employers at a time of organisational upheaval. My relationship with my elderly father as the youngest unmarried daughter improved when both of us were weak and needed help. But while I got better, his physical health slowly deteriorated (although his will remained firmly intact) throughout all the operations, the strokes and the utterly wretched transition from home to nursing home because of the new community 'care' laws.

The things that mattered to me when I began this thesis are not the things that matter now, for I care more about the day to day tranquillity of family, pets and garden than I do about social theories. If some of the men who talked to me agree with little else in this study, here there is common ground.

Of course the information I gathered for the thesis until 1991 has been picked over already by other writers and the sociological discourse is dominated now by postmodernist debates. While my thoughts still bear the imprint of a seventies marxist/feminist education, here the gist of my thinking reflects the postmodernist vogue for deconstructing those things we take for granted: in this case, caring language, beliefs and values. My intention is to attack the inequalities of power - inherent in conventions for women's sex roles for health work and modern values of caring - which silently divides our communities and compromises the way we care for ourselves.

## THE FEMINISATION OF CARE

## PART ONE

The paradox of men caring makes its impact because of the history and culture of women caring. The force of the image is as great as the contrast that makes it: men look like misfits in the caring role because historically, women have been typecast for it. Indeed our ideas of caring have become feminised (1) and partial, so that care means more to do with feelings than the work it involves. Probably this way of thinking has come about because historically, caring has been associated with women.

This chapter explores some of the historical evidence for the feminisation of care - specifically, the language of care and nursing as a role for women. Throughout, I am attacking the deceit of caring roles by attacking the language that describes them and the caring beliefs that are extensions of such language. The chapter concludes that caring's feminisation is the process of a conceptual absolutism that reduces sex to characteristics that are biologically and culturally inescapable for men and women - a mistaken idea that is fundamental to understanding the paradox of men who do the caring. What is required is a balanced view of care as work and feeling and does not typecast women as society's natural carers and men carers as the misfits.

## Naming Care

What is in a name? Writers about care often begin by distinguishing its different meanings. From this they build a conceptual framework (for instance, Roy Parker 1981, Graham 1983, Kitson 1985, Dunlop 1986, Bytheway 1986) (2). In theory, the common view is that care has two parts. Caring *for* somebody is working for them. Caring *about* someone is feeling for them. I am sure the abstraction is correct. However, different groups of people (be they politicians, feminists or nurses) who have very different agendas in mind are using the same term, apparently to address separate parts of human experience. I find this puzzling. Obviously, care is a vague sort of word. It seems that it is not just a question of what is care but who thinks it is and why?

The space for extending our social constructs is pulled about by the forces of nature, structure and culture. In Britain today, care occupies strategic ground, because of a combination of factors to do with population change, new political strategies for health care, medical and bio-technologies, conventional sex work roles and the impetus for professionalisation in caring work. Care is high on the public agenda. Yet it is a confused and confusing concept. Politicians talk about care to mean what is expedient at the time. For example, writers about 'community care' policy note the historical shift of approach, from organised institutional care in the community, to Good Neighbour schemes, and the financial expediency of closing long stay institutions, to mixed economies of care, although the name stays the same (3).

Harre (1986) maintains the language of emotion reflects the moral order of the community (4). Meanings for care simultaneously reflect the practices that

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form the things of which they speak (Barrett and Phillips, 1992). In that case what can one make of the confused concept of care? What does the *lack* of words for naming the qualitatively different aspects of care - feelings and work - signify? Is society in a state of unknowing or initiation? I shall argue that care is a new and malleable construct milked by ruling groups for its affective meanings.

This section examines the confusion in the language of care because of the double meanings of feeling and work. Second, it explores the way this ambiguity is exploited by groups with vested interest in the development of the language. Three studies underpin this thinking: a brief history of definitions of care; an opportunistic survey of the naming of care in other cultures; and finally, a review of the application of the vocabulary and constructs of care in the nursing discourse.

### **Dictionary Definitions.**

Some examples of the changing use of care are to be found in the Oxford English Dictionaries (1964 and 1989). The noun and its verb care comes from the old Teutonic languages, with half a dozen different evolved meanings. An early expression for a time of grief, it was customary to talk about someone retiring to their care-bed. In Old English, the noun found many new meanings, such as take care of,

eg, 'He brought him into an Inne, and took care of him', 1582. New Testament Rhem, Luke 10.32.

More recent switches of meaning occurred in legislation for those needing care and protection eg. The Royal Commission of the Care of the Feeble Minded (1904-08). The verb has various early forms : to sorrow, grieve or mourn, be concerned about, take care about, not care, not mind, like something or someone. To look after, take care of is a recent construction,

eg. 'The child has been well cared for'. Manchester Guardian, 7th April 1887).

These older connotations of care as feelings of grief, fear and solicitude, contradicted my understanding (as a nurse) of care as compassionate concern, and I wasn't sure how the gap between one image and another had been bridged. I had almost dispensed with this study of dictionary definitions, when I heard the new OED was coming out after 25 years, and I wrote to their offices for help. John Simpson, the editor, kindly sent me the OED's two new entries for the now commonplace adjectives derived from care : carer and caring.

The OED examples for caring and carer date their emergence in the language in the sixties and seventies. They may seem familiar terms to us now. In fact they are very new in the English language. Both terms are about ways of working, in terms of service or a job. Carer has two definitions. One reads, 'A person whose occupation is the care of the sick, disabled, etc; one who looks after a disabled relative at home, especially one who is therefore unable to work'. An example is :

'Believers in Cosmic Nursing . . . distribute information . . . to carers in hospitals and in homes . . .'! New Age, Summer 7/3, 1985.

The definition for caring reads, 'That cares; compassionate; concerned; specifically with reference to professional social work, care of the sick or

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~~elderly etc. Frequently as caring profession, society'. The OED's selected examples are waspish!~~

'The word caring in the context of the Tory Party meant that Mrs Thatcher intended to lower her voice another octave', Sunday Telegraph, December 29th 1985.

There are both affective and instrumental aspects to the picture represented by care. These aspects alter with time. The word conjured different images for different eras, for feelings (be it grief and sorrow or compassion and concern) and for responsibilities (from custodianship to domestic tending and professional duty). To my mind, the sense of care as work is still emerging and there is no clear and coherent equation in people's minds. Of course, feminists have driven home the point that caring is work for at least twenty years (from Oakley 1972, to Graham 1991) but society has put other constructions on the matter. Anomalies are common. Take for example, the OED explanation of a carer, whose *occupation* is caring for the infirm. The carer looking after someone at home is *therefore unable to work*. What an ironic twist in our understanding of what constitutes work! The result is that caring described as work must be a paid job. By definition, care carried out in the home that is unpaid cannot be work as well. This is the cleft stick for carers, who can't go out to work because they have a job, caring in the home. If a substitute from an outside agency performs the role, we call it work. But when a carer undertakes it, we call it caring, and the work involved is made invisible. Care is like a magic box and the contents are whatever you want them to be - either feelings or work or both - because specification of the meanings attributed to the word has not occurred.



### **Naming Care in Other Languages.**

This takes me on to the next part of the story in this chapter. Who is doing the naming? For of course, arguments about language are culturally specific. Other cultures may have evolved a range of terms for caring that offers more sophisticated classification than the English language which conflates two concepts under one heading. In an early piece about the nature of commitment for nurses, Altschul makes the same point :

"The onlooker may believe, wrongly in my opinion, that because there is one word for it there must be one thing which exists, separately from the people who are committed to it. This is not however, in the nature of language. True, a word is used to communicate a concept, but there may be complexities in the nature of the concept which are inadequately communicated in the word. In different languages, the varieties of idea incorporated in a particular world may be very different" (1979: 126).

After reading Harre (1987), I decided to borrow the idea of exploring the social construction of feeling in different languages (5). If I came across people who were bi-lingual from other continents, I asked them about the conceptualisation of care in their mother tongue. The investigations were entertaining, inconclusive and informative.

A gentleman called Freeman, who came from Hong Kong and who spoke Cantonese, gave the matter much thought. If I interpret him correctly, he advised me that he can talk about caring about someone in the sense of loving them, which implies an intimate and reciprocal way of relating. There is another expression, meaning the intensive care of someone very sick and dependent on the carer. The other concept that he thought of does not translate easily in English; he called it 'looking at' care, which means watching over and tending

someone. Freeman suggested the correct application of the Chinese terms for care depended upon knowing the power relationships involved.

Two gentleman who spoke Milawian and Shona gave me their translations of care. In Milawian, the word 'kusasmalira' means to care for someone. It carries various meanings in itself : of feelings, involvement, and actions. 'Kusamalira' is a commodious word that accommodates a range of concepts. Shona seems much more careful. In Shona, 'kurapa' means to care for someone in hospital with medical treatment. 'Kuchengeta' means to care for in the sense of look after someone, either at home or in hospital. 'Kunzwira' means to care about someone with feeling, and suits private or public relations.

The Norwegians I asked thought Norwegian had few equivalent concepts because it was not rich in expression. The only way to express caring was in a phrase : ' Bry seg om noen'. They mentioned 'Pleie/r', meaning to nurse. The adjective, 'omtenksom', aroused debate. They eventually agreed that it meant to 'think care', in the sense of involvement, interest, and friendliness. They said that 'hensynsfull' meant to act with care.

My opportunistic and tiny sample re-inforces the idea that the naming process is culturally loaded. Different societies have evolved terms to reflect what is significant for them. The word care in English with its confused double meanings is skimpy by comparison. Chinese Cantonese has a wide range of concepts, apparently differentiated by the social arrangement of power in the relationships. Shona is particularly careful in designating the difference between caring feelings and different types of caring work. There are gaps

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and accents in any language that reflect the way a culture accounts for care.

Altschul remarks similarly :

"The belief that because we have a single word there must be a unitary entity is not one to which I describe. The study of languages shows that the more primitive the understanding of a concept the poorer the available vocabulary with which to explore it" (1979: 133).

The point is that the sparse language of care in English reflects the moral order of a people who neglect to look for other words because they have no need to find them, unlike languages of other cultures. For the final part of this chapter, I shall explore views of care from the nursing discourse.

### **The Cultural Context of Naming Care.**

When I was nursing, I was struck by the different ways of talking about care. Nurses and relatives often discuss 'the care' someone is receiving. They think they understood each other and often that is the case. Yet sometimes there is confusion people find hard to put into words. For example, a nurse knows the initials 'T.L.C.' stand for 'tender loving care'. The instruction, 'For T.L.C.', is a euphemism for the sort of nursing work prescribed for someone close to death. It often goes hand in hand with the note, 'not for 666', a situation where it is decided there will be no life-saving for someone whose medical condition is judged by the doctors-in-charge to be beyond hope of relief from suffering. The nurse is not expected to have feelings about the situation. Nor are her feelings censored unless they interfere with her work. Yet sometimes, relatives do assume that care means emotional involvement with someone they care about, and not just tasks performed on the body. Not

unreasonably, they assume caring means feeling for not detachment from human tragedy. Conflicting perceptions can cause upset on a hospital ward where human tragedy is commonplace.

In his paper, 'The Problem of the Next Instance' (1990), Barnes suggests that language construction reflects power relationships in society. Nurses claim ownership of the terms of reference for the work they do and this claim is strongly defended in the American nursing literature. They seek to appropriate the language of care as a hallmark for the new nursing profession (Gaut 1981, Harrison 1990). For example, the first principle of The International Association of Human Caring states :

"To identify the major philosophical, epistemological, and professional dimensions of care and caring to advance the body of knowledge that constitutes nursing and to help other disciplines use care and caring in human relationships" (in Schuster 1990: 28).

Rawnsley (1990), in an article remarkable for its clarity, suggests :

Caring, defined as "the action of the verb care", is given special reference as a descriptor for professions with primary social concerns. Caring is not identified as particular to nursing. If caring is to be the hallmark of all dimensions of nursing, then discourse, which projects that world through a dialectic between event or the world of practice, and meaning, or the world of ideas must be encouraged. Because care, the root word, is polysemic, multiple meanings are available at the lexical level and emergent meanings are potentially accessible through the semantic transformation of metaphor.

Probably relatives see care as a general term without 'professional owners', with rough and ready co-ordinates that everyone shares. Barnes argues that people conform to conventions of speech with good reason. Yesterday's solution for today's naming problem is convenient for them. They realise that agreement is more important than getting it right otherwise there would be

endless discussion and dispute. As a rule of thumb, they assume that if the term is routine it probably means it's 'right'. A brief inquiry of people around me about caring produced familiar responses so I assume they are 'correct'. All those I asked, men and women, young and old, referred to caring as a way of feeling - loving, giving, kindness, trustfulness - rather than the actions invoked. Perhaps this cliché appears unremarkable. We do think of care in terms of relating to others. Our feelings are engaged in response to the other. In general, people equate care with feelings for someone.

The sense of care as feeling is diluted by popular use in the media - for instance, *The Caring Nineties*. Dorothy Smith (1988) talks about the problems posed by split worlds between male-dominated public language and private experience (6). Meaning from private worlds cannot be transposed into the public context and relayed as a universal message without increasing the sense of dislocation for those who are the target of the message. For example, I see signs like 'Sheffield City Council Caring For You' emblazoned on buses, or old Peterborough hospital brochures declaring 'The Effect is Caring'. Care is taken out of its intimate context and placed on show. The public message on the side of the Sheffield bus relies on people doing the work and connecting with their private world of feeling for the intention of their City Council to impact on them. When intimate worlds are used for commercial reasons, the meaning slips its context, and the new sales pitch makes it into a cliché. Now I don't feel anything when I see the posters in the hospital because I resist doing the work of making the connection. If we stop connecting the phrase loses its clinch and sounds corny instead.

It was Professor Stacey who suggested a way of collecting the evidence for work on professional constructs of care. Years ago, she had explored the terminology of "community" in sociological texts, noting the conflicting specific applications and the way meaning is coloured by the context in which the term presents. The work I was doing reminded her of this particular paper (7). Of course, the volume, range and scope of the vocabulary of care in the nursing literature is very wide. For this exercise, I reviewed the editorials and leading articles in the British nursing press from 1980 to 1990 and the titles and summaries in the nursing abstracts (8).

A glance at any nursing texts shows the extent of use of care. It is a recurrent small word that is used so often it is almost meaningless : after care, balance of care, coronary care, day care, extended care, family care, geriatric care, home care, individual care, maternal care, neurological care, obstetric care, primary health care, quality of care, respite care, standards of care, terminal care, ulcer care, well woman care etc. It turns up in titles in the nursing press : Project 2000 - A Framework for Care, National Primary Health Care, Continuity of Care in Midwifery, Care About Food, Dental Care in Pregnancy, Leg Ulcers and Foot Care, Stoma Care in Scotland, Care of the Above Knee Amputation, Tracheostomy Care, Providing a Caring Service in Prisons, and Caring for the Cleft Lip and Palate. The word care is virtually inseparable from the work that qualifies it in the title, be it a body part or government policy.

The language of care was manipulated by editors of the journals in the eighties. Headers punned the word : Sharing the Caring, Handle with Care, and Care to Talk? An early editorial in The Nursing Mirror (1980) reads :

"All care cannot be in the hospital; but neither can all care be in the community. A balance has to be found . . ."

Nursing jargon has taken over in this example from The Nursing Times (1986) :

"New approaches to care are being pioneered . . . the switch to individualised patient care (a better term than nursing process) . . ."

There are various ways of employing care in the context of nursing. It is used in terms of the divisions of nursing labour based on medical specialities - such as renal care. It is latched onto demographic categories: elderly care. Care is used to refer to the re-organisation of nursing labour, either due to government inspired policy - such as Community Care, Quality of Care - or from changes in the nature of the caring workload because of professional aspirations - such as Care Plan Sharing, Primary Nursing Care, Self Care. There is basic task oriented care, again co-extensive with the biomedical model, such as catheter care, and temporal ordering, such as day care. All indicate ways for managing work. In the language of everyday nursing in Britain, care means a way of working, not a way of relating. The nursing discourse has produced other designations, as we shall see.

After this study, I began to think that meanings attributed to care coincided with the huge growth of caring labour and the emergence of the professions of the welfare state over half a century. This fits with Barnes philosophical conceptions of power and language. Part of his argument suggests that

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professions invade everyday language and push back the borders of meaning beyond ordinary understanding. Is nursing colonising the vocabulary of care? My final evidence is a review of some of the recent American nursing literature which led the way in developing a new nursing knowledge.

This exercise used Fawcett's book, Conceptual Models Of Nursing (1984) and recent American nursing journals, in order to review the context of constructs of care. Fawcett's work offers a comprehensive survey of examples of theories by American nurses, that have extended the boundaries of meanings for care, searching for holistic theories of practice that embrace the mind, body and feelings of the patient. The image of caring as work is like its silhouette, no matter how it is pushed about in the process of inventing new beliefs about nursing to do with feelings, spiritual harmony, energy fields or whatever. The following examples from American theoretical nursing texts illustrate my point very well.

Orem's Self Care Model makes up jargon such as Health Deviation Self Care Requisites (that rightly led to the coining of the term 'oremisation', or the simple made complex). In Levine's Conservation Model, nursing assessment is named 'trophicognosis',

"a nursing care judgement arrived at by scientific method" (Levine, 1966). She continues, "Nurses have long known that patients are complex persons and not groups of parts. It is out of this realisation that attempts towards comprehensive care and total care have come, and it is because we have been frustrated by failing to achieve the ideal of completion that the search for a more definitive bedside care has continued" (Levine, 1969).



Leininger (1981) was the first to argue that constructs of care form the domain for nursing knowledge and practice and began searching for a means of universalising care constructs from different cultures that would inform nursing practice. Some American nurse theorists have realised that "if nursing is to substantiate its claim on caring as a domain construct, then it must assume the responsibility of articulating the ways in which caring and nursing are integral", (Rawnsley M. 1990 : 41). Caring may be polysemic but nurses can manipulate its meanings for their own professional devices. Given these examples from leading publications in the American discourse, there may be a problem with the misappropriation and obfuscation of the construct of caring by nurses, colliding epistemological worlds in the collective interests of nursing expansion that other thinkers should be wary of.

"Holy the Firm and Upward Causation Model of Science can help us harmonise the whole and create an extensive landscape upon which to build our structures [of nursing knowledge], Through them we can pursue wide awakesness for informed passion for [] knowledge of human caring, healing, and health, as a consciousness context", (Watson, J. 1990 : 22).

Unitary man . . . a four dimensional negentropic energy field identified by pattern and organisation and manifesting characteristics and behaviours that are different from those of the parts which cannot be predicted from knowledge of the parts (Rogers 1980)

It seems some American nurse theorists are intent on turning the language of caring into a privilege of an academic few, thus making Barne's point. There appears to be little theoretical grip by nursing writers on the conceptual confusion between the instrumental and affective aspects of the construct of care. Nursing's unthinking appropriation of care words serves merely to repeat and increase the phenomenon of the feminisation of care.

## **Summary**

This chapter seeks evidence from a historical perspective for the feminisation of care which re-inforces the paradox of men caring today. The first part of the chapter explores the construction of care in the language and exposes the polarised meanings of feelings and work and the unequal emphasis on the affective side of care. The emphasis on feeling is part and parcel of the feminisation of caring that identifies caring with the emotional territory that supposedly belongs to women.

The English dictionary describes care and its derivatives as feeling and working. Other societies have thought about the phenomena of care differently, with more or less precision in the terms of reference. Harre suggests that the moral life of the culture is as real as the names produced to express it. Care is a poverty-stricken concept for Great Britain at the end of the twentieth century. A vision of care as feeling that is non-productive and weak contributes to the process of feminisation.

The double-edged meaning of care in English is recent. The inchoate sense of care in our society appears to have emerged with the growth of the caring professions in this century and their ownership of the words that describe the work they do. In professional nursing jargon the term most often appears as unthinking shorthand for work. Some American nursing theorists (eg. Rawnsley 1990) are actively seeking to re-construct the concept and invent a professional language in the process. However, nursing's extension of the language to designate new professional territories has not thought to challenge the ambiguity of meaning that typifies the feminisation of care.

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Caring remains one of those commodious words that people understand without question - a rough marker for the human response to suffering that is believed to be more to do with feeling than a concrete piece of work. Our society has one word for two concepts that refer to the phenomena of feelings and work. What is uppermost in people's minds when they talk about caring is the feeling involved not the work obliged. The language of caring when it is used to describe men nurses and carers has paradoxical effect because the very words are identified with skills and qualities attributed to women and their working lives.

PART TWO

EXPLORING SEXUAL INEQUALITIES IN HEALTH WORK

This section has one main line of attack. Using nursing as the context for examples from the everyday and from history, it seeks to expose the biological, cultural and structural inequalities of power between the sexes that shape the feminisation of care and make the paradox of men caring. Because false beliefs about sex roles interact and generate the twisted sense of the paradox with contemporary values for care, I begin by drawing a distinction between the two conceptual categories.

Two riddles illustrate historical aspects of the feminisation of care: 1. Why was nursing promoted as work for women alone? There are few theories about the shift of caring from female domesticity to male workplace and the establishment of an exclusive job market for women. It would help explain the social mechanics of sex roles and health work that still rehearse women's relative powerlessness in the economy. It also highlights the position of men who lose authority if they compromise their sexual and social status by doing women's work. 2. Why do men complain of discrimination against them in nursing but apparently take all the top jobs? Inequalities in the sexual division of caring labour for men appears as the inverse result of inequalities born by women. Such inequalities of power arise from false thinking about sex

the individual and the group, open to all to share, regardless of their sex. Caring values inform us of our responsibility towards others (even if we choose not to honour it and reject the feelings). The matter of who does the work is not the same as why it should be done.

So who do we assume cares? Two discourses on care offer answers. Feminists write about care as women's experience (Gilligan 1982, Graham 1983, 1984, 1985, Noddings 1984, Waerness 1984, Parker 1985) (9) and nurses describe care as the core of nursing experience (Leininger 1981, Kitson 1985, Chinn 1990) (10). In 1987, when I was reading around and fishing for the focus of inquiry for the MA, it struck me as odd that I take it for granted that women and nurses (by inference, more women) do the caring. Why do I automatically accept the implicit message in the realms of knowledge that men don't care on the whole? This is paradoxical when I know men who do (11).

These extracts come from the semi structured interviews and answer questions about what it is like being a man in a largely female world. A 40 year old labourer, Ian Black, who nursed both of his parents on and off over twenty years, said :

I tell you what. A woman's work is never done. And I am never going to dispute that ever again. It's damned hard work. I've got on the wrong thing here . . . but I've always said a woman should do the ironing. There's no way a man can do it as good as a woman can. I've got to do the ironing if the home help doesn't turn up, or else that's two lots next week. Then she's going to do the ironing and everything else gets left to me. I don't detest it but I can't get the hang of it. The minority of people thought I won't cope. It's too much for a man. Me brothers were saying, "You puff. Doing your tart's work again". It's nothing personal. I just tell 'em to bugger off. Words are words. On the quiet they do secretly admire me.

Charge Nurse Tanner is 24 years old and in charge of a medical ward :

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roles and caring and the fact that those beliefs are re-presented to us by health care services how ever we come into contact with them.

The section concludes by asking why people believe care is women's work? Why is care supposed to be elemental to the female sex? Root cause answers of biology and socialisation are well known themes in the discourse. Answering these questions would help explain negative beliefs about men caring, if they are seen in the context of the pressures that force the feminisation of care.

#### **The Distinction Between False Beliefs about Sex Roles and Health Work and Values of Caring.**

Before exploring aspects of the history of the feminisation of care, it is an appropriate point to introduce some of the theory that will be explained in more detail in the coming chapters. This is to do with the conceptual difference between false beliefs about sex roles and values of caring. In the British feminist critique of care, determinist and essentialist explanations of women's subordinate caring role smothered alternative explanations of women choosing to care. Writers (eg. Finch and Groves 1983, Ungerson 1985, Graham 1983, 84, 85, Parker 1985) who explored women's caring roles, argued that beliefs about women and caring were social constructs that could be changed. Women could be released from the role. But is that so? Supposing wrong beliefs that structure women's dependency were abandoned as the fight for sexual equality was won? Will women really be free of caring responsibilities? In fact, Heller's theory of feelings suggests that caring values and feelings are a separate social phenomena, operating at the level of

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Most people said it was the perfect job for me. I got a few comments at school. "What do you want to do that for? Girls do that! Wiping shitty bottoms all day long!" It doesn't bother me [being a male nurse]. If it did I wouldn't do it. Occasionally from the young patient, "He's sissy, isn't he?" But it goes in one ear and out the other . . . Most people think I am the orderly or the tea boy. They walk up and down the ward and ignore me. Then they come over and say [he lowers his tones], "Can I speak to the Sister?" And I say, "I am the Sister"! Then they say, "Oh, Alright then". Because most people have got this image of Sister in a white apron and frilly hat. And I've just got a white coat and little bits of blue.

Who should care? People tend to believe that women caring are socially acceptable while men who do the caring become figures of fun whose sexuality is questioned and whose social status is compromised. Such *superstitious beliefs* about gender legitimate continued sexual inequalities in the division of caring labour. Chapter Eight notes statistical evidence showing that men do care but my false beliefs are powerful and prevent me knowing better all the time. My unthinking stereotypes for who cares are prescribed by *superstitions* that women should do the job. These beliefs are products of their time and that both place and conform with rationalising patriarchal forces - forces that invade vulnerable spaces and have the effect of furthering the best interests and capacities of men. It is always a struggle for me to know any better because I am moving against the tide that identifies caring with feeling (surely women's prerogative!) in the language - I feel trapped by the very words available for use - and thereby generates the cultural prescriptions for sex roles in health work. Reason is confounded by superstitions and words that capture inequalities of power in their everyday functioning. Men caring are the reverse of what people expect: what sociologists call reverse sex work roles. The nub of the thesis is to explore

the experience of men caring in the light of female inequalities (Cockburn 1983, 90) (12) in order to demonstrate role reversal and explain its origins.

Why do people care? Groups conceive the reasons that caring matters in similar ways. Women (or nurses for that matter) do not enjoy exclusive moral constructs because of their unique place in our beliefs as society's natural carers. Finch and Mason (1993) find evidence of a shared value system in a large scale survey of family behaviours of caring.

At the level of publicly expressed beliefs, women and men say essentially similar things about the value which they place upon assistance between kin and the circumstances in which it should operate. Therefore any difference cannot be explained by the idea that they hold different beliefs about the family or adhere straightforwardly to different value systems. When it comes to looking at what happens in practice, women in general do seem to be more firmly locked into sets of responsibilities to relatives, and men are more peripheral. However, here, as with all our data, we find considerable variations between individuals and exceptions in both directions (1993: 165)

Values that prescribe caring may be familiar to a nation but the criteria that regulate who does the work are particular to the situation, its history and the mediating influences of race, culture, age and naturally, gender (Graham 1991). Beliefs about caring sex roles contribute to the process of allocating the caring job and affect the subsequent negotiation of responsibilities over time. Yes, women and nurses might have *the reputation for valuing care* and they might believe themselves that it is something only they can understand because they are more skilled at handling feelings (this conventional image of women has been dubbed 'The Compassion Trap' and is discussed further in Chapter Six). However, caring values are not exclusive to women or nursing. Morality is accessible to all and not a secret code for some. The morality of caring is a human potential and not a feminine or professional one.

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Houston quotes Kurt Baier when she argues against the possibility of a distinctive female morality of care :

Morality is not the preserve of an oppressed or privileged class or individual . . . An esoteric code, a set of precepts known only to the initiated and perhaps jealously concealed from outsiders, can at best be a religion, not a morality . . . "Thou shalt not kill, but it is a strict secret" is absurd. "Esoteric morality is a contradiction in terms" (1988 : 179).

Baier (1965) claims that morality should be teachable. Waerness (1984) makes a similar point in her essay, 'The Rationality of Caring'. She argues that the sort of work that women do that is caring shows consistency of judgement that can be passed on from person to person. The shared values that premise caring are not the same as the beliefs prescribing who should do the work. Anyone may interpret the value of caring but there is still an assumption that women carers and nurses will usually carry it out.

In summary, why people care and who does the work are separate issues that the discourses of feminism and nursing have sometimes conflated. Caring is not the moral property of women or nurses; the values of caring are in common ownership. Wrong beliefs about women caring are also commonly held views that reflect and reproduce inequalities of power between the sexes. People, who are looking after others, find themselves affected by both caring values and beliefs as they crystallise and change or fracture over the course of their commitment. The caring language they use rehearses the inequalities of power between the sexes that are also contained in beliefs about sex roles and health work and re-confirmed by the socio-economic dependency of many women's lives and the politics that permit and persist with these inequalities in the structuring of our lives. The violence of this ruling configuration can be

judged by its success at a time when the pressures of social change for caring are greater than ever before.

### **Making Nursing Women's Work.**

All the preceding quotes from men nurses and carers reveal how they recognise that they are flying in the face of beliefs about sex roles for caring:

Charge Nurse Tooley said he was used to them [the female staff] thinking of him as a crane, an engineer or a careerist. He wished they wouldn't turn to him when the machines broke down because he didn't know one end of a plug from the other. He related the time when he'd been down the pub with his dad among all his workmates, and they had been talking about work, but he'd been silent. Afterwards his dad had challenged him about this, but he had replied, 'People wouldn't appreciate what I do - I don't think they'd be interested in knowing I spent the day with my fingers up someone's arse' . . . I've made the mistake of telling them, so I do know. If you're not in the profession they don't appreciate it. (Charge Nurse Tooley : 1988)

Why has the sexual stereotyping of care persisted in history? Care work is modelled to fit the vogue for the 'ideal type of woman' and women conform to the allotted role. Feelings are fundamental to the male dominated construct for the biological female and the culturally feminine. Historically, nursing rehearsed the false belief that care is women's role by confirming sex role stereotyping on a vast scale for all to see and copy, in thought, word and deed. In general, why do men nurses contradict the stereotype of nursing? I suggest three reasons: 1. The nursing role was made in the image of women. 2. The role is confirmed because women do the work. 3. The false belief that women are 'born carers' has had a cumulative history because of nursing. Two historical events give substance to my reasoning about the paradox of men nurses. First, propaganda representing nurses as ideal women helped to

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establish nursing as a new form of labour. Second, the job was made inseparable from cultural representations of ideal women. The belief was publicly enforced by adapting prescriptions for women's domestic role in the home to nursing. It is hardly surprising, in the light of such a history, that men nurses - and by extension, carers - are seen as misfits.

This section is based on previous literature, most notably Gamarnikow (1978) and Reverby (1987); personal accounts; large survey data on men nurses (most over twenty years old); and a review of recent articles from the nursing press. Gamarnikow's (1978) essay about British nursing from 1860 to 1923 reasons that the sexual division of health care work arises from biological determinism that is an ideological version of patriarchy. She makes the point that images of the 'good nurse' and 'good woman' were forged together by suggesting their common moral standards for caring :

To be a good nurse one must be a good woman, here we shall all agree  
. . . What is it like to be like a woman? . . . What makes a good  
woman is the better or higher or holier nature : quietness -  
gentleness - patience - endurance - forbearance . . . (Nightingale  
1881) (Gamarnikow 1978:116)

Despite the misgivings of the ruling classes for ladies from 'good backgrounds' to go to work in hospitals, eventually it was tolerated. Dedicating themselves to nursing proved they were 'good women'. Vivid images of *The Lady with the Lamp* chimed with Victorian feelings for the heroic, romantic and humanitarian (Whittaker and Oleson 1974). Nursing came to be seen as acceptable employment for women. The success of this propaganda was more remarkable given the grim reputation of nursing and the hospitals at the time. Spiritual care by nuns and custodial care by the gin-swilling 'Sarah Gamps' were challenged by very

powerful images of caring women. Victorian ideals of sweet, submissive and selfless women remain the archetypal qualities for nurses today.

Reverby's epic work Ordered to Care (1987) covers American nursing from 1850 to 1945. She argues that nursing was a form of labour shaped round women's duty to care. Norms for nursing were made from ideals about women's role :

The obligation to patients and work created a normative tradition that gave nursing a moral and practical basis for its authority . . . Embedded in the seemingly natural or ordained character of women, it became an important manifestation of women's expression of love for others . . . Nursing as labour could thus be separated from nursing as the manifestation of familial love . . . Nursing could become a trade professed in the market place yet learned within the confines of the family. (Reverby 1987)

Reverby argues that care was not and is not valued by society. Women were used as cheap labour for work that was hard and dirty, in the belief that they were born to the job as 'feeling creatures', and their performance of the work proved the strength of their virtue, rather than the job being made to fit beliefs about women and which capitalised on their powerlessness to control their best interests. Biological determinism that produced false thinking about women as natural carers married with political expediency for more women to be self-supporting (in view of the surplus of unmarried and unproductive females in the population) and a cheap caring workforce wholly of women for a new area of employment was the result.

The tasks in nursing work changed but were always connected with women's roles, such as woman and mother. At first all domestic tasks (including housekeeping, charring and hygiene) were done by nurses as proof of their sense of duty.

Ability and willingness to perform household tasks became the hallmark of good nursing. 'If a nurse declines to do these things for her patient, "because it is not her business", I should say that nursing was not her calling' (Nightingale, 1883, p. 13). (Gamarnikow 1978:118)

Gamarnikow believes the stereotypes finally changed from 'the good woman' to 'mother' and 'housewife' during the two wars.

Nursing is distinctly woman's work . . . Women are peculiarly fitted for the onerous task of patiently and skilfully caring for the patient in faithful obedience to the physician's orders. Ability to care for the helpless is woman's distinctive nature. Nursing is mothering. Grown up folks when sick are all babies. (Hospital, 8 July 1905:237) (Gamarnikow 1978:110)

Housekeepers and cleaners were employed, as nurses became more involved with 'carrying out doctor's orders' and looking after their patients. Gartyl Jaco (1958, 1972) wrote two fascinating essays that identified the role of nurse as mother, based on ideals of motherhood and expected behaviours. Traditional western 'bedside nursing' aims to provide emotional support and bodily comforts by getting close to the sick person. With great foresight, Jaco thought this role would be delegated eventually to female attendants, as nurses became specialised healers doing technical and managerial work.

The new occupation of nursing was a precise representation of beliefs about women's role in Victorian societies. The transformation was permitted because of political and economic expedients: nursing was an opportunity for more women to earn a wage and have somewhere to live, in a way that extolled the cultural prescriptions for women's lowly status and high virtue and was tolerable to public opinion. Caring work was brought out of domesticity where it was free and made into paid employment in the public sphere - a transition that traded adulation of womanhood for low value female labour with

astonishing success. Not only are men nursing seen in the context of a history of images that glorify the female sex as nurses but they are doing low value work too - thus undoing key features of their status as men, as I seek to show in the next section.

It is not unusual in history to find a subservient group, such as the first nurses, adapting to the cultural norms of a paternal society in order to meet an economic need (13). Norms for sex discrimination and inequalities were deeply embedded in the new institutions of nursing. Other groups (such as men nurses) who were thought to threaten the status quo that existed between women nurses and men doctors have been fiercely resisted by discriminatory practices, as I shall show next. This is the paradoxical position of men nurses who traded the 'natural' authority of their sex for third class citizenship in women's world and who were shunned by men and women for making such a transition.

### **Inequalities in the Sexual Division of Caring Labour.**

This section explores patterns of sex discrimination in nursing in the everyday. Prejudice against men nurses repeats nursing's history of sexual inequality. However, men nurses are discriminated against at the bottom of the career ladder whereas women nurses suffer discrimination at the top. Such topsy-turvy inequalities are manifestations of beliefs about women's place in the home and the workplace. Men *should not do* "women's work" and discriminatory practices prevent it happening as a rule. If men duck convention to become nurses, they appear to confound the imputed

characteristics of their sex. The stereotypical British man does not show his feelings, does not deal with the dirty work of caring for other people's bodies, attains status from his pay or profession and is 'his own man'. Subservience, duty to others and emotionality are the imputed qualities of women/nurses. Men who take on women's roles are given the prescribed character of the part as well and lose the status of their sex. Because they are different, they are treated as figures of fun. Because they are unequal, they are treated as sexual and social deviants. When men nurses are put in charge of health work or its machines and stay away from the intimacies of the bedside, the confusion of "mistaken identity" is put right.

Men nurses have a long history, a fact somewhat neglected by the discourses of nursing and feminism. They worked in religious, military or mining communities, as Army nurses and St John Ambulance officers (Wood and Campbell 1989, Brown 1973). Men nurses worked in hospitals in the last century when the caring role was more custodial than tending and in this century, were predominant in the psychiatric hospitals (Carpenter 1980, 85). It was not until 1926 when male midwives were finally outlawed by a special provision passed by Parliament.

Both direct and indirect pressures contrived to keep men out of nursing. The rigid attitudes to gender and work that underpinned the old hospital regimes are vividly described by my aunt who trained as a nurse from 1932-36 in the Midlands. In ten years of hospital nursing she never saw a man nurse: "Any whiff of homosexuality in those days was a scandal". She could only remember three women doctors, "and no one wanted them either". Access for men to nurse

training was deliberately reduced and then limited at recruitment (Brown 1973), supported by social proscriptions against sexual deviancy. Resistance came from two powerful groups : doctors and matrons feared losing their power to men nurses and argued against their recruitment on the grounds of discipline problems among a mixed sex nursing workforce living and working in close proximity. My aunt recalls the strength of feeling about sexual mores :

We were so cut off from society, it was like a nunnery. When one of our set got pregnant, she was ostracised by the others. We used to think the vicar was preaching at her directly. We were dreadful really. You weren't expected to get familiar with the patients or staff. Sheila Homes fell in love with Dr Gainsborough and Matron gave her a sound wiggling. Reduced her to tears. Said she wasn't having any of this sort of carry on in her Hospital. Yet one of the theatre sisters was on the morphia and everyone knew . . . She looked odd, you know . . . pin prick pupils . . .

The first nursing register in 1919 was women only. Only female nurses were granted officer rank during the Second World War. After the war, the Ministry of Health reviewed nursing recruitment and proposed that all formal sex discrimination was done away with. The first male matron was appointed in 1947. The Nurses Act (1949) established a joint register. Yet the Royal College did not admit men nurses until 1960. Men were barred from health visiting until 1961 and it was not until 1966, when men were sanctioned to nurse sick children and work on women's wards, that the London nursing schools accepted men for training. The Society of Male Nurses finally amalgamated with the Royal College in 1968. The Sex Discrimination Act (1975) removed the legal barrier to men becoming midwives but training and places of employment for men were restricted to special centres because of strong resistance from large parts of the medical and nursing establishments.



Brown (1973) surveyed 16% of the total men student nurse intake for 1968. He found recruitment procedures were discriminatory. Places were limited by the number of male beds in residence. Officers discriminated by setting higher standards for men, refusing them outright, only recruiting them as pupil nurses, and discriminating against men on the grounds of race, married status, and size (big men to deal with violence were preferred). In the 1990s, the number of men student nurses recruited is still small compared to the women students and this imbalance is neatly reflected in student nursing recruitment for Carrtown DHA where I carried out the fieldwork (14) (see Appendix One).

Of course other factors are involved apart from direct discrimination. Access for men into nursing was restricted by social prescriptions for sex roles at work. The Ministry of Health poll (1968) found that public perceptions of nursing were primarily in terms of hard work, long hours, chores and low pay. A quarter of respondents thought nursing was the best career for women. Men and the over 35s thought that nursing was an unpleasant job and hospitals offered unpleasant working conditions (Brown 1973).

Low pay alone did not stop men coming into nursing. Buchan (1989) considered the history of recruitment of men into nursing and argued that men did not become nurses, even in times of high unemployment, *unless they had previous experience of the work* in the war. Rosen and Jones (1972) retrospective study of men's motives to nurse (a sample of 157 nurses : 88 men and 69 women, in Wessex region) confirms Buchan's argument. Only 1% of men and 2% of women saw any financial incentive to come into nursing. More men than women thought job security was important (17% of men and 10% of women. Significantly, 33%

of the men thought of nursing while serving in the forces. One male nurse's account may be typical of many:

A man nursing in the army is doing a man's job. Nobody thinks it strange. I came out of the army with no skills but nursing skills, but it took some time before I could bring myself to start a training course with 40-odd young girls. But I couldn't get a job when I came out of the army. I was unemployed so I began making enquiries for nursing. Rosen and Jones, New Society, 09.03.72)

Previous contact with nursing through work or relatives gives men a chance to see through the social proscriptions for sex roles in health work. 39% of Brown's (1963) sample intake of men student nurses dropped out of training, giving reasons of long hours, overwork, menial duties and low pay (15) and it may be that recruitment officers deliberately select men students with previous knowledge of caring to avoid the cost of drop outs. All my interviewees knew about caring from experience and that knowledge dispelled the taboos. My aunt was also convinced that conventions about men not doing dirty work and earning a decent wage (ie. more than women) stopped them nursing.

The men wouldn't want to do the work - it was so very hard, badly paid and dirty. I got £18 a year rising to about £25 in the fourth year. We had two weeks off a year - my first fortnight was in November. We worked shifts. The maid used to come and slam your door at 7.30 every morning. You wouldn't think people could sleep through that racket but they did. They were so tired. Breakfast was at 8. Then we went on duty and came off at 9. We got 2 hours off one day and 3 hours the next. We weren't allowed to take bloods. Enemas, that was the thing. Lots of enemas.

Men nurses talk about active discrimination from women nurses, doctors, patients, and relatives and reveal the extent of what is called "role strain" (ie. the person in the role is a contradiction in terms for everyone else around them and suffers their reactions). Most of the articles below are from nursing journals and make plain the inferences of discrimination that

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peppered conversation in the fieldwork interviews. For example, why are men nurses sexed? unless it is to show they deviate from the norm? Are dentists sexed? ie "Ask the male dentist over there" (Thomas 1989, Jones 1990). A survey of role strain issues among men student nurses described imputed homosexuality, overt pressure from family and friends, resistance from patients, rejection by female colleagues and intimidation in all-women areas of midwifery and gynaecology (Wood and Campbell (1989). Most of 50 women survey respondents receiving maternity care did not want specific procedures carried out by a man student nurse and would not choose to ask him for advice (Cooper 1987). A disproportionate number of disciplinary cases are made against men nurses by women colleagues in the States - six times more than the ratio of men to women nurses would predict (Lewis and Snodgrass et al 1990). Harding (1988), Thompson (1989), and Uscroft (1990) say tasks, patients and clinical areas are routinely allocated by stereotyped sex roles for care-giving that prevents them receiving a full and proper training. Jones (1990) jokes that people automatically think he's the porter or doctor not the nurse in charge, and is treated as the ward's stooge. He ends with an ironic plea for men to assert their authority to overcome discrimination:

I am 6'3", 15½ stone, and currently sporting a skinhead. So what do we have to do to assert ourselves in this ward bastion of black tights and Kirby grips? My only advice to my fellow men is to 'tighten your trouser belts and assert yourselves'. (Jones, (1990) Nursing - Journal of Clinical Practice, 4 (19) 27 September 7

Egeland and Brown's (1988) American study found no evidence of severe role strain among men nurses. They concluded that men can and do nurse in spite of the general conviction they can't and don't. They suggested four artefactual reasons for their success. 1. Low pay keeps unsuitable candidates out 2. Men nurses self-select because of their background (16). 3. Men

nurses are androgynous and don't experience role strain. 4. Men nurses escape to jobs in nursing compatible with their sex. Dassen et al (1990) examined gender ratios in Dutch ITUs and concluded that men make nursing careers out of professionalising and technological jobs - ways that re-inforce masculinity. This is a very plausible theory to explain the sudden reverse in fortunes between the sexes in establishing their nursing careers and why men suddenly start to succeed and women lose out. In the career of the man nurse, the images he presents as a caring man are re-moulded to conform with stereotypical ideas about men's roles.

In the middle of nursing's promotion ladder, men and women swop places. Women lose the natural advantage they had on the way into the trade. Hardie (1987a) cites Dingwall's (1972) figures. Between 1964-69, the number of men in posts above charge nurse trebled and by 1972 quadrupled. In 1987, men were 9% of the total nursing workforce but held 50% of the top jobs. 60% of the charge nurses and 70% of Directors of Nurse Education in the West Midlands were men (Gaze 1987). Jones (1981) calculates the number of men nurses rises in inverse proportion to rank ie. 30% are nursing officers, 48% District Nursing Officers, and 50% Directors of Nurse Education. The same sort of disproportionate ratio of men to women in top nursing jobs is neatly represented in Carrtown District (see Appendix Two).

It may be that a significant historical reason for the unequal promotion of men nurses over women has been overlooked. In 1950, men formed 17% of the total nursing workforce and 66% of them were RMPOS or psychiatric nurses (Brown 1973). Men psychiatric nurses qualified as general nurses on a

shortened course. It was unusual for women SRNs to take the equivalent course for psychiatry. It was illegal for men to nurse women psychiatric patients until 1959. However, in the early 1960s, the traditional single sex hierarchies headed by the matron and chief nurse were collapsed and there was one managerial post appointed by the Hospital Committee. More men were appointed because there were proportionately more men applicants (there might well have been discrimination by local Committees against the matrons). Men PNOs learned management and budgeting skills in order to oversee the large psychiatric establishments. Their appointments may mark the start of the disproportionate rise in the number of senior men in the whole of nursing (17). In 1974, the Mental Illness, Mental Handicap and General Hospital Committees amalgamated so that the preferences, experiences and expectations of members appointing senior nurse managers were shared. After Salmon, many senior nurse posts in acute areas went to men with previous experience managing psychiatric hospitals. Three explanations are possible and none are mutually exclusive. 1. The local Committee did discriminate against the local 'matriarchy'. 2. There were more men applicants than women. 3. The men had comparatively better paper qualifications for managing staff and/or the new medical technical specialities than women (18).

This is not to excuse the forms of discrimination against women nurses, which are recognised (19). Hospital employers had low expectations of female ability to command top jobs and/or high expectations of women having duties in the home that would compete with the work. Indeed, Hardie (1987) found women nurses went 'sideways' rather than upwards, collecting certificates, along the exclusive female paths of midwifery, district nursing or health

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visiting, and typically shared their vocation to nurse with a preference to get married, start a family and leave. Talking about life in nursing before the Second World War, my aunt said she thought she was "safe" nursing [financially secure] because she never expected to marry until she did:

The Sisters were jealous of each other and the nurses. I never knew one of them get married. They didn't have time. They were very bossy. There was Sister Mary O'Ryan, an Irish woman, who had been there for years. She attracted all the doctors with her coffee. She put eggs in the coffee - shells and all. The House Officers did a skit one year about the Naughty Sisters and the Haughty Nurses.

Fifty years later, the top women nurses are still single or childless (Hardy 1987). What is more, their success comes later in their careers than their mostly married male counterparts. Work practices discriminate against women nurses if they break their career to have children, admit commitments other than work, are not constantly available in crisis at the other end of a bleep, or are not free to progress their career by moving. Robinson (1991) notes "the paradoxical sense of security" with which potential women applicants for top jobs and justify their failure to compete and win against men as part and parcel of the continuing state of women's oppression that makes ambition futile. She says there have been few cases in employment tribunals that could help challenge discrimination in top nursing management. Where men nurses succeeded in taking the top jobs, perhaps it was because competing women candidates applied later in their careers, were misplaced in terms of skills and experience and were limited in their aspirations to succeed by other commitments.

In order to stop sex discrimination in nursing, employment and work practices should be subject to quality review and there should be a national drive to

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involve staff in teaching and practising codes for equality at work. Equal opportunities policies should enforce fair working practice and positively encourage nurses to change their behaviour towards sex roles in health work (Hunt 1991, Gaze, 1987, Andrews 1988). Positive action should stop sex role stereotyping in nursing careers that devalues men carers at the bottom of the heap and women managers at the top (Morrow 1990, Thompson 1989, Egeland and Brown 1988, Andrews 1988 and Wilcox 1987).

However, I do not believe it is possible to solve inequalities of opportunity among men and women nurses today, without acknowledging the deceit of the ideology that has contributed to the tensions in power relations between the sexes over time and which is discussed next (20).

### **The Deceit of Nature/Nurture.**

Quotes from the fieldwork show that the men nurses and carers I met recognise women are assigned the caring role by society. Some of the carers said caring comes naturally to women. Nevertheless they all believe they can perform the role too. Deliberately, they include work that they know is socially proscribed for men - dirty work, commitment and showing emotion - to make their case authoritative. Their behaviour is at odds with the social code for men's work that they have followed or at least recognised, in the course of their lives.

When the babies were little, we used nappies in those days not disposable things. Connie would give me the bucket with the soiled nappy. "Go and wash it in the toilet". I used to go green. Or if they needed changing, "You do it for me". I'd have run a mile over broken glass. So when Connie came back here, I heard her get out of bed and I went upstairs to see what was wrong. She told me she'd got to go to the toilet and would I please help her. I helped her

into the toilet and I had to pull her panties down. She was plastered with diarrhoea. Very often I look back onto that first time with a certain amount of pride I suppose. I hadn't been able to look after my own children as babies. But it didn't even enter my head. I had to clean her up properly. It was the first time I'd ever done such a thing. I didn't bat an eyelid. (Mr Bibby : 1991)

I suppose I'm a chauvinist . . . a woman's place is in the home. I've never been any good at housework; it's not a man's sphere . . . but caring comes from inside of you. You are one. (Mr White : 1988).

I was the only man in the group (of student nurses) . . . They couldn't understand my reasoning for wanting to nurse . . . Men can't be seen to be emotional, can't be seen to be caring. Once they got to know me as a person and how I felt about things, it changed.

That was the first time I'd done that, tell a relative they've just died like that, in sudden circumstances. I felt terrible . . . awful, very upset. Her husband said it was for the best. I sat in the office with him and cried my eyes out - we cried together. I suppose some would say it's unprofessional that you show your emotions like that but I think it shows you care too. (Student Nurse Evans : 1990).

Why do people believe that caring is women's work? Explaining the reasons that produce this false thinking will also help to explain the negative assertions about the sexuality of men caring and their ability to cope. Recent reviews in feminist thinking have helped me to identify the problem. The feminist debate has moved in stages from radical feminism to separatism and the celebration of the feminine. Both viewpoints hurry over the biological fact of femaleness to discuss the social construction of gender roles. Oakley's classic definition of sex and gender suggests why :

Sex is a word that refers to the biological differences between male and female; the visible difference in genitalia, the related difference in procreative function. Gender however is a matter of culture; it refers to the social classification into masculine and feminine . . . the constancy of sex must be admitted, but so also must the variability of gender (1972 : 16).

In simple terms, the body has been left out because historically, it was the vehicle for women's subordination by men. We have all heard the one about

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women being less intelligent than men, because they have smaller brain size; or that menstruation interferes with women's productive capacities; or that women's facility for childbirth makes them unreliable employees in the long run because their careers are broken up by maternity leave and arrangements to look after the children, and so on and so on through history. There seemed to be no escaping the physical fact of femaleness. Talking about bodies raises the spectre of immutable sexual differences. The imagery of motherhood is biologically constructed and the image extended, eg. women are caring by nature because they are genetically programmed to give birth and suckle their young and take care of them. Women's subordination stems from biological determinism that constructs apparent inequalities in physical ability as part of the evolutionary order rather than wrong thinking.

Tuana (1990) develops a similar theme and offers a solution (21). She says the nature/nurture dichotomy is part and parcel of the cluster of metaphysical dualisms like male/female and sex/gender that populate sociological thinking. Biological imagery dominates the way people see the world. Biology swallows up the foundations of other knowledge (especially sociology) if perceived human variation - race, sex, age, whatever - is falsely imagined as innate, fixed and separate. There are many examples of wrong thinking developed from the pernicious representation of the world by biological names, including apartheid, female castration, Social Darwinism and ageism.

Names like sex and gender are not opposing concrete certainties but metaphysical abstractions. Problems arise because these categories are treated as if they are absolutes that are true rather than approximates about which we

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know very little. There are two rationalisations used to justify caring as women's work. Both offer a variation on the theme of biological determinism. In the first case, caring is natural. Caring is perceived as an essential trait of the female sex. Women have a hereditary disposition for the caring role spelled out by significant sex traits that may be physiological or psychological. The trait is taken to be inborn and immutable and marks the identity of the person. Natural properties like caring in women are as right as apple pie and snow in winter. They spell out goodness. To go against the grain looks like deviance or immorality. Under this logic, men cannot care because they do not have the biological equipment. By implication men who do caring work are sexually deviant.

In the second case, caring is a matter of nurture. Sex differences are not as great as the differences made by the environment that determines learned roles so the species survives. Women are moulded to fit the caring role and take care of other people's bodies from birth to death. Women perform the intimate and dirty work of cleaning the body. Men do not care because they are wrong for the job and have not got the knowledge, skills and behaviours instilled in childhood necessary to protect the species. Men caring is socially taboo and men who challenge these conventions are socially deviant.

Tuana challenges the conceptual straitjacket of biological determinism that locks us up in language that replicates the inequalities it describes. "The point is that such categories stem from an inadequate metaphysical viewpoint" (Tuana 1990: 84). She points out that biologists have devised sophisticated techniques for modelling patterns of interaction between entities that requires

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new language to represent concepts of process and change. So why preserve an outmoded language that science rejected long ago? The entities described by sex and gender are not carved in genetic stone. They are interactive and dynamic processes that weave the forces of biology and culture together over time. Names like sex and gender signify recognisable but complex patterns of change and really, they are nothing more than rough and ready markers that permit the convenient naming of human differences.

Gatens (1992) pursues a different tack, arguing that biology does not precede history as the theory of evolution would have us believe. Rather, biology is increasingly bound up with history. Modern technologies offer the prospect of socially appropriate bodies. Bodies are not outside history. Biological differences, be they race, age, disease and disability and sex are all culturally constructed. Tongue in cheek, Gatens points out that the body politic is there to enhance and intensify the power of male bodies. This has been achieved because the male dominant realm of mind is dominated by male oriented thinking about political economics relations. Bodies - the assumed province of women - have been subjugated to minds.

To insist on sexual difference as the fundamental and eternally immutable difference would be to take for granted the intricate and pervasive ways in which patriarchal culture has made that difference its insignia (Gatens, 1992; 135)

Men who care for others put themselves voluntarily in women's world where bodies and feelings are dominant. These men are strangers in another space. They can challenge the power of their sex by being equal but different. As well, they face challenge themselves for being different and therefore being judged unequal by both sexes, under this metaphysical regime of absolutes.

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My conclusions are twofold. First, I have already argued the language of care is the mirror of its culture, not a rock through the ages. We are both masters of and slaves to the words that echo our beliefs. Caring is defined in terms of feelings because caring is wrongly conceived as a female role. Second, caring for other people's bodies is women's work, because it is wrongly believed they are more feeling by nature or upbringing. The male dominated realm of mind controls the space where such beliefs are constructed and the language is made and effectively locks out women, bodies, feelings and caring from its precincts.

Women cannot escape from their storybook identities as carers until the fiction of sexual difference is transposed. This will not happen unless the deceit of the conceptual absolutism of nature/nurture is exposed and challenged, that restricts women to stereotypical caring roles and degrades men nurses and carers as sexual and social misfits. What is required is a different theoretical mode: a way of conceiving the world that will stitch the natural, social and cultural worlds back together again and that will celebrate human differences, rather than trample on people by denying other ways of being and accepting conceptual schemes of absolutes without question. Most important is the political will to use our whole awareness to make more sense of everyday life and challenge deceits like nature/nurture in "the name of equality that rests on differences" (after Scott (1990: 138) quoted by Barrett & Phillips, 1992).

### **Concluding Remarks**

This chapter seeks evidence from a historical perspective for the feminisation of care which re-inforces the paradox of men caring today. Men caring look like they are in the wrong job for a number of reasons, to do with biological, cultural and structural inequalities of power that are inherent in the feminisation of care.

The first part of the chapter discovers polarised meanings of feelings and work in care and the unequal emphasis on care as feeling. This affective meaning is linked with the feminisation of care and the identification of caring with women and women with the world of emotions. Thinking of care as feeling that is non-productive and weak re-inforces the process of feminisation. For all the professionalising attempts of nursing to build a knowledge of care, it remains a poverty-stricken concept for the twentieth century. The very words of care are identified with female sex roles and have paradoxical effect when used to describe men caring.

Second I argued that the feminisation of care is linked to the growth of female sex roles in health work and the promotion of nursing for women as a role that suited women's virtue and sentiments. Nursing was made inseparable from female qualities and status. The image of nursing represented wrong thinking about sex work roles for all to see and copy ie. nursing is best done by women with feelings fundamental to their sex. Furthermore, the low status dirty work of nursing is built on the cultural history of subservient womanhood coping with the hidden work of the house. The economy of caring is dependent upon low value labour of a female class powerless except through

collusion with the prevailing politics that trades low wages for invisible work with high virtue womanhood. Men nursing are cast in a role with paradoxical attributes considering the masculine context: subservient, dutiful and emotional. Their authority and status is devalued by the role's low status dirty work and there is no saving grace because of the virtue of their sex. The establishment of nursing as work for women served to endorse care in the language as feeling. Today, its professional rhetoric strengthens the metaphorical extension of care as compassionate feeling - an image which may trouble some women whose caring values are confuted by guilt for failing to live up to prescribed sex roles to care.

Third, I argued that sex discrimination in nursing against men and women today repeats the recipe for sexual inequality that inscribes the history of nursing. Men nursing are both the victims and the victors of systematic inequalities that work to keep them out of the wrong job, and if they get in, eventually kicks them out or puts them in positions of authority and/or technical superiority fitting for their sex. The inequalities of nursing sex roles mirror the biological, cultural and structural inequalities between the sexes that spawned them and which grow through them.

Finally, I argued that we assume women are natural carers and men are not because of conceptual frameworks that prescribe our false thinking. The conceptual absolutism of biology makes us confuse work roles with fixed sexual characteristics. The replication in the language of caring as feeling only confirms the biological absolute and emphasises the paradoxical position of men caring. Attacking the deceit of a homogenous womanhood, caring because of

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false beliefs underwritten by their sex and their words, reveals some of the reasons for the paradox of men who do the caring.

Until we replace our divisive structures for thinking with a reasoning process that confirms and constructs equality in the spheres of nature, culture and society, there will be phenomena such as 'reverse sex roles'. The economic guts of current politics, based on least effort by the state and most effort by the family to do the caring work or pay for it, is heavily dependent on maintaining the inequalities of sex roles and health work in future.

#### Footnotes

(1) The term 'feminisation' is borrowed from Cancian's article, 'The Feminisation of Love' (1986) who cites The Feminisation of Culture (Douglas 1977) as her source. Cancian suggests that:

A feminised and incomplete perspective on love predominates in the United States. We identify love with emotional expression and talking about feelings, aspects of love that women prefer and in which women tend to be more skilled than men. At the same time we often ignore the instrumental and physical aspects of love that men prefer, such as help, sharing activities and sex. This feminised perspective leads us to believe that women are much more capable of love than men and that the way to make relationships more loving is for men to become more like women (1986: 692)

(2) Parker, r. (1981) is one of the first to note the dual meaning of care - it is concern about people, as well as work for them that he names tending. Graham (1985) describes caring as a paradoxical labour of love. Kitson (1985) believes feelings of commitment and respect together with labour are key elements in the caring relationship. Dunlop (1986) remarks on the construction of the negative of care, meaning to be indifferent. She thinks the sense of caring as feeling could have emerged as the negation of the negative. Bytheway (1986) questions the 'fixed planets' of carer, cared for and State, and argues that all orbit each other.

(3) See FPCS Briefing Paper (1984) and Parker G. (1985) for examples of how the loose terminology of care fits the context regardless of how the policy that employs it. Abrams (1977) suggests four types of community care that are ideologically opposed. See also Ungerson (1990) and Qureshi (1990).

(4) Harre's work on the social construction of emotion helped me to develop my thinking about the relationship of language to structure and culture. He argues the display and expression of emotion confirms the moral order that prompts it. According to Harre, an emotion word can be acted out in behavioural display and it must be prescriptive or proscriptive. Caring about someone is an emotion word because it qualifies under all three categories. Caring about someone is not a necessary or sufficient condition for caring for someone. *Yet caring for someone surely signifies the moral view of the community that gives grace to the act in a way that caring about someone does not guarantee.*

(5) Harre says it is worth studying emotion vocabularies because it sensitises the researcher to their own ethnocentric presuppositions about emotion. It shows how other cultural groups face similar encounters, with terms that seem familiar but engage expectations based on the moral stance of the community that is wholly different.

(6) Smith suggests women's consciousness is split between thinking concretely and thinking abstractly. Thinking abstract thoughts is a function of male-dominated 'ruling organisations' whereas women have to think concretely to deal with domestic situations. Yet women are conversant with the ideology that provides them with the standard language to think and image the other male-dominated public space whereas men are not usually conversant with the language of caring.

(7) Stacey's early paper, 'The Myth of Community Studies', argues that community is a non-concept "because it embraces a motley assortment of concepts and qualitatively different phenomena" (1969: 136)

(8) I scanned the Nursing Mirror and Nursing Times from the beginning, middle and end of the 1980s as well as the Nursing Abstracts.

(9) For example

This book is about families and the kind of care they are able to provide for the people who live in them. In most families care is provided by the woman of the house. A primary concern of the book is therefore with the work that women do for family health. Graham, H. (1984) Women Health and Family. Wheatsheaf Books.

(10) For example

Caring is the foundational ontological substance of nursing and underpins nursing's epistemology. Watson, J. (1990). Caring, Advances in Nursing Science. Vol 13 No 1, Sept. Aspen Pubs Inc, Maryland, USA.

(11) I know many men who do caring work: they learn to do housework and housekeeping, look after the children and care for sick, elderly and vulnerable relatives and friends.

(12) Cockburn's work (1983, 90) on reverse sex roles encouraged me when I was thinking about this chapter. She criticises feminists for using the conceptual structures of their own oppression to reason with. Instead, Cockburn seeks to move outside that static framework by exploring everyday relationships when women do men's



jobs. She looks at the processes of women's oppression, linking what people believe, with their personal situation in terms of physical and political economic powers. She quotes Thompson (1963) writing that the working class did not rise like the sun at an appointed time but was present at its own making, in order to make the point that sex work roles are not the spontaneous creation of sociologists, but signify a political history of collusion by the sexes for an ideologically sound passport to work.

(13) I was thinking of the work by Eugene Genovese (1968) on the juxtapositions of power among different classes in American slave society. Every political underdog has another tail to kick. This tendency results in paradoxical alignments of power that run contrary to theory.

(14) The Recruitment Officer for Carrtown School of Nursing felt bound to interpret the unequal ratio of the sexes when she gave me the figures : "Well I asked my small nephew about nurse training [as a career] and he looked at me *as if I was a piece of cheese* . ."

(15) Brown found that the drop outs were also characterised by apparent academic failure and reported misconduct.

(16) Men and women student nurses have different backgrounds. Men do not enjoy the same advantages as their female colleagues. Survey findings consistently showed men nurses to be educationally and socially disadvantaged compared to women. Rosen and Jones (1972) found two in three men were married as opposed to one in three women; 75% of the men went to secondary modern compared to 39% of women; 56% of men came from working class backgrounds whereas 33% of women claimed professional backgrounds; 66% of the men left school early whereas the same proportion of women stayed on; half the men had previous jobs whereas most of the women came straight from school. Similarly, Brown (1973) discovered the majority of the 1968 men student nurse intake were over 21; 35% left school at 15 years old; 50% had no qualifications; 66% failed General Nursing Council requirements; most were working class and most did semi-skilled jobs before nursing.

(17) The career paths of men nurses re-instate their masculinity and simultaneously weaken the prospects of their female counterparts.

The appropriation of muscle, capability, tools and machinery by men is an important source of women's subordination, indeed it is part of the process by which females are constituted as women (Cockburn 1990; 88)

(18) This work is based on the personal account of K who is a Chief Nursing Advisor in the civil service. K left school at 16 years old. He applied for a job at the local psychiatric hospital when he heard they played football three times a week in the grounds. It was very easy to get work there. He trained as an RMPA. He said RMPAs were treated as second class citizens by general nurses and men RMPAs were a class below that. He worked his way up to Chief Nursing Officer in less than ten years. After that he got stuck. The next rung on the ladder was District Nursing Officer which appointments were controlled by women Regional Nursing Officers. He wondered whether perhaps some women were settling old

scores against men appointed during the Salmon-inspired reaction against management by matrons.

(19) For example, the work by Hardie (1987) and Gaze (1987). Robinson (1990, 1991) makes the most significant contribution in her panoramic studies of the reasons for the marginalisation of nursing care: gendered work and its economics.

. . . Waged nurses have to broaden their perspective in order to understand the structures and beliefs that oppress all women, albeit with different costs and benefits to certain individuals. The idea to be developed here is the notion that nursing is an essentially marginal activity. Marginal, that is, both to the major policy concerns of the public domain of waged labour and also of the domestic domain of non-waged work. The search begins with sources associated with, but surprisingly rarely directed to waged nursing, feminist theory and health economics . . . (Robinson 1991)

(20) This sounds unduly pessimistic. But I do believe that once individuals become aware of the forces ranging against them, half the battle is won . . . hence the need for education at all costs.

The future is formed out of . . . the illogicalities, inconsistencies, and circularities in individual lives and the sense individuals make of them. Human beings have a great need to be rational and consequential. They do not always succeed. But it is in the struggle to make satisfying meanings of things and to bring behaviour into line with beliefs that change in the individual occurs, if it occurs at all. And change in many individuals adds up to change in trade unions, political parties, and society (Cockburn 1983: 216)

(21) Elias explores the same ideas of hegemonic concepts that stop us seeing the world as process

What are in fact different but wholly inseparable aspects of human beings are thus treated - if they become objects of scientific research - as if they existed in isolation from each other . . . While human sciences with a monistic bent tend to over-emphasise the similarities and to ignore the differences between human and non-human beings, those with a dualistic perspective continue . . . an age old tradition which suggests an absolute divide between nature and non nature straddled by human beings. Both tendencies suffer from an inability to understand the nature of processes. They are still trapped by a powerful conceptual heritage which forces people to represent in static terms sets of events that can be recognised and understood only if they are perceived as parts or aspects of processes, as events in a condition of continuous structured flux . . . Elias, N. (1987). Human Beings and their Emotions. Theory, Culture and Society. Vol 4, 339-61.

## CARING IN THEORY

This chapter examines the perspectives in social theory that have shaped ideas about caring and seeks to explain why these viewpoints give substance to the paradox of men caring. In a review of the British feminist literature on caring, I try to show why the separatist strategy was so successful and how ideas of caring were developed and extended in terms of women's work and feelings. The review points to two problems facing current theorising on caring. First, the dominant feminist view focused on the world of women caring to the exclusion of other groups involved in caring, producing deliberately skewed views on care. Second, researching the complexities of human feeling is a new and problematic area of social research, that is not well served by the sociological divide between theories of human agency and structure to explain human relating (Finch 1993). In the two subsequent sections, I discuss how the discourses of feminism and sociology may have helped to re-inforce the feminisation of caring and what could be done to improve matters.

## Feminist Theories of Care

This review will focus particularly on the British feminists' critique of women and social policy when it was

. . . framed by a particular view of caring. Caring was defined in terms of the unpaid domestic and personal services provided through the social relations of marriage and kinship to those who, for reasons of illness or impairment, found it hard to meet their own care needs. It was a definition that focused attention on gender and on the material and ideological processes which confirmed women as carers (Graham 1994: 461)

The literature spanned nearly twenty years, from about the mid seventies to the mid nineties. The origins of the debate can be traced back to the seventies, when legislation was passed concerning equal opportunities (1970) and sex discrimination (1975) that was intended to give women equal rights in the world of work. However, many academics were arguing that female inequality began in the home with unpaid caring labour. Land (1977) attacked social policy on families because it was loaded with normative expectations about women's role. Finch and Groves (1979) discussed the position of women who were not eligible for Invalid Care Allowance because of their relationship to the cared for and the implicit assumption in that ruling that women should labour for love.

After the success of the article, Finch and Groves at Lancaster University organised a small conference in 1980. In part, their thinking was galvanised by Dulcie Grove's recent experiences of dual roles of caring for her mother and working at her career and how she coped with that situation. The conference papers were edited to produce a book, The Labour of Love (1983), that explore the tensions for women in caring roles. The book includes writers from social policy and sociology backgrounds who discuss different aspects of women's

experience of caring including their feelings, the nature of care work and the cost of caring. It serves to locate the debate in sociology, in terms of a woman-centred woman-led research and to demonstrate the benefit of gathering different methodological approaches to explore the same subject.

The literature on women's caring role was received by an audience who were familiar with the radical messages from women's conferences and campaigns against unpaid domestic labour. Many discussions reflected the convictions of 'feminist separatists', who held that men and women live in separate realities built of different experiences and understandings of the world and that women's reality is dominated by man's knowledge and power. This feminism aimed to celebrate the female sex and to give women a more effective political voice, for example by increasing research and publications about their lives and by raising the academic profile of women's studies. The collective efforts of British feminists to explore women's caring role in the family have been successful according to these aims. Below, I have tried to suggest some of the characteristics of their work and the reasons for their success, to do with who they were, why they got involved, the work they contributed and the implications and consequences of their efforts.

First, the discussion was inspired and led by a small group of women feminist academics who shared the same perspective on caring, although their areas of expertise and academic interests were different. Many of the women involved are now professors and heads of department in their respective fields of health and social policy and sociology. Their academic accomplishments have been recognised although some may argue their viewpoints are still

marginalised. Of course, there are many people who have contributed to this debate and whose work is not discussed here - eg. Dalley 1988, Glendinning 1983, Lewis & Meredith 1988, Nissel & Bonnerjea 1982, Roy Parker 1980, 81, Qureshi & Walker 1989, Qureshi 1986, 87, to name a few. Instead I review the research careers of four women who were involved in this debate from the start, who have researched different aspects of caring and have shared similar successes in their careers.

Second, people shared feminist convictions about the research agenda. They focused on women's experiences of caring - hitherto unexplored and neglected territory - and the impact of state policy on women's lives. Previous debates on social reproduction - the idea of unpaid domestic housework for producing and maintaining people - were 'unhappily married' to existing theories of paid work and its value in the workplace. Many wished to escape the existing frameworks of thinking (eg. Stacey 1981, Hartmann 1981) because they excluded women and their love and labour in caring for others. Some researchers began to explore other aspects of women's role - caring for the sick, the frail and those with physical and learning disabilities. They added a new dimension that was hidden by the old debates about domestic work (Graham 1994). In the context of the new politics of shrinking welfare and the increasing numbers of vulnerable elderly because of what was dubbed 'the demographic time bomb', many writers feared that community care policies held the hidden assumption that women would provide informal care where the state left off and they sought to explain the social context of caring and to expose beliefs about women's sex roles and caring and their consequences (eg. Policy Studies Institute 1986, Parker 1985, Ungerson 1990).

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Third, the feminist debate addressed the problems of theorising and researching care, particularly how feelings and values inform the caring role. Fragments of theory were discussed but there was no coherent framework for thinking and researching how feelings, relationships, values, ideologies and structural forces mesh together to shape women's caring roles until Finch began to address the problems (Land & Rose 1985, Ungerson 1985, 87, Graham 1983, 94, Finch 1986, 1989, 1993). Different approaches to researching caring were tried, that sought to legitimate the experiences and feelings of carers. For example, women's private world of tending sick and frail people, the cleaning and the mess, was a new site for research (eg. James 1989, Hart 1987). New survey tools and interviewing techniques were refined in order to explore people's caring relationships, their thoughts and feelings (eg. Finch 1987, 93, James 1989, 94).

Fourth, this literature marks a departure in feminist studies in terms of increased research and debate about issues close to many women's hearts and about which there was little substantive research. Finally, the effect of this rising tide of feminist research on caring issues has been to help to legitimate proposals to insert new curricula and sometimes new departments in university education through which many more people have come to learn, discuss and respond to the caring debate. For all these reasons, the British feminist critique on caring was successful in its achievements.

The end of the debate is marked by the break up of feminist separatism. Graham (1993, 94) has critically reviewed the limitations of the literature on women caring in the light of contemporary feminist thinking on problems of

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power and difference and the way the old debate structured the omission of other groups involved in informal care. This is not to say that the discourse has not progressed in other ways. The work of four of the participants - Janet Finch, Hilary Graham, Gillian Parker and Clare Ungerson - is reviewed here. While they shared similar views on caring, they could not always agree on alternative policies to resolve the inequalities of the sexual division of informal care and they had separate research agendas, including informal health care, community care policies and kin relationships, which took them in different directions.

Gillian Parker went on to focus research on community care policy and the cost to the carer, helping to build up a large body of research on the experience of informal care. There have been many attempts to develop frameworks for measuring the economy of informal care, from the 'Wages for Housework' campaigns in the seventies to the academic modelling of today. The tools help to demonstrate the dynamic of costs for care between the state and the carer (eg. Nissel and Bonnerjea 1982, Joshi 1987). 'With Due Care and Attention' (1985) reviews the current literature to explore the financial, social, physical and emotional costs of caring at home. Parker concludes that the evidence indicated that all carers pay dearly for their commitment to care and women appear to pay more, not just in lost earnings, but in lost opportunities in life and the toll on their well being. In 'The Myth of the Male Carer' (1992), Parker acknowledges that more men do caring work in the home than was previously recognised and that the caring experience for matched groups of men and women carers may not be so different after all. In this, she echoes the work of Arber and Gilbert who also analysed the statistical data from the



General Household Surveys (1980, 85) on caring relationships (1986, 88, 89) and produced a wealth of information that did not always support previous feminist claims about the circumstances of women carers but did give evidence of the cumulative inequalities over a generation between women's dependency levels and men's (1991).

Clare Ungerson concentrated on sex roles and unpaid caring work and the impact on social policy. Ungerson was interested by the problems also discussed in Stacey's 1981 article, 'Overcoming the Two Adams', that argues there is no adequate framework to help us understand women's world of 'people work' because social theories construct work as paid work in the public sphere. Her early articles, both published in 1985, discuss the hidden dimensions in the work of women carers in terms of the circumstances, skills, feelings and taboos that regulate who does the dirty work. Policy is Personal (1987) is based on interviews with men and women carers in the early eighties that indicates the sexes may have contrasting feelings and views on caring work. Her last book (1990) presents a collection of papers on women, the caring role and social policy trends from the Kent conference of Scandinavian and British feminist thinkers in 1985 and in which, Ungerson pushes the conceptual boundaries of the feminist analysis of caring and the dichotomies of public and private, paid and unpaid caring work. She notes how the language of caring straddles both areas but its dual meanings are associated with one side more than the other: the construct of work in caring is linked with formal care and the construct of feeling with informal care. This conceptual straightjacket locks up our thinking so that ideas of pay for the carer and the health worker looking after the same person appear to devalue both the

moral reputation of the carer and the professional skill of the health worker. Ungerson concludes that what is required is women-centred policies that value women's caring skills and expertise more effectively and that these will only be won if women stake their claims on the political agenda.

Hilary Graham was interested in the problems of conceptualising care and approaches to researching care. Her concern focused on the construction of care from the point of view of those doing the work. In 'Caring: A Labour of Love' (1983), Graham examines early radical thinking about women's roles in an attempt to clarify the tenets of her own thinking on care. She refutes both Marxist feminism and psychoanalytical feminism for their deterministic view of women's inequalities and the objectivist research methods. Instead she suggests that caring defines women's role in men's world and constitutes the fusion of labour and love. In order to discover more about caring, research should seek to explicate the experiences, feelings and skills of the women who carry it out. Her subsequent work researches and legitimates the everyday lives of women looking after their families and suggests ways of modelling the caring role (1984, 85).

Almost a decade later Graham re-casts her previous thinking on care and involves ideas from contemporary feminism, recognising that the theoretical framework of men and women in separatism had the unseen effect of collapsing other divisions of class and race under the heading of gender and keeping contrasting voices - for example, black women, lesbians, care receivers - out of the research results (1991). In 'Social Divisions in Caring' (1994), Graham puts the feminist critique on caring in its historical context, tracing the

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intellectual and political trends that shaped the debate and giving reasons for the successes and omissions in the thinking. Again she argues that this construction of caring effectively silenced other groups - also with parts to play in caring and not included in the scenario of white women caring - by missing out the social divisions and differences among women.

Janet Finch was working in collaboration with Dulcie Groves when the British feminist debate on care got going. Their efforts in writing the paper in 1979, the conference afterwards and the subsequent book (1983) appear to have helped to crystallise people's thinking on care. Finch went on to explore the impact of the politics of community care on women's lives and the impact of feminism on community care policies (1984, 86, 1990). These articles, written before the publication of her research on family responsibilities, make it plain that while she did not share the views of liberal feminism, she recognised its history of advances for womens' equality. She was also sceptical of separatism and its root and branch approach to policy-making by regulating both public and private lives in the name of equality between the sexes. Rather, she suggested the way forward for women carers may be for commentators to put less stress on what the family can do to care for elderly and handicapped kin and more on what can be done within the community to help those who value their independence and require paid help to promote it.

The subsequent research with Jenifer Mason on families as a form of social support opened up new ideas in methodology and social policy as well as the feminist debate on caring. Family Obligations and Social Change (1989) discusses the epistemic perspective of the inquiry in terms of the tensions

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between structure and agency that are collapsed in the caring role. Norms, ideologies and social structures may influence someone's choices about their caring responsibilities but do not make care a compulsory, constant or consistent act. Her theory is more complex and flexible than previous feminist viewpoints that explained the women's caring act in terms of patriarchal, economic or ideological determinates (eg. Gamarnikow 1978, Dalley 1988, Hochschild 1983).

Negotiating Family Responsibilities (1993) reports the results of the large-scale social survey and interviews among families about their caring commitments. The research shows that most people believe that families should pull together in a crisis and help each other and also that the nature and course of family commitments is unpredictable. Structural explanations of sex, class, race or income do not give sufficient reasons for the unpredictability of the commitment to care. Rather it is do with the history of feelings about personal relationships in the family. Responsibilities are created rather than flow automatically from family relations. Finch & Mason argue that the creation of the commitment and its maintenance come from the recognition that withdrawing from the arrangement would damage the moral reputation of the carer in the eyes of others. Finch & Mason's research points to a world where people care if they value their public reputation for the good. In other words, caring actions appear to be regulated more by the value society puts upon them than by personal belief.

As for the feminist explanation that attributes the gendered division of caring responsibilities to structural and cultural determinates that shape women's

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subordinate caring role and generate separate realities for men and women, Finch & Mason report that:

At the level of publicly expressed beliefs; women and men say essentially similar things about the value which they place upon assistance between kin and the circumstances in which it should operate. Therefore any differences in women's and men's involvement with their kin cannot be explained by the idea that they hold different beliefs about the family or adhere straightforwardly to different value systems (193: 165)

They argue that theories of gender relations should be able to accommodate the weight of feelings behind individual decisions to care for family, instead of relying on macro explanations about the structured dependency of women on men to account for women's caring roles.

This review of the British feminist critique of caring has looked at the work of four women contributors on the work and feelings of women caring in the home. The review suggests that the debate borrowed from feminist separatism was successful in meeting its aims: the research was a way of legitimating women's experiences about their caring roles and making their viewpoint heard; the academic discourse was a powerful and effective platform for raising concerns about the impact of state policy on women's lives; and finally, the debate generated a rising tide of research and publications that were introduced into university education and caught the imagination of new students whose work will help to take the critique forward. Arguably, the limitations and tensions that this viewpoint imposed on the debate were compensated by the long-term achievements. The next section seeks to explain the nature of these constraints and why some feminists believed that researching men's caring roles was an unjustifiable exercise - a position that forced me to defend my ideas.

### **In Defence of Men Talking About Caring**

It seemed to people listening to the early working papers for this research that I was going against conventional feminist thinking about women and caring by exploring men's experience. Eventually, I realised this was because the discourse had collapsed biology and culture together. It was thought the sexes lived in severed realities and woman's reality was subsumed by man's knowledge and power. These ideas promoted a strategy that makes the celebration of woman's reality a political necessity. Thinking should be about women rather than for them. Exploring man's deviant copy of woman's world of caring was controversial in a discourse that had fixed care as the province of women.

However, the sexual division of caring labour is re-inforced by a strategy for separate sexual realities as much as it is exploded. Graham (1983) criticises early radical feminist thinking about women's roles and clarifies her own standpoint in the process. Graham argues that Marxist feminists reduce caring work in the home to an economic transaction of goods and services and miss out the women who do the work (eg. Hartmann 1979). On the other hand, the psychosocial arguments reduce caring to learned social behaviour by women and miss out the work women do (eg. Baker Miller 1976, Chodorow 1978). For Graham, both views are deterministic and operate at the macro level. They represent women's caring role as if it were written on tablets of stone. Although the intention is to explicate sex inequalities as the result of patriarchy/capital, it has the perverse result of perpetuating them by suggesting women's subordination is the inescapable result of their sex.

Instead Graham prefers the methodological approach of 'going down among the women' to discover what caring is about from the point of view of those who cope with everyday caring at home, in order to explore domestic sex roles and health work. Many writers have noted the context of application of care among British feminists and the exclusively women-centred approach:

feminist studies have taken the concept of care embedded in welfare policies and explored its implications in terms of gender . . . .  
(Thomas 1993; 64)

Arber and Gilbert (1986, 87, 89) expose and refute the assumptions about men carers implicit in feminist texts on care, using statistical evidence. Bytheway (1985) bluntly calls it the beanz meanz heinz approach: if it's care it must be women. The heart of the problem is epistemological. Caring is discussed by women who say what it feels like when popular belief holds that women are natural carers born to the job or who are moulded into the nurturing role. Caring and women are inextricably linked. Femaleness qualifies women for the epistemic privilege of being the sole arbiters on caring. Instead of one script for two sexes there are two scripts for both sexes. Each role is unintelligible to the other. This is the politics of feminist separatism with a useful strategy for putting women's voices on the political map. Graham says the stereotype of women as carers is a social construct that will pass. Finch & Mason (1993) point out there appears to be no basis in fact for supposing that men and women think differently about their responsibilities to care for kin. Yet the continued exclusive exploration of women as carers has the unwanted consequence of rehearsing the stereotypes.

First of all, it automatically excludes the possibility of reasoning about the inequities of the sexual division of labour because it is a deliberately skewed

view from one side of a particular fence. Second, as Graham (1991, 94) acknowledges, separatism produces other inequalities by dividing the population between white men and white women and ignoring differences of race and class:

Rather than a broad structural analysis of everyday reproduction within families, most feminist research on care has been restricted to one form of care (unpaid care by relatives) and one structural division (gender). The way in which racial and class divisions are embedded in everyday reproductive work has been largely eclipsed (Graham, 1990; 61)

Third, there is a danger that feminists recapitulate the tensions they resist by making the fiction of social constructs about sex roles look like facts (Grimshaw 1986). In gender separatism, the feminine is located in the female body; gendered characteristics arising from the role are collapsed into the sex. For example, Graham (1983) argues that in general, caring relationships are those involving women. Her famous proposal is that caring is both being and doing - love and labour. "Health care is really a term used to describe what mothers do for families" (1984). The thrust of Graham's argument is that caring is the definition of woman's role in a man's world: caring casts the identity of women as well as the work they do. Waerness (1984) argues that we should be listening to the voices of women who do the work in order to devise better models of care-giving (1). The consistency of judgements in caring work is the measure of women's expertise gained by experience. It is a difficult business to expose the fiction of women's role and celebrate the sex without confusing the two.

Fourth, feminists have resorted to crude explanations for the subservient reality of women's caring roles concerning patriarchal and material

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determinates. These theories give more weight to structural explanations than the sovereignty of human will and obscure the possibility that the history of feelings in kin relationships also locks women and men into caring roles (Finch & Mason 1993).

The American debate about gender separatism and caring is just as intense. Gilligan's book, In a Different Voice (1982), describes an ethic of care which is associated with women, as opposed to the ethic of justice associated with men. She uses a similar approach to Graham, using stories of women's experience of moral dilemmas of caring. The book strikes strong chords with women readers who hear their own knowledge of caring relationships echoed and endorsed. Nevertheless, criticisms of female and moral essentialism are refuted by Gilligan:

The title of my book was deliberate; it reads, "in a different voice", not "in a woman's voice". In my introduction, I explain that this voice is identified not by gender but by theme. Noting as an empirical observation the association of this voice with women, I caution the reader that "this association is not absolute, and the contrasts between male and female voices are presented here to highlight a distinction between two modes of thought and to focus a problem of interpretation rather than to represent a generalisation about either sex". In tracing development, I "point to an interplay of these voices with each sex and suggest that their convergence marks times of crises and change" . . . Thus the care perspective in my rendition is neither biologically determined nor unique to women.

Houston (1988) explores the politics of Gilligan's theory and concludes that the real enterprise is that women should have their own say about the nature of caring. Women's voices should not be subsumed by other ways of knowing that claim superiority. Neither should women exclude different stories about care from black people or men when they are claiming the right to talk for themselves for they are merely repeating the politics of inequality. After all

the post-structuralist argument is that no one is the same. The way we construct care in the language is on a time continuum just like our biological selves. To deconstruct the everyday language that people use when they talk about care today is to understand the political relations inherent in their words. Recent feminist thinking about care and its constituent words confirmed the male-dominated ontological viewpoint, that constructs the world in its own image and sees no differences. Feminist caring theories had carved the world up into white men/white women and excluded other groups automatically - a strategy that may have accorded the male elite as much power from its inherent inequalities as it took off them by overt political challenge.

The usefulness of exploring men's views of caring is endorsed by Heller, who notes that men should be selected for researching emotionality, for it is in men that such behaviour is polemically represented, because they are not loaded with cultural expectations of their role as feeling creatures (1979: 211). Also men are less likely to have been locked into the caring role over a lifetime and bring a fresh perspective. It is not inevitable that caring should be conjoined with petticoats forever. Indeed, it would be preferable to be in a position to wonder why caring was synonymous with women rather than drag it into the future like a conceptual ball and chain round our sex. We should be attacking the feminisation of care not rehearsing it.

### **In Defence of Feelings in Sociology**

The second criticism I faced from men research associates was that I didn't know my epistemology from my elbow. In fact, there was a logical sequence of work but I was not confident enough and was more likely to get angry and hurt than argue that a) there are no appropriate theories for caring, b) it is a political omission if there is no conceptual vehicle for a thesis, not a personal one, and c) methodologies are for use not ornament in research and being feminist, marxist or nurse is unhelpful if the adopted strategy induces blind sides. I shall argue that the elision of feelings by male-dominated science contributes to the sense of paradox when men do the caring because caring is meant to be a feeling not work. Here I am trying to learn about men's feelings in a discipline that has hidden emotion from view. This state of affairs should be a matter of concern for sociologists in general and myself in this case: feelings should be defended.

When I began this study in 1988, feelings were not on sociology's agenda (2). The significance of sensitivity to the subject has been emphasised by eminent sociologists such as C. Wright Mills (1970) and Berger (1963, 1966, 1982), but not the significance of feelings (3). Significantly, social historians have written about how feelings colour individual actions, give rise to prescriptions for conduct and bind nations together (eg. E. P. Thompson 1978, Elias 1982). However, sociology usually missed feelings out, and greater importance was given to the thoughts and deeds of men. Homo sociologicus did not make love or war because of feelings. Rather, social relations were viewed as rational acts described by rational means - with the result that feelings were not often seen, heard, spoken or committed by social scientists wanting

objectivity. Often I was exasperated by the gap between dry as dust social theory and my world of nursing where the etiquette of feelings mattered enormously (4). It seemed feelings had been marginalised by the founding fathers of sociology.

It is intriguing that contemporary social theory has its one-sided theories of rational social action, cognitive development, value free science, goal oriented behaviour and other 'heartless' vocabulary - along with chronic epistemological crises. (Mestrovic, 1990; 434).

Mestrovic (1990) argues that social science does not address the world of feelings because it borrows from Kantian philosophy which rejects the idea that feeling plays a part in moral behaviour. Sociology has forgotten Schopenhauer's notion of morality as a human effort. Mestrovic thinks that Schopenhauer's ideas would offer a more useful conceptual framework of human relations for sociologists. Schopenhauer makes moral behaviour more accessible for the purposes of social research because he suggests that human feeling motivates moral acts, not a divine set of Kantian rules. What is the merit of a science about human relations where the possibility of exploring the feelings of research subjects is missing from its conceptual maps?

Jagger (1989) suggests there are reasons why the Kantian inheritance has lasted so long in social science, despite the recurrent epistemological crises in the subject. Traditional epistemologies in sociology are part of an ideology that fulfills the political function of maintaining the power of ruling groups. In western society, there is inequality of feeling among men and women and people of different class and race. In a culture where rationality dominates, to be seen to be feeling (ie. subjective, biased and irrational) is to be weak. By this way of thinking, the more feeling the

opposition of women or blacks to the subordination of their views, the more dubious their testimonies.

. . . the ideological function of the myth of the dispassionate investigator . . . bolsters the epistemic authority of the currently dominant ruling groups, composed largely of white men, and discredits the observations and claims of currently subordinate groups . . . many people of colour and women. (Jagger, 1989: 142)

One way to exert power is to control the 'benchmarks' for epistemic authority - in this case, emotion has been outlawed. White men who defend their feelings compromise the authority of knowledge possessed by their sex, since it is more difficult to discredit them, because they are men. Another reason for the paradox of men who do the caring is that men who connect with their feelings deviate from the strategy of emotionless knowledge that is the hallmark of their sex and puts their authority at risk.

Recent moves to take account of feeling are a philosophical and political departure for mainstream sociology. Historically, there have been different schools of thought on feelings, which has produced some confusion in the sociological debate. It is to be expected that these different views achieve the same political imperative of marginalising feelings, either by locking them up in the person by means of biology or metaphysics or locking them out of the person by means of language, rules and values. The deterministic slant of reasoning about feelings is challenged by theories proposing the sovereignty of human agency as an alternative explanation and it is this debate that I have tried to describe in Appendix Three. It is the aim of this section to seek to address the problems posed by the different approaches, definitions,

constructs and relationships in theorising about the experience of feeling and to suggest a working solution.

Is the only way to make sense of feeling through the mind - a perception that assumes hierarchical order, with thought first? Freud's psychoanalysis conceives that people have unconscious feelings - physical passions that displace reason unless they are expressed. Goffmann's interactionism imagines people reacting to events and appearing to feel, as if feelings were moving pictures on the body's screen. Hochschild's normative theory (1983) suggests people's social situations invoke universal feelings by means of 'feeling rules' - an idea that reminds me of a sociological "Stepford Wives" where everyone is programmed to behave in socially acceptable ways and 'crossed wires' produces deviant behaviour. Kemper (1979) thinks power relationships trigger biological responses that are mentally re-constructed as feelings in a typically positivist cause and effect theory. Harre (1986) treats feelings as cultural and historical constructs of language and values that people know by experience and learn to feel.

What is feeling? Surely these approaches confuse different kinds of feeling - is feeling a physical drive, learned conduct, or moral judgement? Why is feeling? Is it important to decide what feeling comes first in the sequence of feelings - is it the product of biological or psychosocial determinants or self control? These conflicting strategies of inquiry make the epistemological status of feeling look fickle. Male dominated conceptual frames - governed by the requirement for certainty - cannot make feelings into objective facts

without distorting the very phenomenon under observation (Sarbin 1986, Griffiths and Whitford 1988).

Heller's far-sighted work, Theory of Feelings (1979), revises the status of feeling by making it a theoretical category in its own right and not the constituent part of other powerful discourses. In the defence of feelings, this is a significant move. First, she overcomes the problems of definition by making feeling the generic term for different types of feeling states. She defines these phenomena - from hunger to compassion - as a state of involvement with the world outside (5). There are many feelings, each is unique to the situation and expresses a relationship to something or someone. Feeling is wedded to context, that confirms feeling in language, etiquette and values and in the way people express themselves in their day to day lives.

Second, Heller classifies feelings in a multi-level hierarchy from instinctive drive to will. The idea of different levels of feeling explains how someone can will themselves to overcome their basic instincts or resist social pressures to behave one way or another. Heller makes morality the highest condition of feeling and describes the possibility of sovereign existence - people endure other feelings for a feeling they value more and honour (Hollis 1988). Heller divides what she terms 'individualistic feelings' from 'prescriptive' regimes for feeling: feelings have different anchors and the order of their importance is potentially a matter of choice (6). Pitt Rivers (1973), the anthropologist, may have drawn a similar distinction. He explores Fortes theories of reciprocal giving and distinguishes between jural and moral frameworks that order different sorts of relations based on feeling. A

person's moral feeling cannot be forced whereas jural values prescribe what is morally due to another. Once the person feels obliged to give because of jural sanctions, the act is no longer moral. Moral action stops where prescription begins. The tiny domain of moral relations is private, unspoken and unconditional whereas the world of jural relations is public, explicit and conditional.

As an example, caring is not one feeling but a complex tissue of emotions, values and beliefs and acts that change over time. Caring is sometimes enacted through sheer effort of will. People may swallow their instinctive feelings out of consideration for the other person: they exercise will power. There may be external directives that prescribe the appropriate emotional display, such as professionalism. Or people may direct their feelings according to an inchoate code they identify as moral - perhaps their religion. For instance, the physical revulsion a nurse might feel, looking after someone being sick, is transmuted into an air of competent caring. The nurse learns to behave professionally. The husband faced with clearing up after his incontinent wife behaves with utmost dignity. He is behaving in a moral way. If the nurse is a student, and she flees the room or faints, then it is because she has not yet learned how to control her feelings. The expectation is that in order to do her job, she will do so. If the husband leaves his incontinent wife, because he cannot overcome his revulsion, he is negligent. If he should clear up, but make his feelings evident, he is cruel. An uncontrolled moral action has no sense. Moral efforts of will require the person to be in control. For a person to appear caring, he or she must control any conflicting emotions. This moral effort of emotional control may be made

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explicit in a code of conduct or else it is implicit in the private moment of its determination.

A husband may explain his commitment to care by his marriage vows. On reflection, the temporal spans of moral feeling and other emotions are significantly different. On the one hand, the trajectory of unfettered emotion describes an arc, whereas that of moral feeling follows a straight line from a given point. Bursts of emotion are short term episodes, but the nature of willed feeling is long term and it is often regardless of emotions at any specific point. Emotions come and go and do not translate as facts whereas moral feeling endures and becomes fact. The moral determination to commit oneself to caring work is prior to the act and its execution is not dependent on emotion. For example, a nurse who is Christian and is shy of people may well steel herself to nurse in the name of God. But all Christians cannot control their revulsion at the sight of blood in order to care for someone no matter how strong their faith is. A man may decide 'to do the done thing' and look after his wife even though he has fallen out of love at the time. A man who loves his wife is not bound to look after her when she falls sick if he cannot bring himself to do it. Loving someone is not necessary to care for them, kin or not. Without the will to carry care through, other feelings may not suffice to ensure caring in the long term.

Third, Heller contends there are historical tasks in societies like waging war or fighting disease. To start with, these acts are motivated by individuals. Then the meanings and actions of the few become the attributed and diluted meanings of the many who copy the act. Feelings crystallise as a set of

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values that are known and understood by other people and who share them by making them feelings of their own. Each age generates a set of values that normalise imperatives for survival. For example, care/uncaring may well be feelings of our age. Caring for kith and kin is a matter of moral choice but paying tax in order for the work to be done - regardless of personal preference for welfare - is compulsory. However, political speeches that ask if beggars are deserving of another's care and if single mothers deserve public money challenge the individual act of caring for someone on the one hand and society's commitment to a vulnerable group on the other. People start to question conventional priorities to care for others, their families and themselves and so imperceptible change in the moral order occurs. Finally, Heller has identified feelings as work that is common to the productive and reproductive spheres (James 1989). Feelings are the invisible work that invokes labour - in the home and the workplace - and that also helps to confirm the values of the culture.

Heller's work is unique in many regards and here it is the principle defence for modelling feeling in theory for sociological inquiry. In Appendix Three, I have reviewed contemporary theories of feeling separately. None of them manage to explain the potential of self determination, the kaleidoscopic relationship between feelings and purpose that would help explain the complexities of caring for another person over time or the possibility of people evoking the feelings that fit the socially prescribed values for their situation. Heller's theory of feelings offers a conceptual framework that balances structural explanations with human ones. It is a way of

understanding how people still determine their caring responsibilities when seemingly, they have no control over the circumstances of their roles.

In defence of feelings in sociology, an emotive defence is surely our inability to understand or explain the vast largely invisible impact of caring on people's lives or on western economies in terms of public cost and effort, other than by incommensurable sets of figures from a male-dominated science. We should be shocked that the only yard stick for midwifery care is the number of perinatal deaths in the unit or that the service of a hospital is judged by how the organisation manages statistical information such as the figures for waiting lists or time spent on a trolley in Accident and Emergency Departments. The NHS has spent millions of pounds trying to quantify and qualify the standards people expect from professional care. Was it in vain?

People don't remember you for your IV infusion drip or that you prevented their pressure sores - they remember that you took the time to listen and the cup of tea (Junior Staff Nurse Hill)

Probably it doesn't occur to us there is something wrong. A conceptual black hole swallows thinking about the feelings that motivate the effort of caring. Caring is not central to our thinking because dominant ideologies lock it out of existing ways of scientific exploration. Traditional standpoints do not justify the identification of caring as a problem, let alone guide the appropriate methodological strategy for its research. The feelings that lead us through the moral maze of who takes care of granny or the beggar in the street have no authority in political or social theory (Tronto 1987). The stories of men, stuffed into the same ideological space as women if they take up caring roles, are paradoxical because of the contrast of their sex with the

false thinking about feelings that collapses bodies, feelings, caring and women together and conveniently loses them in an intellectual blackout.

### **Concluding Remarks**

When men do women's work, they challenge two conventions in academic debate that reinforce the feminisation of caring. First, men caring are treading on the intellectual toes of white feminists, slow to give up the separatist strategy that characterised the British feminist critique on caring and earned it such success. Second, men caring are betraying the epistemic authority of men for emotionless knowledge by pursuing a course in life which biology and psychology would have us believe is the regular upshot of female feeling. The fact that there are men caring highlights the weaknesses of the academic standpoints. Feminist separatism can give it (ie. equality for white women) but can't take it (eg. inequality for the blacks, the poor, gays, lesbians and men nurses). Giving women carers a voice and exposing their caring role had the the unseen effect of locking up women, their feelings and caring in a strategy that was meant to aid their escape. How can sociologists hope to improve human relations by their knowledge without balancing grand designs of sex, power and money with people's feelings about their lives and choices? Feelingless knowledge has no way of appreciating all the necessary dimensions of the task of the coming generation to care for or pay for more elderly, sick and vulnerable people in society than ever before. A more efficient NHS that has no time for feeling about the people they care for is about as humane a system as the children's homes in Romania and Lebanon to whom we sent aid because we could not bear to see the unloved.

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## Footnotes

(1) Waerness writes :

A central task of feminist research . . . is to look at the context of caregiving work and evaluate the use of conventional scientific concepts and models which may well account for the fact that important problems remain overlooked . . . In this field, female social scientists can use their personal experiences and everyday life to suggest alternative models. These alternatives can contribute then to a change in social theory and research which will better reflect the realities and interests of both women and the weakest members of society (1984 : 194)

(2) I believe Nicky James began the BSA Seminar Group, "Sociology of Feelings" in 1989 and so initiated the British debate on researching feelings. Her research interest flows from her PhD, Care and Work in Nursing the Dying (1986).

(3)

. . . sociology comes time and again on the fundamental question of what it means to be a man and what it means to be a man in a particular situation. This question may often be obscured by the paraphernalia of scientific research and the bloodless vocabulary that sociology has developed in its desire to legitimate its own scientific status. But sociology's data are cut so close from the living marrow of human life that this question comes through again and again, at least for those sociologists who are sensitive to the human significance of what they are doing. Such sensitivity . . . is not just an adiaphoron that a sociologist may possess in addition to his properly professional qualifications . . . but has direct bearing upon sociological perception itself . . . (Berger, 1963 : 189/90)

(4) The arid theory of sociology affected me very much. One morning in 1987, I was assisting at the table with the amputation of a leg from the hip, aware that the list had over-run and I was late for a lecture on the sociology of the founding fathers. It was a bloody operation and left the team unusually quiet and concerned. I vividly remember the frustration I felt, rushing to hear about byzantine theories that bore no relation to the world as I knew it, our feelings about the work that morning and the palpable concern for how that patient would cope with life afterwards.

(5) Harre 1986, also advises that any feeling word should necessarily have an object of intention. Hochschild (1979) defines emotion as a process of involvement of which the person is aware:

bodily co-operation with an image, a thought, a memory - a co-operation of which the individual is aware. I will use the terms "emotion" and feeling" interchangeably, although the term "emotion" denotes a state of being overcome that "feeling" does not (1979: 551)

(6) Harre (1986) proposes three criteria for distinguishing the language of emotion: a) refers to a behaviour that can be displayed, b) is intentional or embraces an intentional object, and c) infers prescriptive or proscriptive rules. Harre does not allow for the sovereignty of will: feelings are the products of their context.

## THE METHODOLOGY

This chapter sets out to explain the aims and objectives of the research, the methods of social investigation and data analysis, as well as exploring some of the ethical issues from the work. The chapter also seeks to explain the role of feminist theory in this study. Feminist theory stresses the importance of speaking for people whose voices are not usually given a public platform. What the researcher says on behalf of others has more meaning if the researcher has practical experience of the things of which they speak. The history of this research can be traced in the log book in this chapter. It shows that I started this inquiry as a nurse and carer, fell ill and needed other people's assistance myself. For most of my life it seems I have been caring for others or others have been caring for me. From where I stand, there should be more thinking than there is about gender relations that lock women into caring roles and keep men out, especially because there is increasing demand for people to care for vulnerable others. The research speaks for people like me who want more men to assume caring roles and to feel comfortable in the role, so that men will have greater practical understanding of caring for others. Also, if there were more men caring more of the time, it would help rid women of the inequalities that prescribe the feminisation of care by overturning the stereotype of women caring.

## **Feminist Theory**

Feminist philosophy changed my relationship to the research. I was looking for help with linking the inquiry to existing theory. Early reading had highlighted the problems discussed in the previous chapter: how the theoretical monopolies that put sociology in business had distorted thinking about gendered relationships and compromised this inquiry and about the gaps in sociology's box of tools for comprehending the world of feelings. Fortunately, the feminist debate was reviewing problems to do with the inequalities of power in sociology, its systems of thought and social research methods and was actively seeking improvements. The feminist aim is expressed succinctly by Harding eg:

Epistemologies - theories of knowledge - are one kind of justificatory strategy. Epistemologies make normative claims; they tell us that one should do x to obtain the best kinds of belief. Traditionally they have appealed to such notions of as divine revelation, common sense, observations, certainty, verifiability, and falsifiability. But justificatory strategies need make no normative claims at indeed, any claims at all. If one is powerful enough, one can gain legitimacy for one's views by having one's critics put to death in the dark of the night, or by denying literacy to potential critics - both common ways to "justify" one's beliefs in the past as well as today. In either case, one's claims are left "justified" by default. More attractive strategies could include social practices that would maximise participatory democracy in the production of belief, and - since power corrupts in science as well as in other forms of politics - even ones that would weight more heavily a belief's fit with the goals of a culture's "least advantaged persons" . . . (Harding, 1989; 189)

Harding shows that feminism embraces theories of power that rehearse a political strategy for social change aimed at emancipation and equality of power for women. Feminist standpoint theory is one way of achieving the aims of feminism. Standpoint theory is an authoritative justification for the feminist claim to interpret human relations correctly. In Jagger's words, the standpoint is "a position in society from which certain features of reality

come into prominence and from which others are obscured" (1983: 382). This is an adaption of Hegel's idea: in the master and slave relationship, it is the slave who is privy to both worlds and the master just his own. Women's subordinate position lets them move between their own sphere and the dominant one of men. Women are exposed to the disparities between the sexes - such as the gendered experience of power, work, bodies and relationships - that men do not usually see (Hartsock 1983).

With the advent of post-modernism, the feminist debate has shifted from essentialist arguments that keep women all the same all the time, with philosophies that will always be irreconcilable with men's. Now standpoint theory offers people who share the same aspirations for emancipation but with different priorities on the agenda a way of researching and publicising their position (Cain 1991). For example, the Afro-Caribbean mother who is a target for racial intimidation has a different set of feminist research priorities to choose from compared to the middle-class white girl - although both may want the emancipation of their sex. Nielson (1991) suggests guidelines by which the authority of feminist research can be judged; in order to produce good quality knowledge, it should be empirical, interpretive and critical. What is required is an intersubjective or relational approach to social research of the everyday, emphasising the relationship between the researcher, the field of inquiry and the methodology; explicit political challenge against false thinking in the discourse that limits understanding of the social situation, and the search for more sensitive and robust methodologies that will synthesise the world of everyday experiences with theory. The following



writing seeks to discuss the study in terms of these guidelines for good feminist social research.

The feminist guideline of a relational approach to social research - exploring the links between self, inquiry and methodology - has strengthened what has been an important but undervalued aspect of sociology (eg. C. Wright Mills 1967) and has encouraged more debate about the practice of what is also known as sociological autobiography (eg. Sociology Special Issue: Auto/biography in Sociology 1993). The reflexive process was complicated by my poor health. Apart from the fact that it is something of a feat to understand where the research fits in the historical scheme and even more difficult to examine heart and mind systematically for research purposes, I lived for work rather than give in to illness and was as blind as a bat to the obvious implications of this until years afterwards. Although I did keep occasional diaries about my time as a nurse and patient, they do not address the odd situation of being an unhealthy researcher. The following discussion and the section on ethics draw attention to some of the aspects of the relationship between my circumstances and the research process.

Social science researchers are familiar with the possibilities in fieldwork of 'going native' or remaining detached as 'the observer' - feminism argues that when 'the native' 'represents' the views and experiences of the group, this is methodologically preferable to a stranger seeking to do the same. The relationship between the researcher and the interviewee is deepened if both share the same experiences and/or perspectives and this wider window on the world of the participant strengthens the meaningfulness of the empirical

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results. Hopefully, prior experience of the research field reduces the risk of oversight, reporting inaccurately or misinterpreting what was said, producing a more robust result. For example, I needed no translation for nursing's professional 'language'. In a busy ward situation or an emotional interview, it helps if the participants and the researcher know they do not have to stop for explanations. Also, the hospital and community care systems were familiar territory and no divergent explanations about the changing NHS were needed. The drawback to this familiarity with the research setting is that some things are taken for granted that some sociologists would pause to question.

The research field - people's innermost feelings about caring - is not easily accessible without the capacity to imagine what it is like and to develop the questioning so that it is open ended, thorough and sensitive. Perhaps my roles as nurse, carer and invalid helped me to see further. The deep-seated feelings of the nurses and carers and the work that goes into controlling appearances that were familiar to me! Probably this anticipation made parts of the interviews simpler to conduct. But there were times when I was thrown off balance by unanticipated turns in the conversation. For example, I had assumed that cross-sex interviewing would prevent frank discussion of the feelings that can come from celibacy or giving cross-sex care and I was wrong. The first time one of the men talked about celibacy, I was taken by surprise and did not know whether to ask more questions. In the later interviews, I followed it up. Only one other man had something to say. Two of the nurses also talked about the sexual implications of cross sex caring. Thinking about it later, it seemed to me that to me relationship between sex, feelings and the commitment to care was another important but separate inquiry.

As I said, part of the relationship between myself 'the researcher' and the research was hidden. Looking back, my state of health affected the research far more than I knew (or wanted to admit) at the time. It took almost a year between 1988-89 for the task of the research to crystallise and another two years to carry out the second stage of fieldwork. During this time, I became chronically ill, spent several weeks in hospital, underwent numerous tests and investigations and was declared unfit to work for 18 months until 1991. The experience of chronic illness was a changing permutation of fatigue, pain, aches, stress and occasional relief. What got me through this excruciating ordeal was studying. Reading a book proved to be effective diversionary therapy and one of the few things left I could actually do without provoking another physical symptom. However, since I was unfit for much else except reading and thinking (and this was tediously slow), the theoretical drift of the work was unconsciously extended.

Another consequence was that the research process was not the seamless effort over 4 years envisaged at the start. It has taken almost 7 years from writing the original proposal to completing the thesis. Progress with the research and writing up was very slow. There were long periods of time when I could not carry on because of illness or re-adjustment to life after illness. Once I was fit to work again, I wanted to earn a living as well as study. My jobs were with the new NHS management - ironically, not the most conducive environment for people trying to get back on their feet. In 1993 I fell ill again and was invalided for another 15 months. The main effect of so many stops and starts, with the fresh perspectives and continuous trickle of more reading material, was the huge problem of maintaining a coherent vision of

what needs to be said and how to say it. This was made much worse by academic isolation and also by the toll of physical stress on my capacity to think straight.

The battles with narrative reflect the difficulties with organising and compressing the volume of data and the history behind it in order to highlight significant aspects. There are many types of narrative in the thesis: first person linear accounts describing how the inquiry unfolded and 'what happened next'; lumps of text, to review and analyse the literature, laced with quotes from my diary, interviews or the nursing press that are meant to provide different perspectives; and quotes and lengthy extracts from the nurses and carers about their views and experiences.

Finally, life can bring much more in 7 years to change the researcher and inform the research than it can in 4, that cannot be anticipated at the start and that the novice postgraduate should consider in their worst scenario planning. For example, in the middle of research on sex roles and health work, I was suddenly on the receiving end of medical care from a number of well-meaning men whose technical armoury could not determine what was wrong with my biochemistry no matter how hard they tried and who sometimes resorted to explanations about my allegedly 'female' psychology, either despite or more likely because of my fierce responses to such sexist holistic hogwash. In 1987, my 70 plus year old father started a series of operations and hospital admissions. Usually I was the carer. In 1993, his health collapsed after a number of strokes and triggered a sequence of horrible events that showed me what NHS and community care is like at its worst. Both times my father

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needed care and it was first-hand experience of the way responsibilities get shared out in families (or how they don't) and how past family feelings charge the negotiation of care in the present. Nurses are used to seeing families negotiating their feelings about caring for a loved one (or an unloved one for that matter). Probably these experiences made me more alert to the feelings of nurses and carers than I would have been. On the other hand, the experience of what I was researching fractured the inquiry into so many separate parts over time, the effort of fixing and finishing the thesis was far far more than imagined at the outset.

The second feminist guideline for this inquiry is that false thinking in the sociological discourse is overtly challenged if it limits understanding of the social situation. The thesis attacks sexist power in our cultures, structures and biologies. Barrett and Phillips (1992) express this intention well:

Here in a sweeping attack on the falsely universalising, over-generalising and over-ambitious models of liberalism, humanism and Marxism, many feminists have joined sympathies with post-structuralist and post modernist critical projects. In the context of these recognitions, many feminists have opted for an analysis of the local, specific and particular. Much of this work is deconstructive in character, seeking to destabilise - challenge, subvert, reverse, overturn - some of the hierarchical binary oppositions (including those of sex and gender of western culture). Thus we have a developing feminist theory whose intention is to destabilise (Barrett and Phillips 1982)

The structure and sequence of the thesis reflects how caring was deconstructed, in terms of language, nursing's historical representation, social theories and men's experience of caring feelings and work. Each aspect provides unsettling evidence of the femisation of care that creates the paradox of men who do the caring. For example, how can one think straight in a language that is the image of its culture? The epistemological conflict of

thinking about crushed corners of female experience - like caring - using the same male dominated words and science that force its suppression, has troubled many women academics (Whitbeck 1984, Smith 1988, Code 1989, Ramazanoglu 1989).

We do not perhaps realise the degree to which our knowledge of the world is already located at a conceptual level prior to the development of a theoretical apparatus . . .

The world as we know it sociologically is largely organised by the articulation of the discourse to the ruling apparatus of which it is part (Smith 1988: 63)

If I had not started to explore the language of care, I would not have understood its dual meanings of work and feeling and the domination of feeling in the construct of care which relates to the history and culture of women in caring roles. Then there were difficulties with the perspectives in social theory that have shaped ideas about caring: the British feminists' writing on women and social policy and writing about feeling. Both areas of work are at a loss to match theory with empirical data. This is because it is not just the language but the very order of knowledge that fragments, hides and impoverishes the phenomenon of care. As well it rehearses the subordination of women caring and makes the notion of men caring appear paradoxical. Feminist separatism explains the fiction of gender relations by structural dependency that limits women's freedom without reference to individual experience of living life. Writing on feelings falls into two camps: that feelings are structured by material, patriarchal or biological determinates or follow the Kantian line that feelings are moral ideals like Faith, Hope and Charity that men aspire to of their own free will. Until I read Agnes Heller's Theory of Feelings (1979), I could not explain either the fieldwork, how its findings fitted with existing theory or how to proceed.

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In this section, I have discussed this study in the light of feminist guidelines for good research. Feminism also searches for more robust research methodologies that will synthesise people's experiences with theory. The next section discusses the research methods that were part of this inquiry.

## **The Research Method**

### **The Research Design**

The study incorporates six different sources of data: two sets of fieldwork interviews; four literature reviews (the literature on caring including the British feminist critique of women and social policy, the literature on feelings, that of feminist epistemologies, and writing on sexual inequalities in the division of nursing labour); a study of the language of caring; finally, a review of data on population, socioeconomic and policy trends. Periodically, I kept diaries about my experiences as a theatre nurse and patient.

The range and level of data collected is more than the original research design indicated partly because of the reasons outlined above. Each phase of the inquiry was a logical step to understanding and explaining the reasons for sexual inequalities of power that had produced the configurations of caring. The first stage of interviewing was conducted after the literature review of the British feminist critique of caring and took its inspiration from Ungerson's work on men and women carers. The interviews suggested that men talked more about their feelings than the work involved in caring. This finding triggered the study of language to explore the idea that the construct

of caring is feminised as feeling in western culture. Confirmation of this point eventually led me back to the field to interview more men about their caring roles. Before this came the literature review of feelings to find a more complete theory to address the difference between values, feelings and beliefs about caring that would help to distinguish between sexist beliefs about sex roles and health work and caring feelings. The review of the discourse on sexual inequalities in the division of nursing labour was intended to assess the historical impact of nursing on the feminisation of care. The review of information to explain the context of care came after the second stage of fieldwork was complete. It was thought this data was important both to set the scene of the study and to justify the importance of the debate.

### **The Samples**

The interviews were aimed at two groups of men - nurses and carers - and their feelings about their caring role. There were two stages of interviews involving 14 people. The first group of 5 people were interviewed in 1988 and the second group of 9 people in 1990. The criteria for selecting the participants were as follows: male, 6 qualified nurses in employment and 6 carers. The criteria were deliberately broad for two reasons. First, it was to make sure the senior nurses who were collecting names of potential candidates on my behalf achieved the numbers and second, because this was a small exploratory inquiry of men talking about their caring role and at this stage, a more structured sample specifying age, race, nursing rank or kin relationship did not seem appropriate.



### **Access to the Participants**

Access to the men participants was arranged by the nursing executives for Carrtown's hospital and community care units after they had interviewed me separately. The ethics of the research were agreed; information about the research was provided for all potential interviewees prior to the interview, all disclosures were to be treated confidentially, and pseudonyms would be used for the site and the participants so that anonymity was assured. It was not thought necessary to go to the Local Ethics Committee although advice was sought. The executives instructed senior nurses to approach potential interviewees to see if they would agree to be interviewed and to pass on their names to me.

When I requested access for the second round of interviews, the new nursing executive at the hospital asked to meet me and also referred me to the new manager of community care (see Gatekeeper Interview in Appendix Four). This time I wanted to speak to the nurses away from the ward and permission was granted for the interviews to take place in work time. The process for obtaining possible candidates for the sample was successfully repeated. Nobody refused to be interviewed. After the initial meetings with the gatekeepers, there was no further contact sought by them or myself to discuss matters arising from the fieldwork.

When I received the names and addresses or telephone numbers, I usually rang participants and then sent them a letter of confirmation. These communications explained briefly the research, the interviews I hoped to conduct, the ethical considerations and arrangements for the interviews.

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The second sample was modified by the inclusion of two women, one nurse and one carer. This was in order to confirm my judgement that the men's feelings and beliefs about caring were not exclusive to their sex. The women were recruited oppurtunistically.

### **The Methods of Social Investigation**

In the preliminary fieldwork, I was exploring the ideas of men nurses and carers about caring, just listening to people talking as things occured to them during the course of their work. Sometimes I was with them for hours at a time. I didn't use a tape recorder because I thought it would be obtrusive and impractical on the wards. So I made notes and wrote them up afterwards as case studies. In the studies of the two nurses I adopted different methods. There was more action to record on the ward and so I used participant observation technique. To try and capture the speed and multiplicity of events, I timed what was happening and wrote down snatches of speech and hurried conversations. The first interviews took four weeks to complete.

The final fieldwork involved semi structured interviews lasting an average of 1½ hours. They took three weeks to complete, finishing just before Christmas 1990 (one interview was delayed until February). These interviews were tape recorded and transcribed by myself. The techniques, wording and question sequences used in the interview were given a lot of thought. The first few interviews saw some experimenting and modification until the format worked well. Some methods evolved from existing sources which I will pinpoint as I describe the steps in the interview. Although I tried to follow the same

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course for all the interviews, I was open to the possibility that the participants might have better ideas and no one was discouraged if they introduced a new view on caring.

The questions started off in a general way as a way of breaking the ice. The nurses talked about their ward and their patients and the carers told me about who they were caring for. My identity was usually guessed at this point. (Although I didn't make a point of telling people that I was a nurse and on invalidity benefit, sharing my own experiences, if called for, was a way of establishing a rapport).

As I got used to handling the interview, I could steer us round to the next topic without stopping the flow of conversation. I encouraged people to explain what they meant by caring, by giving me everyday examples from their caring role and by giving reasons for what they did. The assumption was that they would relate caring either to work or to feelings. The first question was, "What do you think is the most important part of caring?" The usual response emphasised their feelings :

Being involved you get a relationship with somebody. You get that trust. They can open up to you a bit more. It helps .. You show you are interested in them. You build a relationship with them ..  
(Senior Staff Nurse)

If you are going to do the job properly you've got to have a good relationship with the person you are caring for .. Otherwise I don't think you can do it. There's no financial reward .. (Penny Shaw)

Once that was decided we went on to discuss why they thought feelings were fundamental to caring. I sought to do this by suggesting situations where feelings ran high in the hope that they would recall similar moments in their

own lives and remember how they felt, eg. "There is a tragic death on the ward of someone well known to the staff. The relatives are very upset". This is like the method of vignette (West 1982, Finch 1987) but it is not the same. I was using emotive cameos to prompt people to connect with their feelings at a particular event rather than mapping beliefs about social situations :

I knew the patient's son pretty well, and she died quite suddenly .. tragically .. The first I knew she was in, he popped his head round the corner, and said, "Oh my mother's in". And the next thing, my crash bleep went off. They were all stood round the bottom there. And it was her .. I was feeling shocked more, 'I wonder how they're coping?' .. Put yourself in their shoes, and think, 'What would I do?' And you are lost for words. You want to say something constructive. But I didn't know what to say .. (Charge Nurse Tanner)

Then I tried to draw out the reasons for their action. This was achieved by suggesting they were acting a part. By prompting their imagination to see themselves playing a role, they could say how they looked on the outside and how they felt on the inside and why they acted the way they did. This technique was successfully adapted from Hochschild's work on emotional labour that suggests everyone plays a role, manufactures feeling and hides their true feelings in order to satisfy higher priorities such as commercial or family pressures. Hochschild's idea is based on theories of acting, that teach people to act feelings they do not feel and to become another character. The interviewees were interested by this view of themselves and their roles and their reasons for hiding one feeling and playing the other.

The bits of anger I showed me mum was the very hairs of an iceberg ... I used to go outside and virtually chew a cigarette with frustration ... After a while you don't get so mad. You realise it's not their fault they're ill. You've got to keep on. It's an act of caring to hide my feelings ... (Ian Black)

The conversation turned to caring work on the ward or round the house, the sort of skills required and where they learned them from. Many researchers have examined the range of skills, workload and time management in caring with more method than I used here (eg. Nissel and Bonnerjea 1982, Parker 1981, Parker 1985) and in nursing (eg. Sixsmith and Sixsmith 1989, Robinson, Strong and Elkan 1987, 1989). What I was interested in was how they viewed caring work in terms of sex roles:

Run a house, Like a housewife, And I look after her .. The caring is automatic. They're not two separate issues. They run side by side. It's not, 'I'll do the housework 9 till 10 and the caring 10 till 11'. If she wants to go to the toilet now and that's caring, well out she goes. (Mr Gales)

I tell you what. A women's work is never done. And I am never going to dispute that ever again. It's damned hard work. I've got on the wrong thing here . . . but I've always said a woman should do the ironing. I've got to do the ironing if the home help doesn't turn up else that's two lost the next week. (Ian Black)

What a nurse does is clean up other people's mess. If I had a daughter I wouldn't want them to become a nurse (Student Nurse Evans)

At this point, well into the interview, I asked the participants what stopped them walking off the job. Inevitably they went back to their feelings again.

Because here is somebody lying in a bed that is probably helpless, and wouldn't have anybody to look after them if you did [walk off]. My conscience would not let me (Sister Ann Trent)

Sometimes I feel like walking out! Why don't I? Well if I walked off everybody else has got my work to do plus their own . . . And if I did go, I would feel so guilty . . . (Senior Staff Nurse)

The interview concluded with questions about adjusting to the caring role as men and the effect caring had wrought on themselves and their relationships.

I also questioned the nurses about their decision to become nurses.

Yes nursing changed me. I used to be neurotic - I'm still nervous now - and had problems. I think because you need to get yourself together for work, you sort yourself out. I sorted myself out. And

you are face to face with people much worse off than you are, and are really brave and are still being proud and good, and what are you messing about at worrying about the things you've got? (Junior Staff Nurse Colley)

The last questions were about personal details to do with age, previous occupation and nursing experience, if the information had not been volunteered already in the interviews.

### **Data Analysis**

The case studies in the first phase of fieldwork were scanned for common reference points. All I wanted to do was to distinguish one piece of caring work from another in ways similar to Graham (1984), Kitson (1985) James (1987) and Ungerson (1987). Broad categories of what I deemed to be emotion work, moral work and physical work were sketched out. In retrospect, this form of analysis poses many problems. First, it reifies caring into pieces of work. Second, it assumes all caring acts from feeling to tending can be expressed as units of work. Third, abstracting categories of caring work from the context of caring loses sight of the person doing the caring and why they are motivated to care. At the time, Meg Stacey observed that it was paradoxical that the cases studies indicated that men talked more about their feelings than the work involved and that the objective should be to explain the reasons for this paradox. This chance remark helped trigger the search to explain the feminisation of care.

Analysis of the second stage interviews adapted the approach developed by Glaser and Strauss (1967). This type of analysis examines the data

systemmatically for empirical indicators, that is behaviours and events that are described in the documents and words of interviewees and other informants. The indicators are clumped together to derive broader conceptual categories until the process of theming is exhausted. For example:

The Carers Themes, Interviews 1991.

FEELINGS:

Reasons for the Performance of Feeling:

5. Coping as Normal

Carers want to look as if they are coping

Try and live normally

Others still expect things to be normal even if it's abnormal

Carers expect to hide the truth

Put up and shut up

We've got to keep smiling

Fear of being judged incompetent or unable to cope

*\*Worried they would think I couldn't cope*

*Some frightened to ask for help because they feel intimidated by professionals*

*Professional display for other professionals*

*Big fear of breaking down by talking*

*Trying to be very friendly to nurses*

\* The woman carer's comments are italicised.

There were several sub-headings for 'Reasons for the Performance of Feeling' including the need for a professional and/or public performance, fear of social exclusion, being seen to be coping as normal and consideration for others. The bulk of the interview material from both groups was sifted into three categories to do with caring work, feelings and sex role. The next step was to relate the fieldwork results to existing social theory. This interpretation sought to explain the reasons for the paradox of men caring.

### **Considering the Ethics**

Feminist guidelines for good research emphasise the significance of explaining relationships in the field which should encourage the researcher to consider the ethics of their practice. First, there is the matter of explaining the political aims of the inquiry: whose side the researcher is on and why? I have already explained that the thesis attacks the systems that subordinate women in caring roles and locks men out. I am not convinced that all of the the men I spoke to would support these political aims. In other words, I may have appropriated the ideas of men for purposes some may not agree with.

A second aspect is about the authenticity of the researcher's claims to represent accurately the people involved in the inquiry. Is there evidence of practical understanding of their situation or a feedback mechanism that allows the people to have their say about the findings? Someone asked me if I had problems with cross-sex interviewing and whether 'her questions fit his answers?' As a woman, can I claim to represent men's feelings about their caring roles? My participants talked frankly about dirty work, celibacy and imputed homosexuality and while they might have signalled they were on taboo ground, it didn't stop them telling me, perhaps because of my sex (women are reputed to be skilled at managing confidences), my status as a nurse and an invalid (the men assumed they could talk openly about taboo topics with someone who deals with them in everyday life), and perhaps because they felt such confidence was justified "in the name of research".

Finally, who benefits from the research? Were the interviews a reciprocal deal: did the participants consent to be the guinea pigs for the study because

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they thought others might benefit from hearing about their experiences? Or were the interviews prompted because I wanted original data from the private lives of strangers in order to earn a qualification and they were willing to put themselves out for me? Because the participants are informed and choose to participate, does this mean they are agreeing to run unseen risks for the benefit of the researcher? For example, the interviews lasted an hour and fifteen minutes to three hours. Usually it took an hour and a half to finish. Sometimes, the long interviews grew intense and I worried about the ethical implications. The interviews were not meant to be therapeutic but they should not harm. After the event, some said they had benefited as individuals - the carers said it was a rare opportunity to talk to someone interested in caring and the nurses said the questions made them think. However, there was no check on the long-term effects of this kind of interview and I do not know whether it helped or hurt them.

Two people were nursing family members who were close to death and they still wanted to continue. Usually the interviews were agreed two weeks in advance and no-one could anticipate their circumstances on the day. Neither cancelled or wanted me to go straightaway. As the interviews progressed and they opened up to talk about their hidden feelings, they relaxed and so long as they consented to continue whenever I checked, we went on. Four people - nurses and carers - seemed close to emotional breakdown because of the strain they were under. Two of the interviews upset me because I felt like a helpless voyeur, watching others struggle in difficult circumstances, and knowing that it was not my responsibility to help, but to *use it for data*.

## LOG BOOK

TERMS	DIARY
Autumn 87	Meet Judith Clark re MA working title: "Values in ideologies of caring generating resistance to change"
Spring 88	Jane Robinson suggests nursing research grant for MPhil, Ill; 2/52 off work, Meetings with Jane, Judith, and also Phil Strong to refine proposal, Access to field via DHA negotiated with 3 gatekeepers, Ill again; 3/52 off
Summer 88	No grant; criticism of the qualitative approach, research design and lack of biographical data, Re-register for p/t MPhil, Granted study leave by SWHA and money from Govt, Career Development Loan  Conduct open ended interviews with men carers and nurses
Autumn 88	Analyse interviews for themes, Library search for bibliography, Feeling confused about research aims, Ill; 10/7 off, Take course: "Research Process and Research Design"
Spring 89	"Preliminary Discussions on Caring" ; Position paper (1) for Warwick Medical Sociology Group, Research design criticised for using mixing public with private caring roles and using men as subjects because of 'a priori' irreconcilable differences between sexes, Start tuition with Meg Stacey and Jane Robinson, Read Smith's Everyday World as Problematic (1988), Study of historical and comparative use of 'care' in English  Lit. review to survey of caring concepts in nursing, feminist, and social policy texts, Position papers (2) (3) "Chimera of Caring"
Summer 89	Continue survey of caring concepts, Hospitalised, 3/12 off, Take job as p/t research nurse at QE interviewing cancer patients, Exploring theory problems affecting the research design, Meg leaves, Jane takes up Chair at Nottingham, Both concerned by the drift to theory, Read Hochschild's work on emotional labour

## con/ LOG BOOK

- Autumn 89                    Judith back from sabbatical. Course on "Philosophy of Social Theory". "Review of the Research Process" - Position paper (4) for graduate review. Read Strauss on types of care work in hospitals. Position paper (5) : "Caring Work (Self Care)" using own diaries
- Visit Janet Finch
- Spring 90                    Hospitalised for 2/52. Invalided from January 1990 - June 1991. Continue to grapple with theory problems
- Summer 90                    Position paper (6). Draft chapters - "Caring is Work", "Theory of Caring Work" - and submit for re-registration to PhD.
- Read Heller's Theory of Feelings (1979)
- Hospitalised for 1/52
- Applications for funding
- Draft chapter: "Rationality versus Feeling". Turgid arguing about relationship of philosophy of social theory to study
- Autumn 90                    Repeat course "Philosophy of Social Theory". Join Feminist Philosophy Group at Warwick. "Love's Labour Lost" (1990) British Sociological Medical Association Conference & BSMA Sociology of Emotion Group. (A theory of the dual sense of work and feeling). Second draft: "Rationality versus Feeling".
- Preparation for fieldwork : background reading, gatekeeper interviews, methodology of interviews, administration
- Read Hollis (1988) re orientation for interviewing
- Read Harre (1986) re construction of language of emotion
- Second phase of fieldwork: semi structured interviews with men nurse and carers

con/ LOG BOOK

- Spring 91                    Position paper (7) : "A Model of Caring Work" for Warwick Medical Sociology Group. End fieldwork
- "Love's Labour Found" (1991) British Sociological Association Conference. (The negative status of work in caring)
- Research constructions of caring in other languages
- Summer 91                    Review of literature : recent texts and outstanding data - DHA sex/employment figures, national sex/health work statistics, feminist philosophy, social policy/community care, government papers, men in nursing
- Start f/t job with Health Authority as researcher. Suspension of registration from 1st June-30th September
- Autumn 91                    Chap. One : "Naming Care"
- Spring 92                    Chap. Two : "The Context of Care"
- Autumn 92                    Chap. Three : "The Paradox of Men who do the Caring"  
Granted six month extension to May 31st  
Sick leave for 6/52
- Spring 93                    Move to research job in another Health Authority
- Granted six month extension to November 30th
- Spring &  
Summer 93                    Chap. Four : "Caring in Theory"
- Autumn 93                    My father is seriously ill after stroke and compassionate leave is granted. Then I fall sick for 8/52 and hospitalised for 1/52
- Chap. Five : "Caring Feelings"
- Chap. Six : "Caring Work"
- Granted six month extension to May 31st
- Spring 94                    Cared for father over Christmas who appears terminally ill
- Summer 94                    Invalided for twelve months due to stress. Revision of chapter drafts

## THE NURSES AND CARERS

There were two stages of interviews in and around Carrtown, involving fourteen people. The first group of five people were interviewed in 1988 and the second group two years later, in 1990. This chapter presents the results of the two samples and describes the outcome of the recruitment processes, the characteristics of each sample and finally, a series of cameo pictures of the people who agreed to participate in the interviews. The chapter begins by setting the scene for the fieldwork with a brief history of Carrtown's male dominated labour traditions.

### The Site

In the nineteenth century, Carrtown's local industries were weaving silk ribbons and watchmaking. When this work declined, the city adapted and began to manufacture bicycles and then cars, before the First World War. Between the wars, Carrtown attracted a high ratio of young white male labourers who came from other parts of the country looking for work and stayed. Eventually six different car plants set up here to use the skilled male workforce. Cheap housing stock was put up round the factories to cope with the demand for low

cost accommodation. The dominant cultural group was white, male, working class and with roots outside the town. The men worked long hours, earned good money and enjoyed material things like cars and TVs. There was a shortage of female labour because the Carrtown tradition was that married women did not go to work and perhaps this convention was adopted by single women coming to the area for jobs, who got married and stayed at home to bring up the family. All but one of the men carers were of the same generation as Carrtown's first car workers who ended up living in Carrtown for the rest of their lives.

Carrtown has two hospitals, old and new. The old one is in the city centre. All the interviews were conducted at the modern Carr Unit in the suburbs. In 1990, Carrtown School of Nursing merged with nearby Farmshire. The recruitment figures for student nurses and employment figures for nursing staff in the district show the disproportionate numbers of men and women who start nursing and take jobs in Carrtown (see Appendix One and Two). The two men in charge of the hospital and community nursing staff in 1988 suggested two reasons for the low numbers of men nursing recruits. First, Carrtown had a tradition of male dominated labour and second, to help break down work role prejudices in the locality, nursing pay and conditions should match the going rate for skilled labour. According to the literature, occupation, class and income are neither necessary or sufficient explanations for the low number of men nurse recruits.

## **The Samples**

Fortunately, recruitment for both stages of fieldwork was an easy business and of the 14 people invited to participate in the research, all completed the interviews. The sample characteristics are shown overleaf. I was lucky to have the co-operation from the nursing executives in Carrtown Hospital and Carrtown Community Health team to recruit all but one of the men nurses (when I was designing the second stage interviews, I recruited a male nurse myself to help check if my themes and questions made sense) and all of the carers. At the second stage, the process was simply repeated. The women, one nurse and one carer, were recruited opportunistically at the second stage by me.

In the first stage of interviews, I talked to the nurses while they were on duty and watched them at work. In the second stage, the nurses' interviews took place at the hospital, usually in the sister's office or in the canteen. The nurse who was asked to check my interview schedule was interviewed in my home. All the carers invited me to their homes. Usually the person they were caring for was out of the house or was confined to bed. There was one interview which ended up with the husband and his wife whom he cared for and who was there, both joining in.

Six men and one woman were involved who were nurses. At the time of the interviews, the men were all in their twenties; the woman was in her forties. Two of the men were charge nurses, Alan Tooley and Lee Tanner; one was a senior staff nurse, Greg Wright; two were junior staff nurses, Ken Hill and Dan Colley; and one was a student nurse, Mike Evans. The sum total of the time the men had been working in the NHS was 40 years. The sister, Anne Trent, had

## SAMPLE CHARACTERISTICS

### THE NURSES

Group One  
Carrtown and Farmshire Hospitals, 1988

Name	Approx Age	Grade	Approx Length NHS Service	Care Area
Ken Hill	27	Junior Staff Nurse	06 years	Paediatrics
Alan Tooley	26	Charge Nurse	08 years	Intensive Care

Group Two  
Carrtown and Farmshire Hospitals, 1990

Name	Approx Age	Grade	Approx Length NHS Service	Care Area
Greg Wright	26	Senior Staff Nurse	10 years	Medicine
Mike Evans	23	Student Nurse	06 years	Medicine
Lee Tanner	24	Charge Nurse	06 years	Medicine
Dan Colley	22	Junior Staff Nurse	04 years	Elderly
Ann Trent	43	Sister	27 years	Medicine



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SAMPLE CHARACTERISTICS

THE CARERS

Group One  
Carrtown and Farmstone, 1988

Name	Approx Age	Kin Relationship to Cared For	Condition of Cared for	Time as Carer
Mr White	late 60s	husband	Alzheimers	12 years
Mr Rice	early 60s	husband	chronic arthritis & psoriasis	18 years
Mr Badger	mid 50s	husband	paraplegia	18 years

Group Two  
Carrtown and Farmstone, 1988

Name	Approx Age	Kin Relationship to Cared For	Condition of Cared for	Time as Carer
Mr Bibby	early 60s	husband	neurological disease	5 years
Mr Gales	early 70s	husband	multiple sclerosis	35 years
Ian Black	39	son	father had diabetes & respiratory diseases RIP; mother was totally dependent	16 years
Penny Shaw	mid 30s	daughter	father had cancer RIP; mother had Alzheimers	2 years

worked for the NHS for 27 years. They worked in different parts of the hospital but the labels for the care areas are sometimes deceptive. Carrtown Hospital had integrated the medical specialties with the result that care areas were admitting more patients with very different conditions.

The carers included six men and one woman. At the time of the interviews, the men ranged from 39 to 72 years old and the woman was about 35 years old. Five of the men were caring for their wives. The other man, Ian Black, had cared for both his parents and so had the woman, Penny Shaw. Both had recently lost their fathers through illness and were still caring for their mothers. The sum total of the carers' experience is more than 100 years. Mr Gales had looked after his wife, Rose, for some 35 years while the caring careers of Mr Bibby and Penny were less than 5 years old.

The conditions of the people they cared for are reminders that it is not just the duration of care that colours the experience of caring, but the intensity and frequency of the tasks, the level of skill, the amount of watching, the prognosis of the person who is being cared for and the isolation, despair and helplessness that can follow after witnessing someone suffer in private and at close quarters. For example, four of the carers were looking after people who had become seriously ill after long periods of terrible illness, three of the wives had been in wheelchairs - one lady for 15 years, the other for 20 years, and the third (who was also very confused) more recently.

The nursing interviews were conducted before the NHS and Community Care Act (1990) and the advent of the 'health care market'. However, the introduction

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of systems for collecting statistical health information and the devolution of management were in full swing. Appendix Four is the account of an interview with a senior executive on the re-organisation of health services and the effects on staff. All the nurses expressed strong views about the consequences and the implications of the government changes to the NHS (see Chapter Eight). Only two people were on the verge of leaving because they found their situations unbearable.

Similarly, the carers interviews were given before the NHS and Community Care Act (1990) arrangements for financing community care took effect in 1993 and the trends towards integrating packages of community care. However, four of the carers spoke forcefully about the lack of material and human resources from community care services, the lack of organisation of available resources and the poverty they were incurring by doing the state's work for it (see Chapter Eight).

## **The Nurses**

*Ken Hill was 27 years old in 1988. He qualified as a registered general nurse in 1986 and was working as a junior staff nurse on a paediatric ward. I followed him round on a morning shift for five hours to talk to him and watch him at work. He never sat down apart from a ten minute break in the canteen. That day, he was looking after 3 wheezy babies, 5 admissions (including two for tests that morning in the Treatment Room, 2 for blood transfusions and an*

emergency), a quick ward round and two new staff. He came across as very knowledgeable about the medical management of his patients.

Ken was married to a student nurse and they had a young baby. He trained as a nurse after taking a science degree. He had not planned to go into nursing and said he thought of it in his last year at university when he was deciding what to do next. He applied everywhere but was rejected or put on a waiting list until Carrtown School of Nursing finally offered him a place. He was ambivalent about nursing. He liked its intellectual challenge but it wore thin if he stayed in one area, so he kept moving round. He was due to leave to go on a post-registration course and in the long term, he had his eye on nursing research. He saw attitudes he disliked (that point to his latent idealism): nurses' resistance to a scientific approach for nursing, their lack of management skills and the elitism of doctors. Ken also showed me the old special care area which was shut down and had become a dismal dumping ground for all the redundant hi-tec equipment. He said nothing, shrugged his shoulders and walked away.

Alan Tooley was 26 and a charge nurse for Intensive Care in 1988. I followed him round on an afternoon shift for four hours; the results are recorded in full in the next chapter. That day, Alan was looking after 8 patients, the pre-operative preparation of an organ donor patient, 5 staff new to the department (no other staff were available) and at least 2 families in shock because of what was happening to their loved ones. Although working in very

stressful conditions that challenged professionalism and dedication, he appeared calm and cheerful.

Alan spent a lot of time in hospital after a bad accident and that experience made him want to nurse. He felt strongly about it. The family supported his wish. He left school after his 'A' levels and worked as a nursing auxiliary while he waited for a nursing school place. He qualified as a registered general nurse in 1986. After that he staffed on a surgical ward and studied for the Diploma in Nursing. He had been a charge nurse for 5 months and was already beginning to think he was in the wrong job. He felt he had to get out of the situation he was in or go under like the others - four members of staff were on sick leave with stress-induced illness. But he had just got married and they had bought a house; he felt obliged to keep his salary.

Greg Wright was 26 and senior staff nurse on a medical ward in 1990. He qualified as a registered general nurse in 1987. I talked to him one afternoon. The ward had followed the policy of integrating medical specialities and Greg reeled off the case-load that day: 3 or 4 people with asthma, 2 people with myocardial infarctions, 4 people with strokes and a girl who has spina bifida, two people with suspected meningitis, one with glandular fever, one with encephalitis and somebody with diarrhoea and vomiting. The ward had a full complement of staff.

Greg says his family was mostly men - father, brother and cousins. According to him, they were traditional working class. Originally, he wanted to be a

*policeman but was too short to qualify. He had to go to college to do 'O' levels and the only course left was a pre-nursing course so he did that. He enjoyed working on the wards so much he did voluntary work in his spare time which pleased his parents. He was surprised to find his decision to nurse was popular among his mates who asked him lots of questions about it.*

*Greg thought nurses were in a difficult position, with angry patients who felt they had paid their dues for care on the one hand and managers who made the decisions that meant less care on the other. In general, Greg appeared to be smitten with nursing and was optimistic about the future of the profession.*

*Mike Evans was a student nurse working at Farmstone's District Hospital. He had qualified as a registered general nurse and was finishing his contract as a student nurse before taking up a job as a nurse the following week. He was 23 and single. He worked on a general medical ward, where some beds were set aside for patients with leukaemia and lymphoma. The majority of the patients were elderly with physical and social problems.*

*Mike went into nursing because he felt strongly motivated to help people. His family - particularly his father - found his decision hard to accept although they admired him for carrying it out. He was the only man in the group he trained with at Farmshire School of Nursing. This experience prepared him for female prejudices about men caring. He says that after a year or so, the other students got used to him and stopped singling him out.*

Although Mike loved looking after people, he was frustrated with nursing attitudes that had put him off nursing: the tendency to make rituals of the work to be done so that people were turned into work objects, the local etiquettes for managing events like a death on the ward, the lack of effective paperwork systems for processes like discharge, the lack of effective chains of communication and the unquestioning acceptance that nurses should do what used to be medical jobs.

Lee Tanner was the charge nurse on a medical ward. He had worked in the NHS for 6½ years since leaving school. He was 24 years old. That day, the ward was quiet. The case load was mixed, including 4 people with strokes, one of them very poorly and 2 ladies who were in the terminal stages of illness.

Lee had wanted to be a nurse since he was 15 or 16 years old. He used to listen to his aunt telling stories about her work as a nurse. Then he did some voluntary work caring for elderly people and enjoyed it, went on to the pre-nursing course and liked that and so it continued. Because he was happy, his family supported him. Lee says they knew about nursing from the aunt so they didn't suppose it was women's work. He thinks nursing made him grow up and gave him more confidence. Lee says that nurses have less respect nowadays. He suggests nurses cannot keep such high standards of work for reasons that they cannot control and yet to the public, they look like they are in charge. Although he resents his professional standards being compromised, he makes the best of things for the sake of the patients.

*Dan Colley* was the youngest participant at 22 years old. He has just qualified and was working on an elderly care ward. He lived in hospital accommodation and was single. That evening the ward was full. Dan said most of the patients needed a lot of social work and emotional support to get them fit again. It was not just a case of getting them physically better.

Dan says he wanted to nurse because when he was growing up, he used to worry about social issues and how people were affected. He wanted to be able to help. His father was in one of the caring professions. Looking back, he thinks his parents brought him up to care about the world and human relationships. His family and friends thought his decision to nurse was a good one. He was shy and sensitive and the training turned him into a more confident person. He shows himself to be perceptive about relationships.

*Ann Trent* was the oldest of the nurses I spoke to, in her early forties. Ann was a sister on a medical ward and has been in charge for many years. The ward was full on the afternoon I spoke with her. As usual, the case-load was very mixed: there were people suffering with either diabetes, asthma, chronic obstructive airways disease, renal problems, epilepsy, Huntington's chorea or cardiac fibrillation. Two people were waiting for long term care beds.

Ann trained in 1963 as soon as there was a place. She always wanted to be a nurse. Her mother was a nurse and other relatives were nurses. Ann thinks her feelings were sparked because she was brought up to be considerate to others. Her father was not as pleased as her mother with her career because

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he thought it was a hard job. She thinks nursing, by making her mix with other people, brought her out of her shell and made her stand up for herself.

Ann says the pressures of her role as ward manager are building up and she feels frustrated that all she can usefully do is to carry on. The people in charge of ward areas are counted as a pair of hands doing the work at the same time as they are meant to be managing it. Staffing levels are below what they are fixed at and so nurses have to work harder and cut corners. On the other hand, they are criticised if they don't do the job properly because patients think they have paid for the NHS all these years and they don't like feeling cheated by what they see as poor care. Times are tough and patient care is suffering but she just soldiers on in the hope it will get better.

### *The Carers*

Mr White and his wife, Vera, are in their sixties. They were married in the war years and have a daughter. Mr White has been looking after Vera, since 1976, when the Alzheimers first manifested although it was not diagnosed for 4 years. Mr White was a bricklayer who turned builder. He says his hobby is laying bricks. He retired four times because he couldn't give it up. He would be asked to do important jobs like laying a marble floor for the church and he saw it as his mission in life. Then in the early stages of the illness, Vera had an accident at home and that was when he made up his mind to give up his career for her and care for her.

*Alzheimers is slow to progress but looking back, Mr White thinks there were stages. They loved their holidays and he bought a caravan so Vera could still go away. He made the alterations round the home so that she could get about more easily. A couple of years ago, she fell badly and went into hospital. She deteriorated there and Mr White had to work hard to put her back on her feet. After that time, she was afraid of hospitals and nurses. Gradually, her body became less and less easy for her to manage until in 1988, she collapsed again. After that, Vera was dependent on others for all her needs.*

*Mr White says he can still read Vera's feelings despite the disease-induced emotional states. He knows she is terrified of hospitals and is outraged at having to be washed and dressed by the nurses. He tries not to alarm her because if she is upset, her reactions can be violent. He has needed help for the last six months. The nurses come three times a day and he has had respite care too. Their daughter had found her mother's disintegration too painful to witness and he understood that she couldn't help him. He isn't happy with community care; the staff are poorly trained, lack the right experience, facilities and morale and are over-worked.*

*Mr Rice is married to Edna, they are in their early sixties and they have a son and daughter. The son still lives at home and plans to move. Mr Rice had worked as a chargehand at one of the car plants. Edna has had arthritis and psoriasis most of her life. The arthritis has got worse over the last 20 years. In the beginning, Mr Rice remembers helping with the shopping on Fridays when Edna couldn't lift weights and then the washing on Saturdays.*

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A dreadful catalogue of medical incidents altered their lives in 1980. Edna was having injections in her knees for the arthritis until the fatal one which triggered a massive skin reaction on her legs. Treatment made things worse and eventually, the leg had to be amputated. During this spell in hospital, for some reason Edna's jaw locked and although surgery restored the jaw, she could not bite or speak properly afterwards. Suddenly she was invalided. Mr Rice took early retirement to care for her and to run the household.

A few years later, Mr Rice needed surgery himself. By the time he had fully recovered a year later, Edna had been into hospital for respite care and the community nurses had taken over her care when she came home. During this time, Edna got very depressed and went downhill. Her spirits never recovered and her dejection, as much as her physical decline, upset Mr Rice.

The community nurses pop in twice a day. Over the years, Mr Rice has organised all the available facilities from social services very efficiently. Also, their daughter and the neighbours help out on a regular basis.

Mr Badger is married to Amy and they have two children, both married now. Nearly twenty years ago, when they were in their thirties, they were both in a car smash. Amy's injuries were horrific, causing paraplegia. Mr Badger suffered concussion and subsequently, he became clinically depressed. When Amy came out of hospital, they both had to learn how to adjust to the practicalities of daily living.

*Mr Badger planned their lives after the accident, so that Amy could live at home in comfort, he could take care of her, bring up the family and continue his career as a draughtsman. He took too much on himself and suffered a mental breakdown. After that, he retired (although he keeps a consultancy role) and he accepted offers to help with the caring.*

*Mr Badger supervises the care from the community nurses because he and Amy have developed a routine which they like to maintain. They have other help from home helps and community physiotherapists. Mr Badger thinks the problem with community care is the lack of staff training, experience and commitment; pressure of work and lack of interest in chronic care.*

*Mr Bibby and Connie had been together for almost thirty five years in 1991. They had a married daughter and a son who still lived at home. Mr Bibby was retired with a heart condition when Connie was taken ill in 1985. She was still working in a shop. It took twelve months, many brain scans and three consultants to diagnose what was wrong with Connie. In that year, her condition deteriorated in a frightening way.*

*At first, it seemed as if she had had a small stroke because her speech was slurred and her limbs were stiff. Then her emotions started to swing from on extreme to the other; she was severely depressed, then overtly sexual and then violent. Finally Mr and Mrs Bibby were told she had contracted a rare brain disease and had about 18 months to live. In hospital, Connie went downhill quickly and needed 24 hour nursing care at the bedside and drip feeding. Mr*

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Bibby made up his mind to look after her and brought her home. Two years later, at the end of 1987, Connie could no longer talk and a year later, all communication failed. In that time, Mr Bibby damaged himself through lifting and Connie went for respite care until he was better. The situation made him seriously depressed. When he recovered, the hospital sent Connie home with proper lifting equipment and since then, Mr Bibby has nursed her. He dreads her dying although he knows it must come soon.

The community nurses come twice a day. Over the years, they divided the nursing jobs various ways as Mr Bibby got used to things and became more adept at some jobs than the nurses. His son does the cooking and shopping, he does the washing, they share the cleaning and his daughter helps out. Mr Bibby remarks bitterly on the lack of tools to do the job with; basic things like incontinence pads, wipes, blue rolls and gloves let alone the technical equipment like beds, hoists, and suction machines.

Mr Gales and Rose have been married almost fifty years. They have two children. Mr Gales worked in an engineering firm before he retired. He is about 72 now. Rose has had multiple sclerosis for more than 35 years. Her condition has deteriorated very slowly. In the sixties, she could get around with a stick and a bit of help. Then she had an invalid car. Now Rose needs help with feeding, dressing, washing and toileting.

All this involves lifting her body about and Mr Gales points out that he is no spring chicken himself. Part of him wants some help, part of him is too proud

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to ask. The thing is, they are very successful at living a normal life and put themselves out for others - even putting on the family Christmas dinner. Rose says this is because her wheelchair was such an embarrassment in other people's houses and they'd rather have people come to them anyway.

Like the others, Mr Gales and Rose have got their own routine going. He runs the house, cooks the meals and looks after her. He has little help from the community nurses. Rose has been into hospital a few times and both of them are scathing about NHS care for the chronically ill. They sum up their feelings by observing that Carrtown Hospital has got no toilet facilities for disabled people and this is 1990.

**Ian Black** was 39 years old, single and an unskilled labourer. He had cared for his chronically ill mother on and off since 1974 when he was 23. His father was in his late seventies when his health gave way too. Suddenly the household was in a crisis with both parents sick and no-one to care for them. At the time, Ian was working for a security firm and he decided to give up the job to look after his parents. Some time after that, he became a Christian.

Ian's father was suffering from pleuresy, diabetes and asthma and he died a year or so later in 1990. Since then, Ian has looked after his mother. Her condition deteriorated slowly until she needed a wheelchair to get about. Both parents were incontinent and suffered regular chest infections. Sometimes they were too poorly to get up and needed constant nursing. Ian also ran the

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household, learned how to budget, cooked the meals, fetched the shopping and did the laundry. He got a pager so he could leave the house but stay in touch with them if they needed help.

There were 4 other children in the family living nearby. All of them had other commitments and did not offer much support, which led to rows. One brother came down to sit with his parents once a week so that Ian could go to the pub. Ian remembers angrily how little help there was from the state when he packed in his job. He didn't know where to turn to sort out the financial and community care sides and it was a very stressful time. Luckily someone put him in touch with a Carers Group who helped him to organise himself. Now he has bed linen services, some technical aids, a home help and the nurses come once a month to bath his mother.

*Penny Shaw* is in her mid thirties, single, and a qualified nurse. Her nursing career spanned 15 years and was very successful. Her last job had been overseas. She gave it up to come home and be with her parents when they were ill. Their lives changed in 1985 when Mrs Shaw was found to have Alzheimer's disease. At that time, she was about to retire from work and was living with her husband, a retired officer, in London. Then Mr Shaw was told that he had cancer. In 1987, they moved to Farmshire where their children lived.

Penny's original plan had been to buy a place nearby while she helped her father support her mother, whose condition was deteriorating quickly. It started with her forgetting words and her personal hygiene. Eventually her

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*behaviour became bizarre. Mr Shaw found it hard to cope. By the time Penny had organised help from community care services, her father was dying and so she lived with them and nursed them both. His death in 1989 hit her mother very hard. A year later she is close to death from a chest infection, unable to walk, talk or feed herself and also incontinent. Penny has to reconcile her professionalism with her wish for her mother to die quickly and peacefully.*

*The rush of events left Penny without money. She was ineligible for Invalid Care Allowance for 6 months because she had been working abroad. Nor did she qualify for Income Support because she had savings for the house deposit. However she was charged in full for Poll Tax. Penny acknowledges that she wears her nursing hat to get the things she needs to do the job. Voluntary carers come twice a day for an hour to help lift her mother and the community nurses come in the evening. There is a continence service. Voluntary services send someone to stay with Mrs Shaw 4 times a week so Penny can go out. Penny runs the house, does the shopping, the cooking and cleaning. Other family live roundabout and Penny tries to protect them from the upsetting details.*



## CARING FEELINGS

Part of the paradox of men caring are their feelings to care for others when western culture has feminised caring. This chapter seeks to explore the commitment to care among a small group of nurses and carers. Three biographies chart the caring careers of two men carers and a nurse, noting how their reasons for caring change over time and with the context of care. The studies show the basic reasons to go on caring prevail when they lose heart or when their current situation bears no relation to their original commitment. Of the five case studies completed in 1988, these three were chosen for the depth and range of feelings. The reasons for their commitment are explained by Heller's theory of feelings; more data from the second interviews with men and women is used in evidence. The men's caring experiences are examined in the light of the literature on women's caring role with some interesting results. First, it is argued that men and women do share the same caring values; it seems likely more women are compelled to care because of women-only dependency. Secondly, it is suggested men do 'men-only' emotion work to hide the very feelings that would show they care in order to preserve their authority as men. At the same time, men apply feminised definitions of caring of love and involvement.

## Biographies of Caring Feelings

### The Badgers

Mr Badger and his wife, Amy, were in a car crash in 1969 when they were in their thirties. Amy was in hospital for six months. She was a paraplegic. Jim suffered concussion and subsequently had bouts of serious depression. Straightaway, he acknowledges how clear he was about the implications of the accident and re-planned the home so that it was accessible for a wheelchair and still cosy. It is bright and spacious with a pretty view of the garden. *I wanted to preserve a home not a factory . . . She can go in any room. I didn't want her to feel barred from anywhere*.

He goes on to talk about their friends. It's like a smoothly rehearsed speech. He knew friendships would disengage. People didn't want to be involved even though they offered. "This is a long term thing. I didn't want people to feel trapped by an obligation to care". The role of his church was notable. *They came in committees to visit. It's alright. I understood*". It reflected their fear of involvement in someone else's private agony. Very few people understand the agonising consequences of watching someone you love suffer while you are helpless. It was difficult to go out alone . . . *"only half a social unit . . . afraid of being an imposition, don't want to be dependent but it is a reality . . . afraid of embarrassing others with the pain"*. For all these reasons, he doesn't go out now. "You switch off. There's no point making friends if you know they can't continue . . . It's okay if Amy's there. People respond differently then. The roles are normal even if it's an abnormal situation. People still expect things to be normal".

He had kept on working . . . *"I juggled my commitments to work and care"*. He had a nervous breakdown because he couldn't cope. Now he works part-time on a consultancy basis. *"I have to get out. I couldn't stand it otherwise. I think it's a mistake to give up work if all there is at home is more work"*.

He refers to what he calls the psychology of care and says there is a tacit arrangement between himself and Amy to draw a veil over the nature of their commitment. The important thing is not to hurt the other person. One's behaviour is refined; extreme sensitivity to the emotional needs of the other is second nature. *"Amy once mentioned that she had read an article where women like herself divorced their husbands, but I didn't pursue it. She never mentioned it again"*.

Abruptly he introduces sexuality, saying he wants to say this before Amy comes down. *"I think the most important thing that is overlooked is the sexual needs . . . It's a monastic life, not through choice. Like being in prison . . . behind bars and you can see what you want and you can't reach out and get it. No-one ever mentioned this to me [except one man from Stoke Mandeville who came to visit but he did not elaborate] . . . Acknowledgement is not possible because once you expose your needs and make them concrete, the other person is in a difficult position, helpless to help and distressed . . . Amy never talked about it . . . One is a prisoner of one's own moral code"*.

He talks about the nature of sacrifice. He didn't have holidays and little time for outside interests. *"I've not done half the things I intended . . . switched off in so many ways. It's a boring existence. People see it as worthwhile - an*

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*act of goodness - but it doesn't feel like that. There is no reward in nobility, People need to see suffering in heroic terms in order to make it palatable . . .*

He says that people's moral energy is so diminished they can't cope with making changes to their moral frameworks to allow for change . . .

0910-1130 on 01/09/1988

### The Whites

Mr White tells me about Vera, his wife. Vera has suffered from Alzheimers disease since about 1980 when she was almost sixty. It took four years to diagnose. Her condition is very slow to progress but he thinks it goes in stages of degeneration and he can tell in retrospect. He keeps a diary now so that he can look back. Vera worked as a typist and book-keeper. He says she was a pragmatist and a bit dogmatic with Victorian values. Whereas he likes a discussion, she preferred to stick to concrete matters.

Mr White was in the airforce during the war, then worked his way up in his own business from bricklayer to builder. His hobby is laying bricks. His last job was laying an immense marble floor for the church and he was very proud to have been asked. He gave up the job for Vera's sake. *I'm giving by nature. I've got to give love. Caring's not been a problem to me. It's my life. This is what I call Christian.* We talked about sacrifice but he didn't see it like that. He says he only lives one day at a time so it is difficult to think in terms of what he's lost. He hadn't planned his life either so *I don't feel robbed . . . but she's been cheated . . .* He feels angry for her that the world is so unjust.

Giving up work for the last time was a sacrifice, he muses. But it had not felt like a choice. Vera had an accident with the chip pan and burned her leg with fat. That day he made up his mind to give up the commission from the church. He talks about his *three day talking to*. First he had to get over the shock and then he had to adjust and organise. In the first stage of shock, *I felt as if I wasn't going to get through the day*. Then he used to go to bed willing himself to believe it would all look different in the morning. He distinguishes between physical and emotional shocks. There is no point crying over acts of God, if the house falls down or you lose all your money. Emotional shocks need *psychoanalysis from the inner self*. In the end, he decided he had merely swapped one mission for another. He went from working to caring for his wife.

*You're as one, It comes from within, It's not expected of you, It's not a chore*. The most important part of caring is to preserve Vera's dignity in degrading circumstances. He works hard to preserve an atmosphere that is slow, sure and secure. The most difficult thing is to guard his own boundaries against her helpless outbursts. He tries to keep himself in check but sometimes he cannot help reacting. *When you've just about had enough . . . don't push it. The stress is taking the butt of her aggression when you're trying to help*. The nurses come because he can no longer manage. It takes three to help in the morning and Vera is angered by her degradation. *In the past there has been violence, with blood . . . broken toilet seats . . .*

He imagined that younger men who were caring for their wives and had lost their sex lives would feel frustrated. He felt it was no great loss himself but then

he was in his seventies. *Well what they say is true for me; if you don't use it it wears out.*

His daughter was not able to cope with Vera's disintegration. He was sensitive to other people's embarrassment and guilt. *Some people can't face up to all that suffering and pain* he says, so it is kinder to put them out of their misery by relieving them of the obligation so they have the freedom to choose.

0920-1220 on 08/09/1988

### **Charge Nurse Tooley**

I came on the ward at 1750 just when two relatives were leaving the bedside of a man returned from neuro-surgery. The woman was saying, *"I'm sorry about before , , I've never been in Intensive Care before , , It's such a shock"*. Charge Nurse has his hand on her shoulder, makes appropriate comforting noises. She says, *I don't think he knows I'm here , ,* to which he replies, he is sure he did. He arranges she will come back next day. This exchange takes two minutes standing up in the middle of the ward.

This is Neuro Intensive Care. There are 8 beds, 8 patients and 5 staff. Charge Nurse has already changed shifts to cover the ward. Immediately he comments on the staffing crisis. All his staff today have been poached from other areas. He has two SENs - one from neuroward and one from an agency who hasn't done neuro for two years; a student nurse and a pupil on her second ward experience. The unit is full because the consultants are fighting to justify the need for the it. The criteria for admission have been jettisoned to keep the place full.

1755: He goes to answer the telephone. A surgeon in theatre dress arrives and wants a patient file which Tim gets while still on the phone. Then he goes to put a drip on a patient in isolation. At 1800 he helps the SEN prepare a pre-operative donor patient for theatre . . . *"His brain stem cell tests were negative so he can go . . ."* At 1805 he offers sweets around. The vicar comes on the ward, and they stand in the middle, talking intently. Afterwards, he says the vicar is concerned about the patient back from surgery (his family are worried the local parish priest will come to conduct a laying on of hands, and want him barred). Meanwhile two surgeons arrive to consult him on two different patients and there are detailed information exchanges.

1812: He answers another call from the relatives. The pupil is worried because her patient won't eat. Tim goes to see him. He stands at the bottom of the bed and says cheerfully, *"David! Stop harassing this poor young girl!"* Then he issues detailed instructions about Fortanel as a replacement meal. He tries to coax David to explain himself. David says, *"I'm tired. Hungry. Angry"*. An exchange follows, with Tim trying to pinpoint how oriented David is. He leans over the bed intent on the answer, but David is struggling to connect and he fails. Tim cajoles but to no avail.

1820: He goes to tell Evelyn about an earlier call and gets down on the floor by the bed. *"Maira called to say hello"*. She struggles to respond on paper. He assists with slow calm deliberateness. Eventually he says, *"I am sorry Evelyn but I can't get what you're after"*. I see scrawling across the page.

1822: The porter arrives to collect Ken the donor patient but cannot leave without an anaesthetist and so Tim rings theatre to organise one. He tells the SEN five minutes and checks the trolley.

1825: He goes back to Evelyn and draws the curtain. He talks her through each procedure (she is intubated) and since the pupil is with him, he explains what he is doing. This means I hear a running commentary on the other side of the curtain. They turn her over and intend to suck her airways out because she has pneumonia. An alarm sounds so Tim checks all the leads on the machines. Meanwhile another doctor wanders in looking for him, realises he is behind the curtain, goes to see a patient and then leaves. The two anaesthetists turn up to take Ken to theatre. The telephone rings and Tim leaves the cubicle to answer it. He goes back to Evelyn to complete suction and teaches the pupil when he realises by judicious questioning that she doesn't understand suction. His asides to Evelyn are tender, *"I'll just wipe off your mouth now"*.

1835: A doctor arrives to discuss Ken. Snippets of the conversation are about Papworth . . . *who want the heart and lungs - they've come in a car - I heard him give instructions - usually it's the helicopter . . . Newcastle are interested"*.

Tim goes to the desk to do the drugs and starts sorting out the breaks. The SEN comes to ask for help with the patient in isolation and the pupil returns with information about David's food intake and receives more instructions. At this point, Tim tells me about the two cases hidden from view. One man has a cerebral abscess (he has had ventriculitis which has a 95% morbidity rate but he made an uneventful recovery. His sister visits each day and when she didn't turn up one



day, Tim noticed and asked her time if everything was alright. Yes she said, she was fine, but she had been very busy selling her brother's flat and auctioning his belongings). He shrugs and disappears into isolation.

1838: The fire alarm sounds and Tim comes out from isolation to shut down the area, saying that's all he needs. The SEN comes back from theatre and he greets her with 'Thank God you're back!!' (because the lift stops when the alarm goes off). He continues to dispense drugs while talking to the SEN about breaks. He is making up antibiotic doses and at the same time he directs the SEN who is clearing Ken's bay and doesn't know where to put things.

1855: Tim dashes to the canteen. He returns with a Cadbury's Flake, two bags of crisps and a can of orange. He comes into the office, takes off his coat and says, *"I'm coming into tomorrow to have a moan at my DNS . . . I don't know if it'll achieve anything, but it will make me feel better"*. I ask why he continues if it's so bad? He sits down, rubs his hands over his face in what looks like weary desperation . . . *"Don't know, I just don't know"*. He talks more about staffing problems. Three staff are on long term sick leave (two in psychiatric care) and one is on short term sick leave. Only seven permanent staff were left to cover fourteen duties plus their time off and holidays. Asked to describe his priorities, he says, *"Minimum intervention with maximum support"*. This is so glib I ask for details. *"I don't know . . . I can't do my job anymore, I can't be with people, I can't look after my staff, I had ten minutes standing up with the relatives for that donor patient this afternoon, If I was doing my job properly I'd have sat down with them in the office and gone through it with them. That pupil nurse - it's her second ward. She needs support I can't give her"*.

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1910: The SEN pops in to say Ken's brother is in the relatives room, having arrived from Jersey too late to see him before he went to theatre. It is a difficult situation and Tim goes out quickly. In the event, the brother is too shocked to say much and leaves. Tim has trouble persuading him not to return to see the body without naming the gruesome details (*"They make such a mess . . . they may take the eyes for corneal grafts and sometimes take the skin"*) This patient had a massive intercerebral bleed after swimming.

1935: He puts equipment away. The phone goes with another relative's inquiry. I ask him about his background while he writes the kardexes and the ward report. He hadn't expected to end up in critical care . . . *"It's not my forte but they froze the rotation of Sisters . . . mind you, the wards are just as busy so I would be in the same position out there. I wouldn't have time to do the job which is more than just tending to physical needs I think. There are other things"*.

He had no plan as such and things happened in a haphazard way with the only consistent thread being his conviction to nurse. He had one A level but in those days there were waiting lists to get in! Everyone in ear shot laughs. He was accident prone as a child, and in and out of hospital. He had a car smash and was in ITU, so he knew about nursing first hand. He wanted to help people himself. It was a childhood ideal . . . *"Save the world, that sort of thing"*. He supposed he was The Little Helper when he started. *"You begin to realise it's not what you - one individual can do to help - but the team. You are dispensable"*. He talks about the political naivety of nurses who start training with vocational values. They don't realise the political implications of what they do; they are not realists. He had wanted to change things by being a ward

nurse but realised that it would be by teaching nurses and motivating them that he could effect change . . .

1750-2145 on 29/09/1988

*"I was fully aware of the drawbacks. I just wanted job satisfaction - the chance to usefully help people, both individually and structurally. If I'd been materially oriented, then I'd have had the sense not to come into it. I have what I want at this income so money is not a big problem to me. If I had my time again, I wouldn't be a nurse . . . I can't do my job. This is not a job to be doing half heartedly. I regret my job because I can't do it properly. I've set myself on course for a career that I am not happy with. I haven't the nerve to change tack. I've just got married and bought a house so we need the money. I feel trapped. It's just a job now".*

1430-1515 on 05/10/1988

### **The Commitment to Care**

These stories from the men carers and nurse describe the history and context of their caring feelings. Reading them, it seems that commitment crystallises around early feelings and beliefs that can fracture and change under pressure or under duress. Their reasons for commitment form a touchstone that prompts the daily task of caring work. Heller's ideas help to explain the men's experience of enduring other feelings for a feeling they value and honour more, sometimes for a life-time. In the second lot of interviews, I was interested in the reasons that hold people to their task in critical times because they constitute the "bottom line" for continuing to care. The men and women gave

two kinds of reasons that are also identified by Heller's theory of feelings: public values and private feelings.

First, both the nurses and carers acknowledge the jural frameworks that prescribe the commitment to care - or proscribe the desertion of duty - that both groups felt important to honour in order to protect their moral reputation. Remember jural values are public, explicit and unconditional. They talk about their codes of conduct - the UKCC Professional Code of Conduct for nurses and the marriage vows for married carers. Nurses are legally accountable for their actions to their professional body and their employer.

What stops me going off home if I don't feel like working is because I know I've got to be here today basically. I think I'd do the job in the same fashion but I am not as caring as I usually am. Just do it all professional, bw, bw, bw. Professionally speaking, I am the ward manager. And I am responsible for the patients and nurses on the ward. The UKCC would have something to say if I decided to leave! I always said that if nursing ever got to the stage where it was a chore, coming every day, day in day out, then I would consider leaving. I don't think it's fair on everybody else. Charge Nurse Tanner

Married carers face social sanctions because desertion or divorce of a dependent partner is viewed as an amoral act.

There's doing it [walking out] and thinking it's abhorrent for anyone else to do it. Well perhaps right at the beginning I've said, 'No I don't want that job'. But my heart's grown up with it. There's no turning back. Mr Gales

Second, both nurses and carers said there are moral reasons for their commitment. Morality is the private, unspoken and unconditional domain of feeling and stops where prescription begins. These people could not conscience deserting someone dependent on them for help just to live and put the moral entitlement of others above their own needs.

What stops me going off home . . . is that I have a responsibility to the ward . . . I am accountable, legally to the ward and to the Code of Conduct. Morally I am responsible to the patient and my colleagues. Junior Staff Nurse Colley

People come in here who've put a lot of trust in you. If you don't do your best then you're misusing that trust. They're letting you do things to them that they wouldn't let the milkman or Joe Bloggs do to them. Senior Staff Nurse

Because there is somebody lying in the bed that is probably helpless, and wouldn't have anybody to look after them if you did [walk off]. My conscience wouldn't let me. And to be honest, I don't think it would be a good thing if the boss walked off the job! Sister Trent

[It's] Probably a good heart. I've felt like walking out but there's no way I'd ever do it. I wouldn't go to Malta when I could because of them. I knew if I didn't care for them it wouldn't be what I wanted. Ian Black

Well it all stems back to the fact you might get fed up sometimes. That's your feelings conflicting with what you're doing. But you know you're not going to pack it in. It's just irrelevant. You just carry on. Basically because you've always carried on. You know you're not going to leave that person. Love or whatever you want to say. You're married. I can't tell what you'd feel like caring for someone else. We're talking about a husband and wife relationship here . . . a male and a female. It's not just the length of time you had to get used to doing what you're doing, but the history of the relationship that went before. Caring is always there. I might walk out the door but I know I've got to come back. Knowing she can't manage. I've got to come back. I can't walk out . . . Mr Gales

The debates about inequalities in nursing and the feminist critique of caring suggest men have an economic interest to refuse to care in the first place or to continue to care once they have invested in the role. However, the nurses I spoke to believe this is less important than their moral feelings about caring. When their feelings are threatened for whatever reason, they question their reasons for staying in the job, regardless of the economics.

I was fully aware of the drawbacks. I just wanted job satisfaction - the chance to usefully help people, both individually and structurally. If I'd been materially oriented, then I'd have had the sense not to come into it. I have what I want at this income so money is not a big problem to me. If I had my time again, I wouldn't be a nurse . . . I can't do my job. This is not a job to be doing half heartedly. I regret my job because I can't do it properly. I've set myself on course for a career I am not happy with. I haven't the nerve to change tack. I've just got married and bought a house so we need the money. I feel trapped. It's just a job now. Charge Nurse Tooley

There are people who haven't the right attitude to be a nurse. The feeling isn't there behind what they do. They are doing it as a job rather than because they want to. I know money does come into it at the end of the day. I wouldn't do it for nothing. But for some people it's a chore to come to work. They do it because they have to. They arrive because they have to and they are pleased as

punch when they go home. I think you have to want to be a nurse. It's not the sort of job you do because you can't think of anything else to do at the time.  
Charge Nurse Tanner

I started with a great deal of idealism. I thought the NHS was the best thing since sliced bread . . . that nursing was the most wonderful career. A lot of that has changed . . . I suppose you become cynical . . . hardened. It's not the everyday experiences . . . it's not dealing with death, dealing with pain, it's not dealing with distress or worry or anxiety. It's not that because my feelings on that have never changed - I think if they did I'd leave the job tomorrow. It's the system really. I think nurses get a pretty raw deal. It makes you a bit bitter to be honest . . . That would sum it all up. My feelings towards caring have not changed at all - it's very worthwhile and important - I still like to think I've got a lot to give in terms of caring for people. But nursing as a profession . . . as a career, I think my ideas towards that have changed considerably in the last three years. Student Nurse Evans

Two of the men carers were sustained in their work by their sense of faith.

I want to do the job because you know you're achieving something. You're making them happy. What I say is, you're doing God's work. I shouldn't think, 'Why me?' God's made me special so I can look after them. Yes [I am a Christian] ever since they got ill, three or four years ago. It's a big motivation. It's mainly faith. My faith became strong when I left work. I had more time to think about it. It was alive before. I knew whatever happened that I would be okay. It's like getting a seed. Putting a seed on a plate. My faith was there before. But when I left work, I poured water on the seed, and it started to grow and ever since then the faith has been growing. Ian Black

This is a tentative sketch of some reasons that people give for caring for others. Their views fit with Heller's explanation of feelings. First of all, there is a multi-level ordering of feeling. The men and women resist the desire to desert their commitment for two powerful reasons. They stress they value moral feelings more than any conflicting desires - for sex, money, status, freedom or simply for relief from punitive stress. Also they value their moral reputation that is measured by their public actions (Finch & Mason 1993). Heller suggests morality is the highest condition of feeling and creates the possibility of sovereign existence, for people endure other feelings for one they value above all else. More commonly, she believes that people's feelings are prescribed by public values that regulate a social task

such as caring. A few individuals stand up for what they believe in. Then their actions and meanings become the diluted meanings of the many who copy the act. Feelings crystallise as a set of values that are known and understood by other people who share them publicly. If they are required to act on their values, they evoke moral feelings that strengthen their public resolve. The participants perceive that their caring feelings are anchored by their morality as well as their public reputation, which is measured by commonly accepted values and professional codes of conduct.

As discussed in Chapter Three, previous theories of caring did not balance people's views of their commitment with structural explanations for the caring act. Heller's ideas allow for the intricate patterning of human feeling and public values that shape caring labour over time. On the one hand, the participants chart the complex relationship between feelings and purpose that motivate caring for another person over time and on the other, they admit they act out feelings that fit the socially prescribed values for their situation. Finch & Mason (1993) suggest that the commitment to care comes from recognising that withdrawing from the arrangement would damage the moral reputation of carer. From this small exploratory study of (mostly) men's caring feelings, it seems people experience moral feelings that grace their caring responsibilities even though at low points, they may feel there is little choice but to go on with the role from day to day so they don't lose face.

Finally, these findings are more evidence that the sexes do share the same values about caring commitments in the home and in the workplace and support

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the more substantial research of Finch & Mason (1993). The next section examines the feminist literature about women who are compelled to care, in contrast to the above biographies of men who deliberately chose the caring role. This exercise seeks to explore differences between the feelings that motivate men and women to care and the conditions that structure women's caring roles.

### **The Compassion Trap**

At the heart of the theoretical debate about gender relations in caring is the dichotomy of structural explanations versus human agency (see the discussion in Appendix Three). Do people choose to care or is their choice made for them by the conspiracy of social forces in their lives? Freedom to choose to give or not to give is the hallmark of the gift relationship (Titmuss 1970). The arguments summed up in the epigram "the compassion trap" are that women are not free to choose whether to give their care, because they are propelled by other's expectations that they will. Woman's caring role is problematised by power relationships that take away her choice to give freely.

While the stories above show that men and women share the same moral order of caring values, women's lives tend to be permeated by inequalities of power that keep them in dependent caring roles. As I showed in Chapter Two, the men nurses and carers readily acknowledge beliefs about women's work. Their views substantiate the feminist theories about the beliefs that encapsulate women's domestic role and highlight their own role reversal in 'women's world'.



Adams article, 'The Compassion Trap' (1971), is a classic piece of writing that describes the conversion of women's sex role "as reservoirs of protective and nurturing resources" (p. 557) to work roles "in the so-called helping professions" in the twentieth century (Reverby, 1987, James 1989). She argued that the compassion trap is constructed by the false extension of biological imperatives about the female sex to their social role. The naturalisation of women's caring feelings is embedded in a belief system that precribes how women should feel and these feelings compel them to work for vulnerable others in society.

Both family and professional commitments incorporate the insidious notion that the needs, demands and difficulties of other people should be woman's major, if not exclusive, concern and that meeting these must take precedence over all other claims (p. 559)

Adams said the compassion trap was an anachronism in modern society and that women should be able to select their roles, rather than submit to the social conscription to care because they don't know another way. Yet the capacity to select one's career in life supposes autonomy, financial independence, and emotional self sufficiency - achievements still beyond most women a decade later (Waerness 1984, Ve 1984, Graham 1983, 84, 85, Ungerson 1987).

Arber and Gilbert (1991) quantify dependency for men and women born before 1920 in terms of material resources, health and access to care. Distressingly, they show marked inequalities in women's dependency levels compared to men's. Inequalities of income, assets, subjective health status, disability, sources of domestic and personal support and institutional care are evidence of the cumulative results of this generation's dependency over a life-time.

Land and Rose (1985) embrace Ve's work on negative reciprocity in their essay, 'Compulsory Altruism' (1). They too, argue that women's caring role is characterised by dependency. Women are wrongly cast as care-givers because of the false imperative of biology that determines their socialisation. Women carers are economically and emotionally dependent on those served, whether the working relationship is in the private or public sphere. Not only do women feel compelled to care, because they have internalised false beliefs about appropriate caring behaviours, but they are forced by economic and social dependency into caring roles. They suggest that women who care are prisoners both of their compulsive feelings and a compulsory social order:

Titmuss (1970) demonstrated that for the gift [of donated blood] to be safe, that is non-injurious to the recipient, it had to be freely given. What is true for the gift of blood is even more true for the complex and enduring task of caring for another person. For women to be free not to give as well as to give requires that there are good alternative services. Only then will they not feel that they have no choice but to sacrifice themselves for another . . . (1985 : 93)

Dalley writes, "Women have internalised the altruistic ideal; society has capitalised on it" (1988: 18). She suggests the ideologies of familialism and possessive individualism rehearse beliefs about the caring role of women and the social structures of family and state re-inforce them.

Some two decades after Adams wrote 'The Compassion Trap', the trap still exists although our understanding is different now with changes in the discourse. The word caring represents and rehearses the feelings that are assumed to be women's prerogative and has resulted in the feminisation of caring relations. The language of caring beliefs extends its inequitable meaning wherever there is space for the information - including the feminist discourse. Everyday institutions - families, churches, hospitals, schools,

offices - in which the everyday world of caring activities is embedded re-inforce the feminisation of caring. Biological and cultural imperatives for women's role colonise women's minds, so some believe they have a duty to care for others. The moralising cant about women caring is internalised by some women as psychological justification for performing the role. For all these reasons, women's freedom to choose to care is collapsed by the manifold pressures that conscript their sex to the caring role. The final inequity of the compassion trap is that women who somehow afford themselves the conscious choice not to perform the role may be perceived as socially and sexually deviant by denying their 'natural' feelings as well as morally wrong by rejecting public values.

### **The Paradox of Men with Caring Feelings**

In a second twist of appearances, the men and women emphasise love or involvement as the most important part of caring (Noddings 1984, Ungerson 1987) (5). The feminised definition of care emphasises feelings - love, emotional intimacy and relating - for another person which are expressed by the display of shared emotion. Yet, in another part of the interview, without exception both sexes accept that the usual etiquette is for men to hide their feelings. The following excerpts show the shared understanding between men and women that feeling is the most important of caring:

#### **Senior Staff Nurse Wright**

*I think one of the most important parts of caring is showing by actions, not by words . . . that you're caring for the person. Being there, not just for the*

medical thing, showing you are giving an interest. If you do show that, you get a feedback from the patient and it motivates you to carry on. There's a lady last night who wasn't very well at all. We didn't think she was going to make it through the night. She had persistent falls. And yesterday she started having a lot of abdominal pain. She was admitted yesterday. Then all of a sudden, she started passing fresh haematuria . . . Not very well at all. She was 92 and scared of what was going on. She knew she was passing this nasty stuff. She was getting worried. She thought she was going to die. I was on last night, and made sure somebody was always there. I kept looking in . . . If the son was away, someone was with her. Not doing anything physically. Just being there, sitting there . . . You know, if she's in pain? And talking to her about her family. We were doing her pulse and blood pressure every half hour. Taking her mind off things. It's being involved . . . Being involved you get a relationship with somebody. You get that trust. They open up to you a bit more. It helps, if somebody is a bit anxious and not too sure about what's going on. You show you are interested in them. You build a relationship with them. If they come back in again, that relationship is still there and you don't start from scratch again.

### Charge Nurse Tanner

The most important part of caring . . . is generally to be yourself. To be very friendly and take your time to let them get to know you. And treat everybody as an individual . . . We've got this one little lady. She faecally contaminates her hands and is very upset about it . . . she doesn't know why she does it. Little things like that. Just talk to them. Understanding their problems really. Talking. Being a friend to them . . . I have worked with people in the past . . .

*the patients look at you, you know . . . I'd want to ask the ward sister if I could talk to them. But they only talk to them if they want [something], like 'Can I have this?' 'Can I have that?' Not as a friend. That's not the way I like to do things. I like patients to call me by my Christian name. You get a better rapport with them and their family. It's best for them to see a friendly person, rather than be somebody [prim] who storms about in an apron. Reading the research, it says the people who communicate most with patients are the domestics and the first years. Well I've thought about that. I've made it my personal goal to be friendly.*

### **Ian Black**

*Making sure they're comfortable. As long as they are happy, I am happy. If they're in pain, it's as bad as if I'm in pain. If I can relieve them. That's the main objective. It doesn't matter how much pain I go through. In time - it doesn't matter what carers or how much you love them - they're going to lose them. You're caring for them because they're ill. Until then, as long as they are content. Everyone could see when they was content and everything was going right because I was happy. My discontent was when I was treating them with drugs and they weren't responding. I know I only administer them. But I was trying to do as much as I could. But it wasn't getting anywhere. Blind alley job again. Fighting twenty four hours a day to look after them and they aren't responding. That's soul destroying. I can take alot of work. If I'm happy, any amount of work I can do. It's your feelings.*

**Mr Gales**

*[It's a] willingness to do it . . . Well the fact is if you don't do it, the person you're looking after is . . . I don't think you'd get this sort of caring in a paid way. It's got to be a wife from her husband, or vice versa, or a son or a daughter. You've got to have love there. How you define love. You've got to have that wanting to, because of how they are. You couldn't do it for anyone else. You might do it as a kindness or a charitable act. But you'd never carry on year after year unless there was something there. You might joke about it and say there isn't. Some way never admit it. But you wouldn't carry on. Even though it gets to be an accepted way of life.*

**Penny Shaw**

*If you are going to do the job properly, you've got to have a good relationship with the person you're caring for. I think that is vital. It has been in my experience. Otherwise I don't think you can do it. There's no financial reward. If it's somebody you don't love them there is a real danger of abusing that person if they are dependent.*

These accounts answer questions about the most important part of caring. Of course their feelings are mediated by the history of the kin relationship or the circumstances of involvement with the patient. The quotes point to a shared understanding that caring is about involvement with another person. Yet the reminiscence of care that favours meanings about relationships and emotional intimacies with others is conflicted by social etiquette for men to hide their feelings and women to show them. Yes the stories of the men and

woman nurses and carers are crossed by other explanations about why they don't show their feelings and are discussed in the next chapter under emotion work. However, the following excerpts refer unambiguously to beliefs about emotion work and sexual identity.

### Charge Nurse Tanner

*Normally it's very difficult with a male relative to know whether to approach them and hug them. You think, 'Is this what they want?' . . . Normally I sit there and stroke their arm. I don't hug them . . . If it's a female relative, quite often I've hugged them anyway. But you don't know if a man would want to, because I think it's still 'The Stiff Upper Lip, I'll be Alright' sort of thing. I've only once or twice seen a man cry . . . You can see them bottling it up . . . They're off before you can say or do anything . . .*

*Men do feel as if they've got to cope. It's still taboo for men to cry. I think it's better than it was. I haven't been nursing that long. But I've seen a change. Men are more ready to cry than they were. But I still think they wait until they get home or they are on their own . . . I don't show [relatives] tears because I'm not that sort of person anyway. I don't show tears. If it was in my character I would do. But I've never been the sort of person to cry in front of people. I've been the one to sneak outside - support everyone else first - and then cry in a corner.*

### Mr Gales

*Well I think men do hide their feelings. Sometimes it might come out. No-one's infallible. But on the whole I think they do. Perhaps I'm old fashioned and*

*think women are the weaker sex. In a way, [it's a sign of strength], You're holding back. You might feel like giving way. Sometimes you get to the pitch you've got to let to go. It's a safety valve. But you'll be on your own.*

**Ian Black**

*It's an act of caring [to hide ne feelings]. Me dad knew I was dying. I didn't give any emotion to him. Only on the last but one day. I showed my feelings then. He'd drifted away that much he didn't realise. I would rather go upstairs and have a cry than be upset in front of him. I was thinking if I'm strong, he'll be strong. The last time he went into hospital he knew. There were things he told me. I can't say it. That's life isn't it. We've got to keep on smiling.*

**Sister Trent**

*I think that everybody thinks that males shouldn't cry. They are masculine and they shouldn't show their emotions. They are superior to females. We are all human beings. We all have the same feelings. I think they should be able to express them more. Oh yes [I put my arms around men too]. Yes [I've seen men cry]. I don't think there's anything to be ashamed of. We should all be able to express our feelings regardless of what sex you are. When I first started training we didn't have any men. I've never seen a male nurse cry. I have known times when they've been upset. But they actually try to cover their feelings up. But we don't have - although there's alot more around - that many coming to the ward.*



*I think patients have got a lot to learn. We still have to protect our males to a certain extent. One of the guys we've got on the ward at the moment, only a young student. He said to me, 'What about chaperoning?' I said to him, 'Look, if any of these women come on to you, just walk out. But better still, don't go and do anything for a woman without one of the others - a female - being with you'. Especially with our adolescent female diabetics, getting crushes on the men, we do have to be careful with them because it can be very embarrassing for the men. We as females have got to protect them from female patients - or the female nurses! There again, even if they're up this end of the ward and you've got somebody being funny down the other, I think you know you've got a male . . . somebody . . . you can call. If you get somebody who's stroppy and they see a male, it calms them down. In that respect they offer us a degree of protection.*

*I think the patients do see men as authoritative. I would say yes, everybody does. Because they come round in a white coat and they think automatically they are a doctor. We just laugh. We go and tell 'Dr Smith' to sort out Mrs So and So. They take it in very good part. Yes they do see males as more authoritative.*

There are two twists in the stories from the nurses and carers about their caring feelings and sexual status. First, the men discuss the moral feeling that motivates their caring role. At the same time they all admit public beliefs that endorse women for caring roles. It was clear from Chapter Two that the men carers accept the sexism and some even acknowledge their thinking is sexist. The men nurses discuss sexist beliefs about women's

caring roles although they do not share them, mostly because they recognise that sexism is not in their best interests, their female colleagues or their profession. It seems that men and women share an understanding of the moral feelings that motivate caring for others, but only women are the target of social pressures to assume caring roles as the literature suggests (Finch 1993). Second, men and women's shared understanding of caring is that - at its most basic - it means involvement with another person. It is a typically feminised definition of caring that locks women in and men out of caring roles. Whereas women are permitted emotional display that suggests and perhaps supports involvement with another, men are more ambivalent about letting their caring feelings show in case they undermine the authority that is imputed to their sex. This is shown by stories from the men and woman that discuss the sexist beliefs that endorse tougher performances from men to gain and sustain authority in the caring role. The men appear to filter the emotional act of caring through their moral feelings and their beliefs about their sexual status as men (Hochschild 1983).

### **Conclusion**

Men who show their caring feelings challenge convention. Women, feelings and caring roles are spun together by wrong beliefs that both compose and confirm biology, ideology and social structures. As I argued in Chapter Three, the identification of women with feelings only compounds their inequality in a male dominated world but it also creates the paradox of men with caring feelings who were equal with other men until they made themselves different.

When the nurses and carers discuss feelings of commitment, they expose both the gift and the grudge of giving (2) that is hidden in women's world by the conflation of sex, feelings and work roles. The men can enjoy the freedom to choose to give out of feeling, a freedom afforded by male power, whereas potentially, women are trapped into caring roles by the powerlessness of their sex but which their caring feelings are meant to justify. Thus men enjoy the sense of giving care (until they feel trapped) whereas women do not want to perform the role conferred on their sex (unless they can choose). The women - who feel they have no choice but to care - do not dare admit their feelings to others for shame of being blamed as a grudge and if they admit things to themselves they feel guilty as charged.

When the participants identify the most important part of caring as involvement, they are identifying with the subordinate and contextual world of connectedness, relationships and emotional intimacies that the feminist debate understands as caring. The men unwittingly challenge the politics of feminist separatism that makes women the epistemic arbiters of caring - a strategy that I argued against in Chapter Three. What separates the caring act of men and women is not their values but the different sexual status. The emotional etiquettes for both sexes are underpinned by gender and power relationships. On the one hand, men are distanced from caring because it contradicts the authoritative status of their sex and on the other, women are pulled into caring because of the 'compassion trap'. The differences in language, beliefs, feelings and work roles that represent inequalities between the sexes are not immutable. There are no absolute barriers between the sexes - only bridges to

be built that can challenge the inequalities of power between the sexes which are exploited by the present politics of care.

**Footnotes**

1. Ve's work, based on Sahlin's (1965) anthropological accounts of recipricosity, describes three categories of women's care-giving: generalised recipricosity (no expectation of return); balanced recipricosity (the cost and return on effort is calculated); and negative recipricosity (the exchange is marked by exploitation of the dependent partner).

2. When Professor Margaret Archer read some of the interviews, she spotted expressions of what she called the 'gift and the grudge' and which I have used here, thank you.

**PAGE**

**NUMBERING**

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## CARING WORK

This chapter is about the men's accounts of their caring work. Reading the transcripts, it struck me that the men's images of 'emotion work' and 'dirty work' are particularly startling. Why is this? The skills and knowledge for caring work are buried by wrong beliefs that fuse women, feelings and bodies in a biological lump. Emotion work and dirty work are naturalised jobs for women; the caring work role rehearses the imperatives of biology, ideology and structure and preserves the powerlessness of their sex. When men do caring work, the socially prescribed authority of their sex makes a vivid contrast with the apparently valueless world they occupy, that is the unpaid or low paid, sometimes taboo and generally invisible work in women's world.

Naming invisible aspects of caring 'work' is problematic, since the word 'work' usually applies in the context of visible paid labour in the male dominated workplace and is loaded with economic and cultural messages. The metaphorical extensions are unavoidable in the context of invisible unpaid labour in the domestic sphere. In that sense, the construct of work is about as useful as a fork to eat soup. In our culture, the imperial meaning of work is the value of

that expertise on the job market. Paid work equates with visible effort that commands a price for making a product that constitutes business. Without 'work', the person loses one way of identifying themselves in terms of skills, status and power (Wadel 1979, Stacey 1981) (1).

Wadel argues that Western culture has a lop-sided concept of work that identifies and measures 'value' by jobs on the market. Whereas some societies lack the possibilities to measure economic value, they are rich in conventions for measuring social values that ours cannot. There, work is constructed as an act which is indistinguishable from the social relation that invokes it. Wadel suggests that work should be re-conceptualised in social theory as a potential aspect of all social relations. From the standpoint of the economist, caring work is non-economic and therefore irrelevant unless it commands a price as a job in the workplace. From Wadel's standpoint, caring work is prescribed by the conventions of social relations. However, Wadel's theory lacks an appreciation of power let alone the logic of its application that results in the deletion from the frame that prescribes the value of paid work of certain types of work - for example, caring work.

The deletion of caring work has two possible causes in theory: the power of capitalism and of patriarchy. Strategies of production and consumption in the family transmit themselves across the generations and give rise to individuation in terms of race, class and gender. The production of people - reproducing them, caring for them, teaching them etc. - derives the potential labour power for the mode of production (Murgatroy 1985). With the advent of capitalism, work for profit was leached out of the home, leaving residual

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domestic labour. In her ingenious essay, 'Overcoming the Two Adams' (1981) Stacey also explains that there is no adequate framework to help us understand what she calls 'people work' because social theories construct work as paid work in the public (ie. identified with men) domain. As we have already seen, reproductive work in the home - identified with women, feelings, caring and bodies - has been locked out of male dominated social science. In order to rescue this work in theory, Stacey proposes re-constructing work as a process of interaction between people rather than a unit of economic activity. However, Stacey is aware of the politics behind the construction of meanings for work. She suggests that mapping the hidden world of people work should be part of the feminist strategy to uncover this fundamental division of labour between the sexes:

Never shall we be able to understand the social processes going on around us so long as we tacitly or overtly deny the part played by the givers and receivers of care and service, the victims of socialisation processes, the unpaid labourers in the processes of production and reproduction (1981)

The gap in social theory that cannot conceptualise relationships between reproductive and productive work has serious repercussions in social policy today and underlines the importance of the debate. Ungerson (1990) points out that the British distinguish between formal and informal care. Informal care takes place in the home and is a one to one relationship guided by kinship ties and commitment to care for the relative in need. Formal care implies that care takes place in the public sphere with paid labour organised economically to meet specified needs of the sick, frail and vulnerable. Informal care is attributed with moral value which makes it *better work* than formal care which is not freely given (that is, the visible work is paid for). The problem for social policy is that there is no measuring stick to

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conceptualise both areas of work for planning a mixed market of community care except money. But paying the carer and the health worker to look after the same person appears to devalue the carer's moral reputation to give freely and the professional skills of the health worker. Qureshi (1990) describes a community care scheme that experimented with making small payments to 'helpers'. The ideal of caring relationships between the elderly persons and paid and committed helpers was matched by more awkward relationships because for example, the strength of moral feelings to care for one conflicted with an organised economy of paid labour to care for many.

Star's 'The Invisibility of Work' (1990) was written in honour of Anselm Strauss who taught her.

Finding the silent blueprint to life means looking in areas of darkness. Anselm's maxim for this, said in gentle tones to all of us students looking for the right focus in a welter of visibles and invisibles, was simply "Study the unstudied". Look at the things other social scientists have forgotten, the things they consider unimportant, the things behind the scenes - and you're likely to find some important deleted work (1990: 2).

Star describes some methodological rules of thumb for the "sociology of the invisible", as she calls it, based on the work of Glaser and Strauss and her own thinking. Her ideas are relevant here because they speak to me about the feminist task of restoring the deleted world of caring work. Like Stacey, Star pleads for the researcher to stay awake to the mechanisms of power that shape the deletion they are investigating - in my case, the subordination of women to perform caring work. Star's last methodological rule of thumb is The Rule of Invisibility. In order to bury an area of work, the assertion of power is required. The more successful the suppression of knowledge about the work that is done, (so that it is not just hidden but unthought), the more violent

the force that opposed it. As we have seen, the volume of caring work is growing with the gathering effects of socio-economic and demographic change. Yet caring work still remains obscured. Why? Because of the cumulative suppressions of 'women's work' by biological, cultural, political and structural imperatives in a male dominated praxis? In which case, the impact of men demonstrating caring work - shoved out of sight by the transhistorical weight of so much white male authority - is a scathing irony.

### Emotion Work

In Chapter Five, I sought to show that the commitment to care is a weave of values, feelings, beliefs and acts that change over time. The biographies depict different levels of feeling that the person who is caring for another negotiates as a matter of course. It is their moral feelings that underpin the commitment to care and hold them to the daily task of caring. In contrast, this section is about the routine work of emotional performance in order to care for someone. First Hochschild's theory of emotional labour is discussed in the context of caring work. Extracts from the second interviews reveal the daily job of emotion work that people accomplish to care for others. The findings are compared with previous writing on emotion work and caring.

Hochschild invented the concept of 'emotional labour' in her famous study of the invisible work of emotion management of air travellers by American airline cabin crew, called The Managed Heart (1983).

The emotional style of offering the service is part of the service itself . . . seeming to love the job becomes part of the job itself (1979 : 5-6) . . . The term emotional labour means the management of feeling to create a publicly observable facial and bodily display; emotional labour is sold for a wage and therefore has exchange value. I use the synonymous terms emotion work or emotion

management to refer to these same acts done in a private context where they have use value (1979: 7)

Hochschild implicitly accepts the dualism in male dominated social theory between the public and private. She splits the function of "managing the heart" into labour (ie paid) and work (ie unpaid) and focuses on the commercial exploitation of people's ability to control their feelings as paid labour. Emotional labour is defined by three criteria: face to face or voice to voice contact with the public; work involving the production of an emotional state in another; an employer controlling the emotional labour of employees by training and supervision. Hochschild's research explores how everyday "filigreed patterns of feeling and their management" are insinuated into the working world (2). Capitalism invades the world of feeling. Employers seek to mould their employees' feelings to sell their service in a uniform way. Feelings are instrumental in executing the business. Hochschild suggests that, "surface and deep acting in a commercial setting . . . make one's face and one's feelings take on the the properties of a resource. It is a resource to be used to make money" (1979: 55). This kind of standardised emotional labour makes it possible for total strangers to have amiable exchanges in everyday business transactions (Flam 1990, Fineman 1993).

Hochschild theorised about the gendered division of feelings, arguing that the 'doctrine of feelings' is underwritten by the more fundamental relationship of gender and power.

Women make a resource out of feeling and offer it to men as a gift in return for the more material resources they lack (1983: 163).

She suggests women's structured dependency puts them in a position where they learn to manage feelings unthinkingly and are channelled into utilising their skills with emotion management on the job market or in the home. Hochschild found that the men cabin crew were also skilled at emotional labour but were more likely to be referred the aggressive customers whose feelings the women could not diffuse themselves. They achieved this by exerting an authority even the senior women perceived they lacked and tended to defer to. Hochschild suggests this was a way for the men to signal their sexual identity. On the other hand she suggests that men who do emotional labour make themselves different from other men, regardless of how they play the role.

For a man the principal task is to maintain his identity as a man in a woman's occupation (1983; 171)

Men who do this [emotion] work well have slightly less in common with other men than women who do it well have with other women (1983; 20)

Managing emotions in caring work does not fit neatly with Hochschild's theory. Smith (1992) looked for evidence of managerial control of emotional labour by student nurses during their education, because she supposed that nurses trained to deliver an emotional style of nursing care would affect the patient's view of the quality of care received (an important thought given the new 'customer knows best' approach in the NHS). However, she showed that nurse training is medically oriented and that the emotion work, although implicit in the nurses' conversations, is *deleted from official spaces* (Kitson 1985, Pembrey 1989).

Strauss (1985) suggests different types of emotion work in hospital underpin medical work but *remain hidden* by it. He names them 'comfort work' and 'sentimental work' and offers a model of each type of activity. The illness

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trajectory is ordered in medical terminology so that discomfort or stress is invisible because it has no space for expression unless it becomes acute. Thus the work by nurses and carers to humanise inhuman medical treatments and make someone feel better goes unnoticed. It is naturalised as 'something people do anyway' (usually women, but Strauss contains himself about the sexual division of health care work) and made invisible. Yet should it fail to be done, it creates difficulties for the total trajectory of illness management, with misunderstandings, fraught exchanges and grave emotional infringements - in fact, reasons that recur in most hospital complaints.

Invisible emotion work can only be seen when it goes wrong and therefore, the only handle the public have on it is in the negative. Emotion workers, caring in the workplace and in the home, feel under pressure to succeed in silence, for losing control of their emotions or injuring those of a dependent would result in public embarrassment and private humiliation. Public surveillance of their performance makes the actors feel that a lapse from the norm would be interpreted to mean that they are unable to fulfill their obligations over time (Graham 1984, James 1989).

Regulating emotional performance for caring work in the workplace does not appear to be determined by profit so much as individual judgements of context and power, as in the home. Importantly, James (1989) extends the definition of emotional labour to cope with this anomaly:

I define emotional labour as the labour involved in dealing with other people's feelings, a core component of which is the regulation of emotions (1989: 15)

Her strategy ameliorates the commercial motive explicit in the marxist dualisms of exchange/use value of emotion labour/work that Hochschild proposes, (although James does not lose sight of the capital gain by deleting emotion work in caring). In her later study, James (1993) explores the interface between the emotional labour of patients and health service professionals, whose actors seek to regulate their emotions according to their context, judged by how equal and/or different they think they are to each other. In this sense, emotional management in caring work is contextual and ideosyncratic and unlike the deterministic slant of the commercialisation of feeling.

Unlike Hochschild's airlines, pricing the emotional premium for staying in one Trust and not another has not yet occurred. The texts suggest that nurses and carers work in a 'grey' zone, adjusting their daily emotion work by their sense of predominant cultural values, institutional or household etiquette and the feelings of themselves and others. Since emotion work is 'deleted', it commands no price in the hospital or the home unless the ethics that animate the emotional performance break down for one reason or other. Furthermore, emotion work is believed to be the province of women and is associated with low status dependent roles. When men perform caring roles that require emotion work, they may take steps to assert themselves in the role in order to preserve the authority of their sexual identity.

The following extracts picture the everyday work of emotional management by men and women nurses and carers. They describe their emotional performance with remarkable insight and explain how they learned to manage their emotions, what it feels like to act the part and why they do it.

**Ian Black**

*[Talking about looking like he's coping no matter what] "At first I was very shy - before I left work, I'd make out I could do the job, If they asked was I alright? I'd always say yes, I was frightened to ask for help, Used to say I could cope lovely, As soon as I'd turned them away I'd think, 'You fool, I could have done with that', I thought they would think I couldn't do the job and wasn't looking after them proper, Of course they don't, It's only because it was me, The only trouble is, when someone comes and you tell 'em you're coping, they don't come again, So if anyone asks me am I coping? I say, 'No I'm not, I'm in a right bloody state here, Come and give us a hand', I really get to the point with people, If you don't tell them what's the matter, how on earth do you expect them to respond? They think, 'Oh he's alright, We'll go and see someone else who needs us more',*

*[Talking about everyday problems of caring] "Firstly it was trying to get some sleep, I took the hand set upstairs from the phone so if mum wanted me she would page the handset, So when you're lying in bed trying to sleep, you imagine you hear a voice shouting, 'Steven', You jump, Out of bed, rush downstairs completely starkers, You open the door, And it's quiet, You think, 'You stupid idiot', Every night I'd hear something, come downstairs and it was all peaceful, On tenterhooks,*

*"The other frustration was the morning, It was hell, Me dad was so demanding, He couldn't help it, He wanted to get dressed before his breakfast so I had to dress him, Then I'd tell him to sit on the bed so I could get his breakfast, I was trying frantically to do that, Then me mum would want something, The blood*

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was boiling. I just wanted to shout, 'Get into bed and STAY THERE!' People used to come round and I used to shout at them. They'd tell me calm down. And I'd say, 'I've got to take me frustration out on someone, I can't take it out on them pair'. I'd say, 'Come round so I can shout at you and I'll feel better then'. One fella came round. He says, 'What you need is a bucket hanging from the ceiling with a bit of string. So when you get frustrated, You can kick it'.

"When you've got breakfasts, you had to sort the tablets out. Some tablets they had to take before breakfast. There was times, 'NO! You can't eat that yet. You've got to take your tablets'. And I pour 'em a cup of tea. 'Oh come on. I'm HUNGRY'. 'Just take your tablets . . . and then you can have your breakfast'. And then you hear something fall in here, you rush in, and see mother trying to get . . . And you say, 'If you want something, SHOUT to me'. And she says, 'I daren't shout because you'll tell me off' . . .

[Talking about how feelings on the inside differ to the outside ones] "The bits of anger I showed me mum was the very hairs of an iceberg. She realised, I used to go outside and virtually chew a cigarette with frustration. The poor old dog came out and I was snapping at it. After a while you don't get so mad. You realise it's not their fault they're ill. You've got to keep on. It's an act of caring [to hide my feelings]. Me dad knew he was dying. I didn't give any emotion to him. Only on the last but one day, I showed my feelings then. He'd drifted away that much he didn't realise. I would rather go upstairs and have a cry than be upset in front of him, I was thinking if I'm strong, he'll be strong. The last time he went into hospital he knew. There were things he told me. I can't say it. That's life isn't it. We've got to keep on smiling.



*"I've been accused of being callous. It's okay showing emotions. But you've got to draw a line somewhere. You've got to be strong for the other one. It's like a mountain climber. You're the head one. But you've got to hold that rope to stop the other one from falling. Same with emotions. Once one starts, the whole lot . . . Not just emotions. You've got to be tough. If you fall apart, well you're the head one so everything falls too. In caring, you've got to have a leader. You've got to show strength. It doesn't matter how tired you are, how things are going, or your emotions, you've got to be strong. If you want a cry, go upstairs. But you've got to show the people you are leading you are strong. I think anyone can do it. They've got to be strong in will. You've got to keep going and going. You've got to believe in what you're doing.*

*[Talking about losing control of the act] "I have erupted something chronic at times. Feel great afterwards. Because you've relieved all the pressure. Never at my parents. When it first started, and I was thinking, "Why me?" Me mum was delirious, and I was trying to get her in one position and she took another. Then there was times when you felt like it. Giving her a slap, 'BEHAVE yourself!' But never ever. I'd rather walk out of the room and let them fall on the floor first.*

### **Penny Shaw**

*"If I wasn't seen to be coping by all these people coming in and out of the house. I was worried they would say, 'She's not coping anymore and we need to move mum out'. I kept my feelings to myself about mother's condition. I didn't want to accept the idea she was dying, which was very upsetting. I knew if I discussed it and became emotionally upset, they would interpret that as 'She's*

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*not coping'. Everyone would have been pushing me into having respite care which I didn't want. I wanted [to sort things out in my own time]. I've had other carers (older than me) tell me they've done it. They're so worried that the professionals will think they can't cope.*

*"Inside I was feeling anxious for the future. Frightened. I was disorganised because I was worrying so much. I was thinking I was going to have to ask all these services to change their routines. Because of the way I thought my mother should be cared for. I wanted people to realise she was dying, her needs were changing and I wasn't being fussy. I wasn't sure my mother was dying. Is she? Is it just me? The Nurse said, 'This isn't good'. The Daughter said, 'Oh no. She'll get out of this one. I'm over-reacting because I'm tired'. So when the carers came, I said everything was hunky dory. It's very difficult when you are caring for someone at home, not to be affected by the way the support services judge you.*

*"I have hidden alot [from the family]. I play a role with them, protect them. I don't want to upset them. So I say, 'Everything is fine. Mum is feeling a bit poorly today'. It's a load of nonsense. I was up all night with her. And all these things going through my head that she really isn't well. Alot of that is clouded because my father's just died. I don't want to put more on them. Plus it's coming up to Christmas and they've got young kids. I don't want to spoil things for them. So I act out a bit - I'm not performing on a daily basis. I don't think I could cope with the stress of it.*

"I think it's an act of caring to mask your feelings if you are trying to relieve someone's suffering. I don't tell my brothers and sisters when I am under a great deal of stress because I know they will feel incredibly guilty. They are not close enough [geographically] to do anything about that. I want to protect them from the guilt. So I mask my feelings and say everything is fine thanks. When I do cover up, I am short with people. If I am worried about something and I can't tell them that because I am going to break down. This big fear of breaking down. And I don't want to do that. So I cut them off short.

"If you love someone, you are genuinely concerned and you want to make things better. If you can't, you feel impotent. The other day I had just been sitting with my friend, crying, saying this is the end. And somebody popped in the house and asked how she was. So I said, 'Oh fine thanks'. Automatically. My friend said, 'How can you say that?' It's because I couldn't accept it. I almost did the same thing as those who ask who don't want to know. You can feel people feeling uncomfortable when they ask [because they don't want to know the truth]. You get your cues off the person you are relating to. Unconsciously perhaps. You react and show as much as you think that person will take. Most people hide their feelings. I've a couple of my friends who don't. Who say what they are feeling. They are difficult to cope with. They don't have any friends. I'm sure it is because of that. To live together and to relate with people you have to do it. Or we'd just be bombarded with emotions. Not everyone is as receptive as each other at the same time. If everyone said what they felt . . . we wouldn't survive very well.

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*"People protect each other, The nurses protect me, I can read it in their faces - mother is dying. But no one had mentioned it, I have, In a roundabout way, Playing games, 'How is she?' 'She's really bad today . . . the infection', No one talks about the eventuality of death, Says, 'How do you feel about that then?' Maybe I am sending out signals that I don't want them to because it hurts, If grief could be accepted, If nobody was going to think worse of you if you burst into tears, It would make so much difference . . .*

*"There are times when you feel so tired and desperate, Because I'm under stress, I'm tired, My life is totally taken over with this role, It might be something silly like taking too long with her lunch because she doesn't open her mouth when I feed her, Or I am hurrying because the home help is coming soon to get her up to bed, And I feel resentful, I might swear or something, I have done, Said, 'Sodding hell', And I show my anger, Then I feel guilty, It's not her fault, But I check that quickly, Make myself aware of it, Talk to myself about it, Because if it grows, I can understand why there is violence, If that is bottled up and not expressed,*

*"I got my father to accept she couldn't help what she was doing, Instead of trying to talk her out of it . . . She wanted to go out at night - that's one of the classics . . . And it was difficult, You have to be one step ahead, Change the subject and get her on something else, And yes it gets tiring, To the point where you say, 'I don't care what you do, You're not going out, Sod it', Pure anger then, No understanding . . .*

"Yes. A few times [I've got to breaking point], Then I'll do what's necessary during the day. Phone my friend and get her to come round then I will have a good cry with her. I don't know what I'd do without her. I'd have to cope with all that on my own. Just the times when - for no reason - you feel so low. It's stress. You keep hold of it, hold of it and then for no reason - it's not reaction, depression - it's just 'Oh God, I am tired'. A few gin and tonics and a good cry and I feel much better the next day.

### Junior Staff Nurse Colley

I asked if nurses put on an act in upsetting situations, such as a tragic death on the ward. "I think yes. You put on a brave face . . . for the relatives. You really need to keep yourself together. It's no good falling apart about it . . . and of course, you are upset as well. But for the relatives, for the respect of the patient, and the other patients too, you need to be cool. You can come into the office and have a cry with the relatives if you want. But on the ward you need to be professional. Not uncaring or hard about it.

[Talking about if what he feels inside is different to what he shows people] Yes. Most of the day. It would be untrue to say that you don't get fed up. Sometimes you feel angry about the care of the patient. Or maybe they are being difficult. In that case you cover the anger. I am not saying you're mad, that you've got horns growing out of you . . . But you try and be normal, polite, keep that cool. At other times you can be with someone who is desperately ill and is cheerful and they have a poor prognosis and you think, 'Oh poor soul' . . . But you don't let that show. You try and keep a brave face for them. That can happen from patient to patient all day . . . You develop it from the start . . . It's

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*important that you need to understand other people and their attitudes, and to understand why they are like that; and to have an insight into your emotions and how you feel and how you can organise your emotions . . . If you don't have that insight, it's not going to work really, unless you try very hard . . . it's something you learn from the beginning of your training.*

*"[Talking about his reasons for covering up his feelings] It's because it's not fair to do that to the patient, to be upset or angry. I'm not saying you don't show certain amounts of emotion . . . You do show you're disappointed, or that 'That's not the right thing to do' . . . you try and show them that's not acceptable . . . Out of respect for the patients. They are ill. Or there is something wrong, that's why they are in hospital. That's one problem . . . But for yourself as well, you can't be having these . . . It's much easier to have a protection and ride it out, rather than have a head to head each time with your emotions. I mean each time to let yourself go and think, 'Isn't that terrible?' or 'He's getting on my nerves' . . . You would just feel drained at the end of the day. You would have had that many emotional collisions . . . And it's easier to get the job done if you're in control.*

*"[Talking about the consequences if nurses let their feelings show] . . . I don't think it would be a good idea. It's a caring profession but we don't really care about the workers. There is that problem . . . When nurses get fed up and things like that. On the ward level, with your skills with the patient, it's important to keep control. But you should have someone to talk to . . . I don't think there is enough opportunity for a lot of people - you hear people need counselling, needing to go and talk. But on this ward you can do that . . . take someone aside*

and say, 'I'm really fed up today' and have a chat about it . . . It's important to get a good level and not let yourself get angry or upset. Or if it has got to you, go and talk to someone about it. In alot of places you can't. You feel you couldn't go. I've got friends who are very fed up and who can't talk about it at work but manage to talk to friends about it . . .

I asked him if he would still put on an act if confronted with a possibly violent drug addict . . . "Yes I would. I would probably be frightened of him anyway. Just to start with. It's the idea it conjures up . . . when you think of drug addicts . . . or the fact he may be violent. I wouldn't be as approachable. I'd be a little bit back. In that sort of situation, I would feel that if I was as open or as involved with him as with the older chaps it would be easy for him to manipulate me. You would need to be a bit wary. But then it would not mean I would not care. That I wouldn't do my job. I would just be a little bit off.

I say that it sounds like there are degrees of involvement that get acted out. "There are certain situations where it would be harder for you to be in control. And then you would perhaps go for 'a total protection act'. Play the nurse, and that would be it. Rather than be involved. It's a different aspect of caring. You are caring all the time - but it depends on what level you want to go into. The job itself means you need to care. And you can always stay at the level of nurse, doing the job, doing their physical needs, the routine work . . . and leave it at that. But at other times you can become involved, sit and chat . . . in certain situations then, you would not draw back altogether, but use the uniform and stay as a nurse. [That's what you do with the drug addict] initially and then afterwards, it's depending [on the situation].

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*(Nurses act a part on the ward) as a whole . . . "You realise you are acting out of 'a different personality'. I am aware when I'm at work of my appearance to other people. If I'm talking to relatives, I'm aware of how I look - not physically - but the image". I asked him if he forgets when he is getting more involved with people. "I don't know. You are probably just yourself. At work you need to have a self image; you as 'a nurse'. And . . . during the day, it's up to you whether you want to let it drop, or when you want to use it and to what extent . . .*

### **Sister Trent**

*(A violent drug addict was admitted to the ward one winter weekend. It snowed so heavily the hospital was snowed in and the nursing shifts stopped. Sister Trent and a skeleton staff stayed on the ward for the weekend and didn't leave. Early one morning, Sister Trent went down to the canteen to get her breakfast but returned unexpectedly. The drug addict had threatened her Staff Nurse at knife point in an effort to gain access to the drugs cupboard. He has already cut her hand open and on being surprised by Sister Trent, is running to hide in the bathroom).*

*"I wanted to shout at him and I wanted to shake him. But I didn't. I just tried to talk to him in a rational manner. That sounds silly! Probably I was acting a part then because if I showed my true emotions I would have stood and screamed at him. But knowing everyone else was upset around me . . . the elderly people especially (because he didn't make any bones about it - he'd told everyone he was a drug addict). If I'd started bawling and shouting at him, it would have upset them even more. No [I wasn't afraid of him]. I could have murdered him to be quite honest. Mainly because there was very little staff and I thought, 'What a*



thing to happen on a Saturday morning with everybody snowed in', I was furious with him. That he could slash a nurse. And totally disrupt a whole ward and upset all the staff as well. To my mind he wasted 2 hours of my time that I should have devoted to the other 25 patients on the ward. He used words I didn't even know existed! I felt angry about it . . . But I didn't show my temper. Which funnily enough, I would have expected being quick tempered . . . Although I know he needed . . . He eventually did come out of the bathroom. And went and sat with a nurse in the dayroom and went to sleep . . . I did try and talk to him . . . Really and truly when he was in a good mood he was a very likeable chap. It was just when he was playing up.

"I suppose you are [acting a part]. Because everybody seems to think, or they used to think, that we were angels. We are only human beings. Carry on as normal. I knew I should have been on the stage. I'm not conscious of it when I am working . . . I suppose it's what people expect of us [senior nurses] really. They expect us to have a stiff upper lip and not let any emotions affect you. I suppose really people expect you to be a bit cold. In cases of death or where somebody's very ill, I am not afraid to show my feelings but people don't expect us nurse] to then. Everybody is looking up to you. They don't expect you, the more senior you get, they don't expect you to have any feelings at all, these juniors . . . They don't expect you to react as any other human being would. They expect you to be placid and just looking and not saying anything . . .

"No I don't think [we all show our feelings]. I don't think patients always show their feelings. Nurses don't either. I think they bottle things up. People certainly bottle things up because they never tell you what they mean. They

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won't tell you whether they're frightened or not. The general students, when they first start, outwardly they look extremely confident, but underneath they are quaking in their shoes. They are all acting . . . The younger ones, especially not long after starting, they get terribly emotional if anything untoward happens on the ward . . .

"[When I trained in 1963] it was not the done thing to show any kind of feeling at all. You just didn't. You didn't cry. I think we [our generation] can contain our feelings more. We used to go home and cry. We never cried at work. It just wasn't the done thing . . . Yes I have cried. Especially in cases of death. Especially if you've had them for a long time. Obviously in a medical ward, they are in for months sometimes. I have cried with relatives and I don't feel any shame at showing my emotions like that. A lot of people would probably say the usual things and say how sorry they are. Then if they want to go and have a cry, they have a cry in private. Well I always feel it's quite nice to have a cry with the relatives. When they're in here for a while, the relatives and patients, they are like friends.

" . . . But you can't like everybody. And to a certain extent, you've got to mask your feelings towards that person . . . You know you've got to work with them. And you hide your feelings for the sake of the working environment. It's like that with patients as well. You've got to put a mask on really.

All I seek to do here is to indicate some reasons for the day to day emotion work of caring. These people describe cultural values, institutional norms and

personal feelings as reasons for its accomplishment. Their logic echoes the other participants and the texts. Moral feelings of caring are woven into their narratives. They make it clear that taking daily care of other people's feelings by managing their own is necessary to the rest of the work. Like their commitment to care, emotion work is necessary to the caring role. Yet emotion work is not acknowledged unless it goes wrong. This puts them under pressure to control their feelings and manage others as a prerequisite for achieving the rest of the work and avoiding criticism of their conduct and/or capacity to cope. In other words, they are always working at working - doing a job behind the job (Strauss 1985, Graham 1984, James 1989).

The nurses and carers valued emotion work for the following reasons. It is for the sake of the feelings of the person they are caring for, to protect them from harm or to make them feel better. Penny Shaw was also trying to protect her family and friends from her feelings because she judged that sharing her suffering with them would not improve the situation. All the carers identified with shielding family and friends from a painful reality and how lonely a job it is. Sister Trent points out that the junior staff take their emotional lead from the person in authority, who stands alone. The problem is that it is difficult for the individual to change tack in emotion work (for example, for the carer to admit to family how they feel) without compromising their conscience and their reputation.

Losing control of feelings upsets time-tables and interferes with the daily routines and can affect the schedules and workload - and therefore the feelings - of people around them. Staff Nurse Colley stresses that patients

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and colleagues depend on him to stay calm so that everyone's work gets done. Sister Trent makes the same point when she discusses her response to the drug addict. Both Penny and Ian talk about losing emotional control when they are rushing the care and making more work for themselves. They both said they fight for emotional control for their own well being if - tomorrow - they still have to cope with the same thing that is upsetting them today. Staff Nurse Hugill, Mr Bibby and Mr White said much the same thing. Mr Badger broke down under the strain of trying to keep to all his time-tables and stay in control.

All are afraid that their day to day performance is under surveillance by outsiders. The carers feel they have to live up to norms for emotion work set by professionals and family. They feel obliged to act as if they are coping well. Ian Black and Penny Shaw did not want the statutory services to think they could not look after their parents and so for a time, pretended there were no problems. Penny Shaw was reluctant to express her grief to the community nurses because she didn't want to compromise her appearance as the competent carer. Mr Badger and Amy, Mr Gales and Rose are used to 'keeping up appearances' for their family and friends even though life for them has changed dramatically. Mr Bibby, Mr Rice and Mr White, whose wives are ill, are also aware of working to meet other's expectations that they can cope.

Nursing's emotion work seems to be imbued with concepts of authority. Staff Nurse Colley admits other nurses put up a front on duty that they only let down in private when they feel that to talk about negative feelings would not threaten their job. All the nurses think that losing control of their

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feelings would compromise their presentation of themselves as professional people, jeopardising their authority to play that role to others. Sister Trent points out that emotion work in nursing is different now from thirty years ago. Then the 'stiff upper lip' act of the nurse was a sign of having command of oneself and was encouraged. Nowadays there is more freedom for emotional expression, although as we saw in the last chapter, the men are ambivalent about showing emotion.

All these accounts emphasise that emotion work protects people from being bombarded by emotion and is part of caring for oneself.

This small exploratory study does not show that emotion work is governed by deterministic rules (Hochschild 1983). Rather patterns of emotion work seem to be delicately inlaid by personal feelings, cultural norms and values. From the accounts, emotion work in health settings appears to be more contextual and idiosyncratic than the application of 'rules' (James 1993). Individual acts of emotion work are an expression of personal commitment, emotions, the equality of the relationship and the context of relating among other things.

The evidence is that both men and women nurses and carers understand emotion work and share similar reasons for using the skills. It suggests that emotion work is accessible to both sexes, even if access is not equally shared. Nevertheless, there is still reason for thinking that emotion work is gendered and which partly supports Hochschild's thesis that the doctrine of feelings is underwritten by gender and power. In Chapter Five, the men and women describe their views on how feelings relate to sexual identity and show how women,

feelings and caring are still locked together in public belief while men are meant to hide their emotion in case it undermines their sexual status. This suggests the men's experience of emotion work is affected by their status as men, because it is one way of judging their performance and how others see it. When men are seen to do emotion work in women's world, their role is not different from women's but they may choose to play it with an authority born of their sexual status in order to maintain the same.

### Dirty Work

This section looks at the literature on dirty work in health settings. Following this the men nurses and carers talk about dirty work in caring (the women referred to it but not in such unsolicited detail). The interviews draw attention to the contrary image of men in caring roles tackling dirty work and their presentation of themselves in relation to dirty work.

Hughes (1971) suggested the concept of dirty work. Strauss investigates Hughes' idea in a review of sociological theories of work in The Social Organisation of Medical Work (1985). He cites Hughes, suggesting that "work become dirty when 'it in some way goes counter to the more heroic of our moral conceptions'" (1985: 246). Hughes distinguishes between work that is 'physically disgusting' and 'something that wounds dignity'. Emerson and Pollner (1976) refer to 'shit work' where something is done to a person despite their active opposition. Strauss suggests that the context of application of 'dirty work' is occupational and moral and consequently, all work has the potential to become 'dirty'. It may be physically or symbolically

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dirty. It is not necessarily constant or a regular part of the job. The worker re-constructs the meaning of the work because some aspects are satisfying, as Hart's study (1987) of hospital domestics shows. Dirty work can involve deep emotion work because the patient needs to be shielded from shame and guilt at having required the work. Again Strauss refrains from commenting on the gendered division of dirty work in caring labour.

Ungerson (1985), however, suggests that cultural taboos about dirty work order the sexual division of labour. She refers to early studies of the allocation of jobs in families caring for handicapped children and points out that the majority of men did not change nappies, toilet their children or dress them and neither parent thought things should change. \*Women are expected to be able to cope with body excrement and dirt because the job of disposing of human waste is naturalised as part of motherhood in British culture.

Crucial aspects of the image of mothering are translated into tending handicapped adults; dealing with incontinence and other human excreta is doubtless another of these aspects. The fact that women have a virtual monopoly in dealing with these aspects of tending can be most easily ascribed to a system of taboo in contemporary society about the management of human excreta. I use the word 'taboo' rather than 'norm' in order to convey the idea that the transgressing of the system is polluting and dangerous. (1983: 73)

Hart's fascinating account of the invisible work of NHS women hospital domestics (1987) shows how cleaning jobs in hospital are ordered by the sort of waste that is removed. "Bottoms" clean the "dirty dirt" in lavatories and floors. "Tops" clean the "clean dirt" round the beds and cupboards. The women domestics are sensitive about their low status work. Hart suggests that they seek ways of transposing the stigma of pollution by seeking status from their own high standards for cleaning, that even transcend the hospital's 'scientific solutions' for hygiene (3).

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Below the men nurses and carers talk about dirty work.

### Mr Bibby

*"In the early days, the nurses came. I was bushed. Lost I suppose. Trying to come to terms with everything. That I was going to lose her. I accepted the District Nurses coming in, sorting Connie out, and clearing off. Then I started thinking, 'What am I doing, waiting for them?' The nurses say they are overloaded with work. I know after thirty odd years just how Connie performed in the morning. She used to go in the bathroom, disrobe, and wash herself from head to foot, every morning. I decided to look after her the way she looked after herself. Which is what the nurses weren't doing. Nobody has shown me how to do it. Nobody has shown me how to fit the incontinence pads. I do it my way. The District Nurses were shown by the people who make them. But when the nurses are ready to pad her up they sling me the pad. They say I do it better. I think I'm more in practice than they are.*

*He describes conversations with the nurses about expectations of cleanliness. One slung a towel over the radiator to dry and he took it to wash it. She was surprised because she expected him to use it next time but he was horrified by the idea. Other nurses had also commented on the hoist because in other homes it is black with excrement, but he washed it when it was dirty. He talks about 'clean' towels and 'dirty' towels for bed bathing.*

*"One nurse used to come . . . Jane. I'd get terribly embarrassed, absolutely red faced. She'd strip Connie down and wash everything. To a nurse, Con is just another body. She's not just another body to me. Jane knocked alot of that out*



of me. She lifted Connie's breasts. 'Look' she says, 'They're going red'. Not having a bra which keeps them off the body, you need to put cream underneath to stop perspiration making her sore. She played round downstairs and showed me how to keep her clean. Well I went to wash her one day downstairs, and blimey. She was just bubbling cream. Not just a little dribble. It was one big blob. I flapped and thought, 'What the hell is it?' I washed her and there was this terrible odour. I am still embarrassed by this sort of thing. I washed inside her. There. When Jane came, she was in a mess again. 'Oh', she said, 'She's got thrush'. And showed me how to clean her properly. She's never had thrush since. Well this is a dark area isn't it? Last week I was washing Connie between the legs, and I got a hot sensation and she was tiddling in my hand!

#### Ian Black

'At first when me mum and dad was took ill, Mainly my mum first. Incontinent. People said, 'You shouldn't have to do that'. I detested the job. It made me feel sick. The first few days and gradually started to get used to it. I always thought, 'Agh. I shouldn't be doing this'. I did it. I think what helped me is because I've worked on the farm. I used to lamb. All the dirty filthy work. People come down - they wouldn't even retch, they'd just keel over. I've done the dirtiest jobs you can imagine on the farm. What I thought was me mum and dad was two cattle and I was just mucking out. It got me through. After the first few days it got natural. It was just their bodies couldn't function right. They never thought, 'Well I'm not worried. Ian will clear it up'.

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**Mr Gales**

*'You don't have to be a disabled person [talking about nurses doing the dirty work] . . . You can be a person just come out of an operation and is all wired up and what not. 'Here's your tea, Mr Green'. He can't reach the bloody thing. Can't touch it. And they walk away. Same with his dinner. They wait for his wife and daughter to come and spoon feed him. Told you, about them leaving her in bed and she wanted to go to the toilet. It's 5 o'clock in the morning and they left her. She was coming out that day. I had to take her home in her wet nightie and put her in the bath. That's disgusting. [Rose says, 'I smelt rotten I did. But they didn't bother']. Four of them to take her and put her on the toilet. When I come home I have to take her on my own. I'm not Superman. I'm only an ordinary bloke.*

**Student Nurse Evans**

*'I regret training as a general nurse . . . because all you do all day is carry out rituals - task oriented, the lot. What a nurse does is clean up other people's mess. If I had a daughter I wouldn't want them becoming a nurse. You wash people, dress them, take them to the toilet, feed them, assist with mobility, make sure they're warm, give them their medicines, do their observations, make sure their drips are running to time, empty their catheters, their drains, drain their naso gastric tubes. It's very very practical. What gets me is that it's all ritualised. A lot of people have lost the essence of what it's all about - nursing is not about doing things to people. If it came to a point where I went to work, and all it was was washing people, and emptying this and dispensing that . . . I'd give it up. To me the job satisfaction . . . is what you get . . . the inter-relations with the other person . . . while you're doing these things . . .*

### Charge Nurse Tooley

*[Charge Nurse Tooley] related the time when he's been down the pub with his dad and all his workmates and they had been talking about work, but he'd been silent. Afterwards his dad had challenged him about this, but he had replied . . . "People wouldn't appreciate what I do - I don't think they'd be interested in knowing that I spent the day with my fingers up someone else's arse . . . I've made the mistake of telling them so I do know. If you're not in the profession, they don't appreciate it.*

The men talk about doing dirty work, tending other people's bodies. They explain that it is physically disgusting. Their revulsion and embarrassment at handling human excreta passes quickly. The carers and nurses have different attitudes to dirty work. The carers tend to paint themselves in heroic terms for accomplishing this sort of work. For example, Mr Black says that he coped with the job of clearing away his parent's waste by reminding himself that he done similar work as a farm labourer and that it was, after all, just a job like any other. However, by pointing out that onlookers used to faint at the sight of the mess of birth at lambing time, he draws attention to the specialness of coping with dirty work. Mr Bibby, nursing his wife who was comatose and fading away before him, acknowledges that he is breaking a taboo by discussing how he deals with her incontinence and vaginal thrush with a stranger, but continues nevertheless to break with convention, perhaps for the sake of making the point that caring taught him that he could. Mr Bibby said that when he was younger, he would rather have run a mile than change the babies nappies (see Chapter Two). In his caring career, Mr Rice had cared for his wife's dreadful skin ulcers, spoon feeding her liquidised food and managing

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her incontinence, but said he was squeamish about treating the pressure sore which she contracted in hospital.

These stories show how the men seem to perceive their status as heroic rather than stigmatised because they are doing dirty work in a caring role. There are possible two explanations for this in the literature. Hart's work shows how the definition of dirty work is re-constructed so the person in the job feels justified in doing it. Strauss points out that deep emotion work that may accompany dirty work in order to protect the person requiring the work from humiliation. Mr White discusses this same situation (see Chapter Five). In other words, the carers present the accomplishment of dirty work as proof of their commitment and a reason for satisfaction. If they rejected dirty jobs before because they didn't fit men's sex role, but accept them now because they are abiding by a moral priority, this is treated as further proof of the depth of their caring feelings (Ungerson 1983).

The nurses on the other hand, seldom mentioned dirty work except to note the public image of nursing and people's reactions. Student Nurse Evans finds nothing noble in doing the dirty work because it feels like that is all he does. He complains that there is not enough space in the daily work routine to get close enough to people to make them feel better. Charge Nurses Tanner and Tooley refer to jobs in nursing that people find repulsive - extracting and cleaning away human excrement. Charge Nurse Tooley observes that people who know nothing of health work feel uncomfortable if he talks about jobs he has done that are deemed 'dirty'. Their stories suggest that paid dirty work

cannot be re-conceptualised as proof of the nurse's commitment to care because the profession treats it as taboo (Strauss 1985).

Mr Bibby continually compares his standards of cleanliness with the nurses who function as his bench mark by which to measure the quality of his work - washing towels, removing stains, keeping Connie's body clean and free of infection. He was not alone in priding himself on his work. Mr Gales, Mr Badger and Mr Rice all gave examples of nursing standards for dirty work that they believed they could improve on.

### **Conclusion**

Keeping up appearances is something we all do; our act may get uneven and lost altogether if we are stressed. Here the participants agree that more emotion work is required when they are under pressure and their commitment to care is tested. Mr Black uses the metaphor of a climbing expedition, where covering up emotion is crucial in moments of danger in order to lead everyone to safety. The Staff Nurse suggests that in tricky situations, emotion work increases at the same time that he is pulling himself back. When the men discuss emotion work, their sexual status both confirms and rehearses authority for their role. Again, when some of the men talk about performing dirty jobs, it seems as if they are proud of their achievement. Because it is unusual for men to do dirty work, their acceptance of the jobs emphasises their commitment to care. From this initial showing, it seems that men's sexual status is confirmed by caring work as well as diminished.

On the one hand, it seems men are misfits for learning skills that conflict with their sexual and social identity. The compartmentalisation of public and private worlds by the ruling forces is a male dominated device. Men do not usually work in spheres where the logic of what is done cannot be measured by today's economic criteria. We believe that the stereotypical male does not participate in emotional management at home or in the workplace. After all, the conventional gaps between home, work, sports and friends are preserved in a way that re-inforces male sexual and social identity. When men take caring roles that emphasise the connectedness and intimacy associated with women's relating, they look like misfits. In British culture in particular, dirty work is usually low status paid work or deleted work in the home. Men usually avoid this domain. Men are excused from clearing up the human waste of others and cleaning bodies of excrement, because these jobs have been naturalised as women's work. It is taboo for men to engage in cross sex dirty work, whereas women are permitted. Men who trespass the boundaries of taboo are in danger of compromising their sexual status in the eyes of others, as well as defying the feelings of those they care for.

On the other hand, it may be that beliefs about authority naturally attributed to men are so powerful, the value of caring work appears enhanced by the sex of the person performing it. The paradox is that when men speak about emotion work, the false logic for its deletion is challenged. A few men realise that emotion work is important to maintain the quality of life for themselves and others in the workplace and in the home. When they discuss their emotions in as much detail as women, they give them the added weight of their male authority. Also, when the men carers speak about the dirty work,

they dump the superstitions that prescribe sex work roles and low status and that nurses avoid. Dirty work is one way of tending vulnerable human beings who depend on someone else's commitment to care for them when they are unable to keep themselves clean. By going against convention and by breaking the taboos, these men afford themselves special status by proving their commitment to care matters more to them than social prescriptions for men's identity.

### Footnotes

(1)

Economists may be said to have made their insight into society more available than other social scientists. But by concentrating their attention on one sector of society, the market economy, and developing a coherent conceptual "kit" to analyse the creation of value exclusively within the sector, their insight is limited. They are not interested in the creation of values that are, in their view of the matter, non economic (Wadel 1979: 379)

(2)

To manage private love and hates is to participate in an intricate private emotional system. When elements of that system are taken into the marketplace and sold as human labour, they become stretched into standardised social forms (1979: 13)

(3) Having witnessed 'scientific' rules of cleanliness in theatres, the one upmanship of domestics is perfectly comprehensible. We used to have 'clean' passages and 'dirty' passages in theatres. The clean passages were for theatre staff in clogs or overshoes and theatre trolleys but somehow parents and surgeons in 'dirty' shoes and ward trolleys managed to get up and down them without being struck dead by Silv, the theatre sister. Theatre porters meekly scrubbed the same floors at night that surgeons walked across in their 'dirty shoes' like Jesus on the water and they too never sank from sight.

## THE CONTEXT OF CARING

In this chapter, the social context of care is explored using data compiled from official statistics, the literature on demographic, socio-economic and social policy and the views of the carers and nurses. It was written in 1991/92, before the fourth victory of the Conservative party in the General Election, before the implications of the National Health Service and Community Care Act 1990 were fully realised in practice or the budget of November 1993 and its pruning of social security benefits was a remote possibility. The text is updated in the light of these events.

Caring is in the public eye: social surveys show health and welfare is a major public concern in the early nineties (1); the Royal College of Nursing and British Medical Association make the news when they comment on today's care; local Carers Groups have become a matter of course. What are the reasons for this rising interest? I have already suggested that the feminisation of is linked to the growth of the mainly female caring workforce this century. But what is the context of these shifting images of meaning? What are the main current structural forces that interreact with the feminised culture of care?



Typically demographic and socio-economic trends are discussed by commentators on social policy who either point out the growing need for care (for example, Parker 1985, Green 1986) (2) or discuss the impact of structural forces on family responsibilities to provide care in view of the increasing need for care (such as Wicks 1986, Finch 1989) (3). Here the context of care is explored from three sides. First it is suggested that demographic changes and bio-medical technology are creating a biological revolution with the effect of making more caring work. Not only is there an absolute increase in the numbers of elderly requiring care, but the remit of care work is expanding too so that more is possible. Second, there is already a re-configuration of socio-economic relationships between the sexes and different generations that is going to influence who will do the caring and who must pay for it. Third, the welfare infrastructure for care has changed and probably diminished, in keeping with modern political rhetoric of saving the public purse and encouraging the individual to look after themselves and their families (4).

### **Demographic Changes :**

There is a substantial literature about the impact of an ageing population on society (5) (6). There are complex arguments about why it has happened and its likely social implications. In this section I seek to explain the factors involved and show why they are so important to the context of caring.

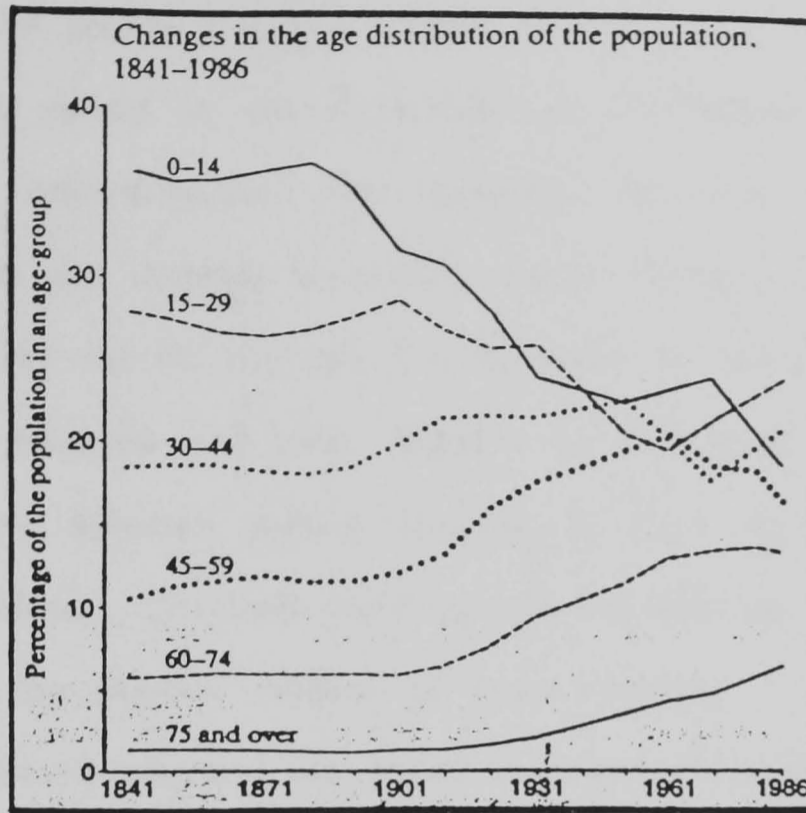
Two factors create an absolute increase in elderly population - past numbers of births and the phenomenon of ageing (other things being equal). An ageing population is a relative matter. It means a sequence of shifts in the

proportions of young to old. These are more to do with cumulative forces of reduced fertility occurring at the bottom of the population pyramid, not reduced mortality at the top (Hendriks and Hendriks 1977). An ageing population is a historical phenomenon that has been building over centuries and it is not simply the effect of modern medicine in extending longevity (Halsey 1988). Figure One (page 200) shows the changes in the age structure of the population over 125 years. It is plain to see that fertility rates in the last century dropped before mortality rates improved in this one.

There has been a large historical swing from a youthful to an ageing population. The age structure still shows fluctuataions over time, because each cohort carries the imprint of events in its life-time, whether it is the introduction of vaccines or the ravages of war, as described in Figure Two (page 200). Therefore, although there are oscillations in the ratio between age groups, the people of the UK (and elsewhere in the Western world) are seeing absolute increases in population for each cohort over 60+ for the first time in the biological history of the species.

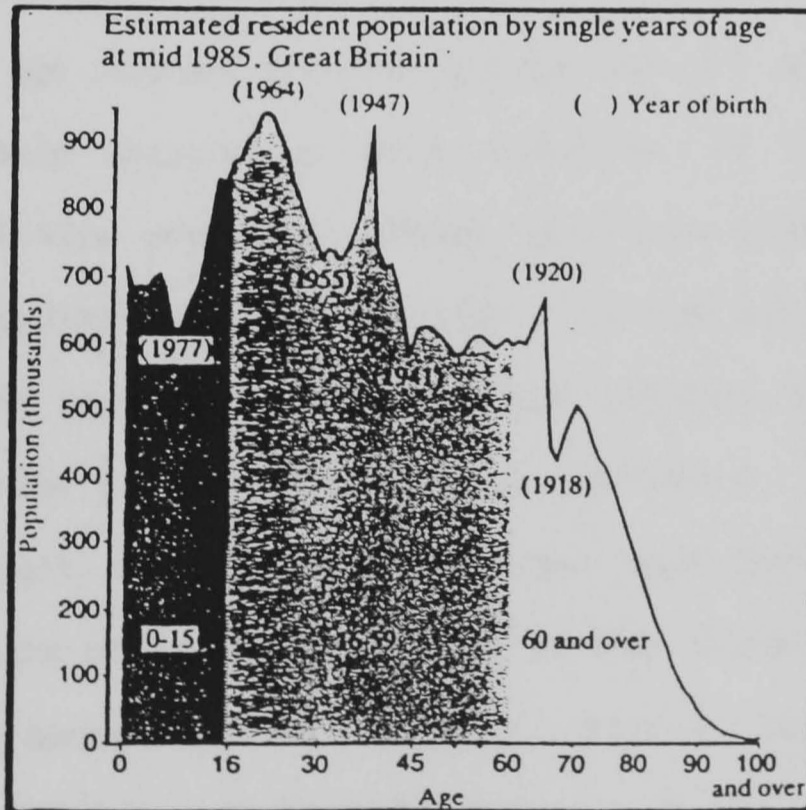
Furthermore, there is a unique shift in the balance between the numbers of elderly and their progeny. Wicks (1986) notes the change in ratios of elderly people to women a generation younger. In 1901 there were 24 women to every person over 85. By the year 2001 the ratio will reduce to 3:1. Halsey (1988) and Ermisch (1990) discuss the reasons for the historical decline of total fertility rates (TFRs)(7). Halsey argues that marriage has more status as a factor than the Pill. Previous generations also show a sudden decline in TFRs.

Figure One: Changes in the Age Distribution of the Population



CRAIG, J. (1987) Changes in the Population Composition of England and Wales since 1841. in *Population Trends: 150 Years of the General Register Office Summer 48*. London. HMSO

Figure Two : Estimated resident population by single year of age at mid 1985, Great Britain



THOMPSON, J. (1987) Ageing of the Population: Contemporary Trends and Issues. in *Population Trends*, Winter 50. London. HMSO

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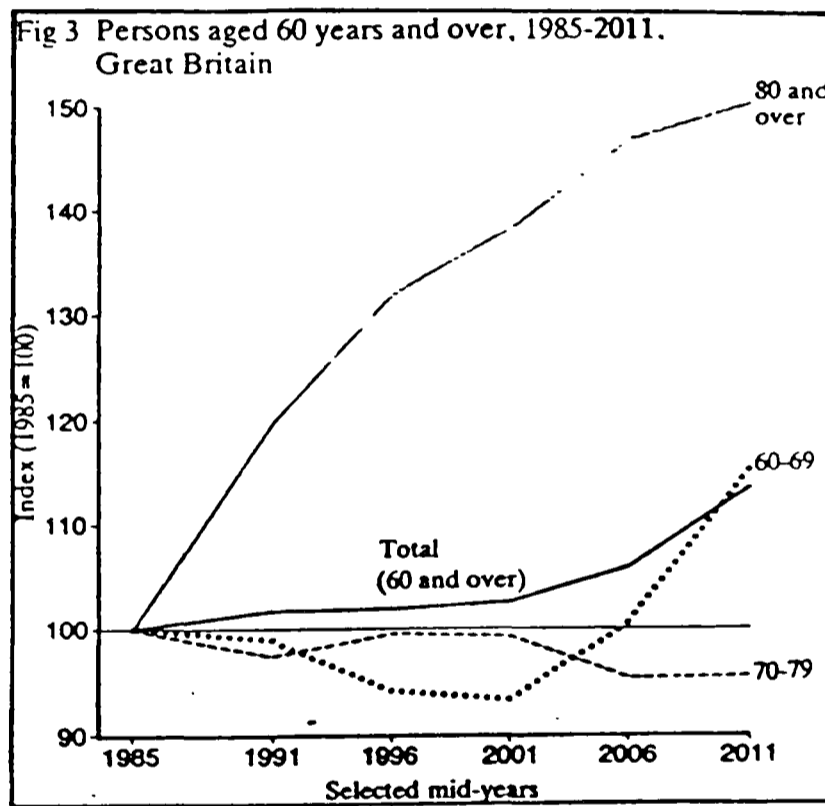
Either marriage was postponed until it was economically viable or people stayed single. He points out that other factors, such as sexually transmitted diseases, tend to result in the increased use of condoms. Ermisch argues that new methods of contraception (for example, The Pill) generated the recent reduction in TFRs and created secondary social effects that help to perpetuate the cycle. In 1964 the UK TFR was 2.9 children; in 1988 it was 1.8. He coins the terms Baby Boomers and Baby Busters to represent the TFRs of previous generations. For instance, people retiring in 1990 are Baby Busters, born in the Great Depression. Children born in the mid sixties are Baby Boomers, who will retire in the second decade of next century - the biggest pensioner population in British history, supported by a shrinking workforce (8).

Medicine is popularly believed to have produced today's elderly population by reducing mortality rates. This is not the whole story. I have argued that the significant factor was a steadily decreasing fertility rate. Yes we associate death with old age whereas previous generations had no such illusions about the lives of their children or older relatives, at a time when infectious diseases and TB were prevalent. Death is a more predictable affair for us than for our forefathers (Hagestad 1986). Bio-medical advances affect late-life mortality in particular. Technological medicine acts like a repair and maintenance service for a growing elderly population. More people live with diseases like heart disease that would have been fatal before. Indeed the strategy in "Health of the Nation" (1992) is that today's health work prevents common diseases among tomorrow's elderly. Strauss, the American sociologist, says we are witnessing a biological revolution in the history of the species

(1985). Society is saving and perpetuating the lives of more chronically ill people than ever before. What are the implications of this unique human state?

There is a strong correlation between age and disability. Disability is a function of need (and does not imply its satisfaction) (9). Look at the differential growth in age groups over 60 in Figure Three (see below) that shows the growing numbers of the 80+ population compared to the rest.

Figure Three : Persons Aged 60 Years and Over, 1985-2011, Great Britain



THOMPSON, J. (1987) Ageing of the Population: Contemporary Trends and Issues, in Population Trends. Winter 50. London, HMSO

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If the greatest volume of need for care is among the oldest, that area of need is growing exponentially. Hagestad writes graphically about ageing society in the United States,

Since 1988 there has been a 30% reduction in mortality in the United States. These recent changes have made the very old - those 85 and over - the fastest growing segment of the population . . . If mortality stays at its current level, general life expectancy in the year 2025 will be 80, and 22% of the population will be aged 65 or over. However, if we see the same rate of improvement between now

and then as the one observed since 1968, life expectancy will be 100, and 33% of the population will be 65+ (Siegal and Tauber, 1986). It can certainly be argued that we seem to have a levelling off in mortality decline which makes it doubtful the next two decades will repeat the patterns since 1968 (1986; 3).

Hagestad also notes women will shape the world of the very old. Typically women marry older men who will die before them. Men are more likely to re-marry than women. Women have a greater life expectancy than men. Kiernan and Wicks (1990) compare households between all those over 65 and women over 80. For the age group as a whole, 45% are married, 36% live alone, and the rest live in mixed households. But for elderly women things are very different: 61% live alone and 27% live with relatives. The two main prospects for future society are the sheer numbers of elderly women living alone with increasing physical frailty and an invisible minority of elderly widowers cut off from the world because their wives did all the "relating". Most importantly, anyone thinking about the new demographic order should be alert to the constructs with which the debate is conceived:

1. Age is sometimes used as a determinant of health 'need' because of its correlation with disability but does not necessarily match the individual instance. Not everyone who is old requires help and some people would refuse it anyway. Ageism is implicit in statistical portraits of 'the elderly' and their 'needs'. When employing age as an indicator of health 'need', we are simply using a conventional shorthand to describe consistent ideas about the typical "distance from birth". It is merely a reasonable predictor of the trigger point for 'need' for caring work. Life expectancy is increasing and it should be remembered that age is a flexible marker not a fixed one (10).

2. Professional labels like 'health need' or 'social need' are also normative: definitions of a person's condition depend on author, time and place (11). It is today's NHS policy to audit professional judgements of 'need' to calculate the costs of caring in terms of human and material resources. This device is a rough and ready map of current conventions of 'need'. It is not the compass as well, unless one intends to go round in more efficient circles (12).

3. Elderly people are stereotyped as dependent (Walker, 1982. Qureshi and Walker, 1989). Dependency expresses ideas about relationships that are distorted by cultural beliefs about old age. In Britain, the elderly lose their status because they give up their economic role in society and are perceived as the economically dependent and subordinate group. Researchers have challenged negative thinking about the elderly in the discourse - the problem centred approach of social policy. Their work shows the elderly as givers as well as takers of care who build reciprocal relationships with family and/or friends to their meet instrumental and emotional needs. Like anyone else, they prefer to cope for themselves, they don't want others running their lives and they feel better with their own things around them (13).

4. Present politics romanticise past 'family' ways of caring - the belief is that 'family' always took care of kin. Laslett (1977) points out how little we know or could know about the history or culture of kin relationships, as well as its lack of relevance to the uniqueness of current English demography. However, historical accounts of the sexual and economic division of labour in the home and workplace are fascinating for insights into popular constructs of caring for dependents (Lancaster 1986, Lynam 1986, Gittins 1986).

Our society is in a unique phase in the transition of the human species. The population structure has shifted from young to old over many generations, as the fertility rate decreased. Medicine's technological capacity to stop fertility and to prolong life has supplemented this development. A new social condition for human kind is the result. A more caring society is not an inevitable response to the predicted increased need of more of its members. In the next sections, I shall examine the socio-economic context and the political milieu that inscribe social attitudes towards caring.

#### **Socio-Economic Conditions :**

It is predicted that an ageing society will cost more in material and human resources. The Swedish Secretariat for Future Studies sponsored a seminal work in 1984 that analyses the cost of caring. Lagergren divides the costs into two areas of health and welfare. On the one hand there is organised care for the elderly, sick, and disabled. On the other there is collective care in the form of social security. Using this framework, I shall explore the socio-economic consequences of resource transfers between generations for the State and the household.

I should stress that comparative longitudinal data on health, personal services and social security benefits for England and Wales, Scotland and Northern Ireland, is virtually unobtainable because of the number of policy changes on what, how, where and when things should be measured in the last decade. The collection, classification and ownership of the government's statistical data alters from year to year. When I tried to update data collected in 1990, I



despaired of finding comparable categories of information with any meaningful status and as a last resort, turned to the bland findings of the Guardian's publications.

Bradshaw (1985) defends the record of social security. It is a vast demand led enterprise with a budget three times the size of the combined expenditure for health and personal social services and education and involving more than twenty main benefits. The cost of funding the four most important benefits - supplementary, invalidity, family and retirement pension - has escalated anyway because of the recession and the so-called "double whammy" effect of more claims on the system and fewer people paying taxes to fund it. Total government spending on social security in 1993 was £79.2 billion - an estimated 29.5% of government expenditure and 13.2% of GDP (compared to 1978, when DSS payments were 22.7% of government spending and 10% of GDP). In 1982, Bradshaw figures that 75% of all household units received part of their net income in the form of a benefit in 1982 and that some groups are more reliant on social security than others - benefits make 70% of pensioner net income. Even in 1993, after much "trimming" of points of access to the system, DSS written answers showed that more than 10 million people - one in six of the population - were living on income support (14).

There will be inevitable pressure on future welfare costs in Britain. By the year 2000, a £14 billion rise in social security benefits is predicted (even if unemployment should fall by 25%) - one third of that rise is feared in sickness and unemployment benefits (HMSO 1993). Bradshaw notes the cost implications of the state earnings related pension scheme will not be fully

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realised until 2020 when it reaches full maturity and the generation of Sixties Baby Boomers are drawing their pensions altogether. According to Ermisch this will be at a point when the ratio of workers to pensioners is projected to drop 35% between 2000 and 2030. Or to put it another way:

The number of those over 75, who are costliest to the welfare state, which in 1991 was 3.6 million, was put at 6.1 million by 2031, 18% above the previous forecast. The number of younger people available to support them would fall, so that by 2031, there would be 79 dependents for every 100 people of working age". (Guardian Political Almanac 1993: 120)

Ermisch suggests ways round the projected socio-economic problem: smaller pension, higher taxes, a longer working life, or perhaps an immigrant labour force or some other unpredicted way of increasing economic growth could support the expected demand on welfare (see Thompson 1987). Bradshaw says that cutting the costs of social security is not a viable political option. Contributory benefits are not hand-outs but a right guaranteed by the pay-as-you-go condition. Maybe the state was reluctant to slash social security but "prune" it certainly has, as I shall seek to show in the next section.

In Britain, spending on health increased in real terms by 55% since 1987, to £34.6 billion in 1993: an estimated 12.9% of government expenditure and 5.8% of GDP (compared to 1978 figures of 10.4% and 4.6%) (14). Lagergren's study of the implications for health care predicts the cost of funding organised care in Sweden will expand by 50% by the year 2000. Only 1/10 of that increase is attributed to population change. In fact, he argues that if population was the only determinant of health costs, over-spending would not be the inevitable result! Lagergren's argument is complex but useful. It helps by exploring the socio-economic forces on State organised care. What generates spiralling

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costs in organised care? Lagergren says this is because the caring workload inputs for each patient episode increase. Two main forces shape the effect. To begin, health care work is not demand-led. Medical definitions of health needs outstrip the level of individual demand. There will always be more that is technologically possible for each patient to make them "better". Public 'demand' for care is shaped in the image of previous monopoly supply. Public opinion is not driving the market forward. Rather, expectations of receiving existing levels of care maintain the status quo.

The drive to reduce expenditure generates new costs. Rationalisation of the division of caring labour invokes new costs such as computerised planning systems for patient information and more administration. Technological medicine and rationalisation of work is meant to cut costs by reducing the time people stay in hospital (15). Of course, this increases capacity to care for more patients with the effect that total costs increase because the system is more efficient. Time spent on basic hands-on care is irreducible. It is labour intensive work. Caring labour is the most expensive item on the hospital budget. There are more reasons for expanding this workforce. There are more patient episodes. A larger proportion of patients are the chronic sick. They require more care for a longer period of time because it takes longer for them to recover. Inevitably the chronic care workload rises in relation to acute care. This puts more pressure on planners to make more beds available by increasing throughput. Capital costs for beds and equipment are rising at a faster rate than inflation. The wage bill is forced upwards by affording an expanding part-time workforce in terms of wages, administration costs, training and liaison work, and by pay awards. Lagergren suggests ways

to avoid a financial crisis in Swedish health care: community oriented care, crediting the user of care with responsibility to sanction it on their own account and breaking the supply-driven circle of medical technology.

Ermisch describes how the socio-economic consequences of reduced fertility affect everyday lives and form additional pressures to reduce the birth rate. It also produces changes in patterns of caring in the household. Typically, marriage is taking place later in people's life-time. Cohabitation is more usual. Consequently, women as a group have more time to gain more labour skills and their work experience is more marketable. The trend for part-time female staff in the tertiary sector and public services has developed very quickly with pay-offs for both parties. Employers have cheap skilled labour with few rights or conditions for work and women feel a sense of greater economic independence outside the home. It also means women have less time to care for others. Each commitment to care by the woman has a higher opportunity cost in terms of losing more income and for any household, the potential direct costs for bringing up a child are sobering (16).

Ermisch argues that the economics of divorce is less of a constraint if both parties are earning. The divorce rate has gone up and there are more lone parents. A couple may have fewer children because the chances of divorce are greater. Their elders are also casualties if the caring network breaks up. Other circumstances should support all these trends, such as the laws for abortion and equal opportunities, by enhancing the career prospects for women. A so-called consumer society prefers leisure to the risks and stresses of child-rearing. In conclusion, there is a troubling conjunction between an

ageing population and socio-economic trends. Baby Boom elders and their progeny will be negotiating the business of care when kin networks are very small, members are dispersed over great distances, and female members - the intrinsic domestic resource for previous generations - have other commitments.

Typical carers today are women in the 45-64 age group, locked into what has become known as the caring cycle (17) or being 'women in the middle' (Brody 1981), looking after children, their elders, older husbands, and neighbours. The 1985 GHS survey of Informal Carers (Green 1988) predicted that 1 woman in 7 was helping someone sick, disabled or elderly, and that 2/3 were over 40. Most of them would be caring for their parents and most would be married. Will this generation of female domestic carers be replaced by the next (Rimmer 1983, Ungerson 1987)? Ermisch suggests the unpredictable difference is that the up and coming female generation are more likely to be life-long income earners with economic commitments who are unable to fulfill caring obligations as well. Feminists argue that women always find some way of juggling their commitments (eg. Land & Rose 1985, Parker 1985, Balbo 1987). They resort to reciprocal care arrangements, paid substitute help and part-time work, because the structural and ideological forces that prescribe the caring role are stronger than socio-economic reasons to escape it.

Changes in the composition of the population are occurring simultaneously with changing socio-economic trends that crucially affect the future provision of care. Just when there is a projected increase in demand for social security and organised care, there will be fewer women of working age to do the care or people to pay for it. Indeed, there may be other unseen considerations that

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will affect the future provision of care, such as the influence of poverty on family care, future EBC policy or population migration. What has been done by the state to manage this new condition of society?

### **The Political Context :**

Demographic and socio-economic factors should combine to make the management of care for others a political priority. Yet recent health and social policy fails to address the issue. The White Paper, Caring for People: Community Care in the Next Decade and Beyond (1989) does not mention the demographic motor of elderly need and caring labour until page 62 of a 100 page report. What is the context of thinking about health and social policy planning? In the eighties, populist right-wing rhetoric ran thus 'on yer bike, stand on yer own two feet, look after yerself and yer own and no more nanny state'. Perhaps reducing state expenditure on welfare was hoped to strengthen the individual's resolve to help themselves? Finch (1990) argues this thesis is too simplistic to explain for example, the reasons for policy on community care. This idea cannot be explained just as a naive expression of political ideology or a macho economic conspiracy to cut welfare costs, send the men out to work and keep women at home as unpaid carers. Rather, Finch argues, it is the result of the desire to be seen to spend the public's money responsibly, to target need among a growing elderly population, it is the appropriation of a left-wing agenda for responsible citizenship, a desire to restore traditional community and family values and finally, a response to feminist publicity about the situation for carers, particularly women refused Invalid Care Allowance until a ruling by the European Court of Justice in 1986 (20).

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Nevertheless there have been cuts and charges in welfare which have had the effect of re-locating both the material and human cost of care with the family or the individual. The nurses and carers talked about the impact of the re-distribution of caring resources on their lives and my experience as a nurse and carer matches theirs. The interviewees volunteered unsolicited information about the impact of cuts and charges on care because they were concerned. Their stories and mine are spliced with the statistical data below, in an attempt to show how policy translates in the lives of people who are its recipients.

Five Social Security Acts in eight years from 1980-88 prescribed many ad hoc cuts in social security provision: eg. the uprating of benefits was altered, some benefits became eligible for tax, maternity grant was stopped and so on. Up to 1985, the total saving was less than 5% of the budget and Bradshaw concludes spending was trimmed not slashed. Anyway spending grew more than 50% in real terms from 1982-92. Bradshaw argues that it is politically inappropriate to cut social security benefits because 3/4 of all households in the country count the payments as part of their net income. Nevertheless there have been changes eg. tax incentives to take out a private pension (with consequent loss of state pension from 2008); the retirement age for women was fixed at 65 in 1992, to be phased in over 15 years from 2000, saving the revenue about £3 billion. The recent increase in spending on Social Security gave the Treasury further reason for introducing particular changes in the 1993 budget including National Insurance and income tax increases and targeting benefit payments (at the expense of others already surviving on benefits).

An Institute for Fiscal Studies Survey for the Guardian suggested that the overall effect of the 1993 budget would be to disadvantage the poorest families by slightly under the average. But an analysis using the LSE/Cambridge University tax and benefit model concluded that the poorest 1/10 of the population might be hit twice as hard as the richest 1/10 (Guardian Almanac 1993: 122)

Health and personal social services have been cut about. The NHS and Community Care Act (1990) introduced the 'free market ethic' to the NHS that was meant to break up the medical supply driven economy, renovate the doctor/patient relationship and cost acute health care in detail. In 1992, an all party Commons Select Committee concluded that the NHS had been underfunded to the tune of £200 million since 1981. Carrtown District Hospital had its share of staff shortages, ward closures and bed crises as the interviews show. All but two of the nurses alluded to sporadic staffing problems, one showed me a closed down ward and two were in the middle of coping with a bed shortage when they were interviewed. In 1988, I was doing agency nursing in my spare time in another city and was appalled by conditions for patients and staff in local hospitals which were worse than anything I had seen or heard about in Farmshire or Carrtown:

Went to staff on [X] ward for communicable diseases. Couldn't believe it. One sister handed over to me from the morning shift - just her and an auxilliary on duty. I was the entire afternoon shift and had never set foot in the place before. On a 28 bed ward with the dead, the dying and the poorly. The nursing officer was frantic and the sister didn't go home until they managed to find another agency nurse and borrowed an auxilliary. It was like world war three. There was no equipment - not even simple things like mouth and eye care kits to swab out the orifices of the dying. The sister just shrugged and wrote her kardexes. We abandoned barrier nursing if the things weren't there to use. In the end, we were just rushing in and out of the rooms trying to sort out whoever and whatever we found. One chap had been virtually dead all day but no one had been in to see him because there was no one. Imagine dying alone in your own shit. In the UK. In this day and age. Never again.



New arrangements for community care came into force in 1993 and the first year of funding was calculated at £539 million - £200 to 300 million short of what was required, according to the Opposition's arithmetic (18). Local Authorities are responsible for funding community care assessment, technical services, domiciliary care and nursing/residential placements from their budgets ie. revenue from the problematic Community Charge and the allegedly depleted government grant. Underfunding for Local Authorities is nothing new but it might be the proverbial straw for community care, when one considers its existing pressures.

From 1980-92, the number of daily available NHS beds (England only) fell by 31% (19). In this time, the nursing workforce increased by 13%; the numbers of medical and dental staff went up 18%; the number of patient episodes increased by 23%; and lengths of stay fell by nearly 30%. The chronic care workload was effectively displaced from hospitals to the home and community care services. This chapter was already drafted before my family found out how the new NHS market, hospital discharge policy and community care scheme work in practice.

In Autumn 1993 my dad, who lived alone, had a stroke one evening when I was chatting to him on the phone 150 miles away. He was hospitalised. In a bizarre series of manoeuvres by the consultant (who wanted his bed), dad (who hates hospitals) and the staff (who wrote in the notes that discharging him was unsafe), dad was sent home after a few days. Innocent of the situation, my brother drove dad to his home for some rest. Within days dad had a second stroke and started to fit, wrecking both his newly replaced knee joints and causing such pain he was banging his head against the bedroom wall, incensed. My brother's GP, a fundholder (who did not want to be saddled with care of a temporary patient) caused the family to drive dad 200 miles back to the local hospital.

After the second admission, dad was confused and unsteady on his feet. Some family are overseas. After they flew in for a family conference, 'convalescence' for dad seemed the best option (that is, remedial care until his prognosis was clearer). The Community

Assessment Nurse rejected these plans because dad wanted to go home and sent him home without consulting his children.

I was designated the main carer, living 1½ hours away, working in another town and by then, in hospital myself. A home help popped in every day to see him. Dad - in sole charge of 84 tablets a week - gradually overdosed on the new drug for his fits because he was so unsteady he couldn't halve a tablet less than ½ cm wide. More confused and distressed by the day, he lived off bread and jam as his hands no longer gripped things properly. This was how I found him. The home helps were not unduly concerned because they'd seen worse.

The story underlines the impact of factors that are discussed in this chapter on decision making processes in managing care and the regional differences in standards of care. The physician's aim was to keep beds open for new admissions which was achieved by cutting the number of bed days for each patient episode. His multi-disciplinary team aimed to discharge the patients least at risk in their professional judgement and if there was a risk, covered themselves by writing in the notes. The GP practice did not want to work for a patient they were not paid for or take over a situation that they blamed on the physician. The Community Nurse supported the wishes of the patient to go home. The family was excluded from a process, steered overtly by the patient's wishes and covertly by the need to ration public resources and that forced a situation no one in the family could take on. Social services were responsible for my father's welfare. However, the Community Assessment Team had no policy to standardise decision-making about the allocation of resources, no criteria for judging when a patient required more support (for example, if the patient is confused, doubly incontinent, requires assistance with medication etc) and no scale for measuring a deteriorating situation. It suggests that in some districts, the frail elderly living alone and at risk have no one to turn to other than existing informal networks to raise the alarm.

The carers' interviews were conducted before the watershed act of 1990 had taken hold. At that time, they were more concerned with what it means to have no caring resources and no client-oriented services when they have volunteered to do the caring for free that the state would have had to pay for. Penny Shaw, Mr Gales and Rose, and Mr Badger thought that formal care was organised to suit the needs of the staff and not the clients.

[As a nurse] I worked in the community so I was used to supporting people at home . . . I didn't understand what support was until I needed it myself as a carer. The services are good. The quality is excellent. But the quantity is not enough. It is provided for the service provider not the client. If I am going to get support, I get Monday to Friday, 9 to 4. At night when I am at the end of my tether, if I've been up all night, trying to stop mother going out of the house or she's been very distressed, there's no help . . . If I want nurses to help put mother to bed, they can come any time between 7 and 11. I can't plan my routine round that. [Penny eventually patched together support from social services, the local voluntary services and the district nurses]. (Penny Shaw)

All the carers had had some regular help to care, including district nurses, community nurses, remedial therapists, home helps, volunteers, substitute help and respite care. However, the mix, range and level of support services offered to carers in similar situations was very different and seemed to be something of a lottery, reflecting my experience. Both Penny Shaw and Ian Black point out that often carers take over in a crisis, don't know what support to expect from the state and have no time to find out. All the carers I spoke to were thrown in at the deep end and had to teach themselves how to manage the situation as they went along. There is no point of contact of national repute where people who face this situation can go for information and advice (20).

[On channels of communication with statutory services] Disgusting. There should be more help and the Government should realise that. What I went through to find the bits of information is stupid. Especially the DSS. When you've got pack up your job, When you keep writing and they don't acknowledge them. You should know which

road to take. There should be a number to call with someone trained to give advice . . . If carers have got no one to tell their problems to, no one knows. I was stuck in a fog. I never even knew about the Carers Club. (Ian Black)

I couldn't get any physical help like sitters. We got home help. Funny thing was, they stopped the home help when I left work to look after them. Because they're thinking, 'Well he's at home all the time'. It's a stupid attitude. Really they should have given me more support instead of drifting away. They was coming once a week. Well if they could come three times a week - even if it was only for an hour. They could be here while I could get off. Help me to go for a bit of shopping. Just a bit of space. Even if it was only over the other side of the road like. Space from work.

[Things he didn't know about] The bed linen service because they were both incontinent . . . And a proper hospital bed . . . fleeces so they wouldn't get bed sores . . . [After Ian got in touch with the Carers, services improved]. The nurses got involved but they were overstretched. They come once a month to bath me nun.

One of the longest serving carers, Mr Rice, had realised the importance of keeping an address book with the names and numbers of people running all the services to which he and Edna were entitled in 1988 (although he had not been wholly successful in negotiating for them).

The Engineers (stair lift breakdown on call service); Technical Officers (for alterations such as ramps for steps etc.); Medical Aids Centre (loan of equipment such as ripple beds); local Health Authority (incontinence aids); Community Services (disposal of incontinence waste); the hospital; the health centre; the nurses (separate day and night service numbers); the GP; the GP Emergency Service; the social workers; Meals on Wheels; DSS (separate sections for pensions, attendance and mobility allowances); Town Hall (rent rebate section); Age Concern.

From 1979 to 1987, material resources for care like personal aids and adaptations to property have increased by 89% and 130% respectively, but meals on wheels and holidays have decreased. Staffing levels in day centres and the home help service have increased by 65% and 28% respectively from 1978 to 1988. Parker (1985) argues that any percentage increase in service provision must be seen in terms of how little there was before the growing numbers of

elderly and the increasing levels of need, in order to see the inequity in services now.

Talking about coping, what bothers me is the lack of equipment to do the job. We're forever being cut back. Connie has to have incontinence pads. Well they're cutting back. Sponges on sticks to clean teeth with. I get those when I'm lucky. I have to make do. Blue rolls, we use alot of but they are sometimes in short supply. Last week I was using kitchen rolls but they are not suitable because they are more soluble. Wipes, they've gone. I've washed the bloody things rather than throw them away, until they fall apart. But you shouldn't have to do this. The sort of stuff Connie throws out, you should throw it out not wash it.

When the nurses come to sort Connie's bowels out, they need rubber gloves. I had to get the doctor to give me a prescription for plastic disposable ones. It took the local chemist 6 weeks to get me those. In the meantime, the nurses had one pair of gloves between them. Here's me using plastic bags from Sainsburys on my hands.

Suction . . . I was talking to the lady who organises the giving sets. I just happened to say about the foot operated suction pump. She was horrified [and ordered an electric one]. I don't know if it will come in time or if I'll get it at all. Before the suction pump [which came out of the back of a cupboard in the hospital] I used baby suction tubes and washed them out (Mr Bibby).

Apart from the cuts, there are direct charges for personal social services and health care. People have to 'choose' whether to pay or do without - nursing care, the home help or new glasses etc. Prescription charges increased by 125% since 1979. 86% of dental charges are paid by the patient and in some areas there are no NHS dentists. Under the new 1993 Act, people requiring daily care start to incur contributory costs for assets over £3000; family legacies including property sales are used to pay for the cost of care. The task of negotiating an 'individual care package' for grandma falls to whoever controls her money. Unfortunately my father was caught up in these new regulations and more tragedy followed.

Dad did go to 'convalescence' in a local nursing home eventually. Community Care still made weekly assessments (even though they were not paying). With all the visits, dad imagined people were after

his money and was horrified at spending his life savings on living his time out. He became so distressed he wanted out by fair means or foul. Staff found him making tea in his suitcase one day in a wretched bid for freedom (he thought inappropriate behaviour would result in his discharge). Persuaded to stay in the nursing home to get better, against all the odds he recovered just in time to find that his house had been put on the market to pay for his future care with the assumption that he would never go home. He had another stroke that fulfilled the expectation.

Under the new scheme, frail elderly people lose most of their life-savings for care at the end of their lives that they thought they had already paid for.

Charnley (1990) compares the income of UK OAPs with those in the rest of Europe and argues that our elderly are economically disadvantaged and present strategy will only increase the inequities. Pensions are price indexed while wage rises outstrip price increases thus widening the gap between pensioners and wage earners. In the future, there will be proportionately more OAPs who depend on the State pension alone. Will the result be an underclass of poor elderly sick who queue for hospital treatments, cannot afford the prescribed services and refuse to pay for care to die in peace?

Increasingly the cost of care for the elderly and sick is displaced from the state to the household. This was plainly the intention in the Government White Paper, Growing Older, although probably the implications for people in real life were not imagined by the authors:

Whatever level of public expenditure proves practicable, and however it is distributed, the primary sources of support and care for elderly people are informal and voluntary. These spring from the personal ties of kinship, friendship and neighbourhood. It is the role of public authorities to sustain and where necessary, develop - but never to displace - such support and care. Care in the community must increasingly mean care by the community. (1981).

Abrams did point out the consequences:

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From a public point of view the provision of expert services is of course very costly and the provision of neighbourliness very cheap. But from the point of view of the individual, the situation is reversed ; the costs of community care are exorbitant, those of the welfare state are low - or at least unavoidable. (1977:127)

Wicks estimates what the tax payer saves at the expense of other tax payers:

There is no doubt that the 'value' of the care provided by Britain's carers is considerable. There are different ways of demonstrating this, but we have calculated that an estimated 1.3 million carers could be providing care each year valued at £5.1 to 7.3 billion. Moreover if just 10% of Britain's carers were not able to provide such care, and instead those that were being looked after had to enter residential accommodation, the public cost of providing this would be some £1.1 billions. (1986: 17).

To put this in perspective, capital expenditure on health for 1986-87 was £1.60 billions. Fiscal costs should not be the only costs for accounting. What about the lost opportunity costs for carers? What else might they have done with their lives (Parker 1985)? The carers described the losses they had incurred. Six had given up full time jobs to become carers. Three had taken early retirement. One of the carers had suffered a nervous breakdown from the acute stress of his situation. Another carer ripped all the ligaments in his hand while lifting his wife and became clinically depressed because of his incapacity. This gentleman has a heart condition as does one of the other carers. Five carers had problems in the family to do with asking for help or getting it. All of them noted the loss of freedom to pursue hobbies, friendships or holidays and the increasing social isolation and loss of confidence that caring can bring. Two carers knew how much their efforts saved for the state.

The GP says that having Connie at home I am saving the NHS £400-500 a week. That doesn't bother me. But for God's sake give us the bits and pieces to do the ruddy job. Talk about coping. I reckon we can cope so long as we not only have the back up but the means to do the job decently. It gets me down. Really upsets me. You shouldn't be in that position . . . (Mr Bibby)

The consequences on my life? Number one, Financially. [Penny left her well paid job abroad to come home to help the family and has spent her savings]. It's also the job . . . Not using the old brain cells anymore. You lose alot when you pack up a job you are well into. It was a 15 year career . . . the longer you care for someone at home [the more it puts your career prospects at risk]. Socially that has totally changed. I don't have the freedom anymore . . . you can lose your self confidence both professionally and personally. Not as socially adept as we used to be - very isolated. And to be honest, it's boring. If you go out and they say, 'What's your day been like?' Well what can you say? 'This morning I got up, evacuated my mother's bowels and gave her lunch'. It becomes very boring. I read alot. One day is much like another . . . it undermines your confidence. (Penny Shaw)

Ungerson (1990) and Kiernan and Wicks (1990) explore the slack language of community care policy that accommodates the blurring of boundaries of responsibility between public and private caring. The state can diminish its public role to care but private replacements may not exist. Perhaps there is no close family, no sense of commitment to care or no intention of spending the family fortune to pay for grandma? What happens to those in need of care who have no social support ?

In a culture that turns structural inequalities into the responsibility of the individual to overcome, the upshot is victim blaming. The self-righteous belief in unequal access to care for those already deprived of health is the unhappy result, for the powerless and vulnerable members of society must in some way deserve what they get because they didn't sort themselves out before. Believing this, the moral majority turns a collective blind eye to others' miserable lives and suffering. Despised for situations beyond their personal control, news of beggars living in cardboard boxes on the pavements, the crippled poor in court for non-payment of the hated Poll Tax, pensioners waiting years in pain for an operation they have a right to expect, people



found in their homes long after they died or starved, no longer shocks because it is routine.

The Minister has inherited a policy which has condemned the psychotic to wander the streets in numbers unseen since the 18th century. (Prof. Robin Murray, July 7 93, in Guardian Political Almanac 1993; 114)

The free market ethos exhorts people to fend for themselves. The point at which the state intervenes to care for the elderly, sick and vulnerable has been lowered. The state has abdicated responsibility for clarifying who most needs what care today to 'market forces' at a time when demographic and socio-economic pressures make a humane strategy for care - not a market for survival - an elemental sign of moral order. Uncaring is a normal part of today's society and caring is highlighted at the level of individual acts for others that are outside the tissue of caring values for family or profession. Good citizenship by the few will not alter structural inequities worn by the many. As Dalley observes,

The manner in which individuals care for each other is not simply a matter of personal and practical responses to particular needs. It is permeated by the ideological attitudes upon which other social relations are based (1988; 138).

#### **Footnotes**

(1) The 1980s have seen a strengthening of public endorsement of centralised tax-financed state welfare (Taylor Goodby, in Jowell et al British Social Attitudes: the 8th Report 1991: 41)

(2) Both texts begin with summaries of population changes as a way of determining the prevalence of the need for care, with caveats about the social construction of need or the meaningfulness of the statistical data.

(3) Wicks and Finch acknowledge the structural settings for care of demography, economy, the law, and politics. Both assume the social practice of caring is embedded in structures but not ruled by them. Wicks discusses the potential capacity of the family to care. Finch focuses on family dynamics of the obligation to care in response to need.

(4) Dalley explains caring in the context of the dialectics of collectivism and individualism. Both are described as ideologies and structural principles. Collectivism relates the social organisation of work to the social good whereas individualism turns on the separation of public work from private family life and the atomisation of beneficence in individual acts.

(5) The measure for an ageing population is taken to be a rising median age. In 1977 this was 34 years and by 2010 it could be 40 years (Thompson 1987).

(6) eg. texts from FPCS, OPCS and British Society of Gerontology.

(7) The total fertility rate (TFR) is the rate of child bearing among all ages of women, measured as the sum of all women's fertility, calculated by summing the age specification rates.

(8) Crude ratios of dependent to working populations are misleading by themselves and should be seen in terms of the values of the society that inspired the categories.

(9) Walker (1982) and Qureshi and Walker (1989) address the elision of constructs of dependency and disability. Disability is the function of instrumental or affective need (usually calculated in terms of one's capacity to care for oneself). Dependency describes the loss of power in personal and social relations: its use in the discourse about the elderly and disabled merely rehearses the inequalities of power between generations. By extension of the language, dependency also means the amount of work someone's disability (ie physical or psychological dependency) makes for another eg. dependency ratios are measures of nursing workload.

(10) Hagestad writes that the predictor of decline in individual functioning is approaching death itself - be it in patterns of social interaction or the functioning of the immune system. It is not age (ie distance from birth) but distance from death that is significant (1986: 2).

(11) Bradshaw (1972) produced the formative model of social need : normative, felt or subjective, expressed (or unmet demand), and comparative need. Isaacs and Newton (1976) divide potential 'need' from actual 'need' as it is defined by the service giver.

(12) Depts of Public Health in Health Authorities work from available epidemiological data and data for hospital events to calculate 'need' in terms of predicted specified clinical interventions for local populations.

(13) Sixsmith (1986) describes how Newcastle pensioners value their independence, highlighting the negative connotations of dependency. Wenger's study of Welsh rural life found that people do look out for each other in a network of kith and kin.

(14) Source: McKie, D. ed. 1993 The Guardian Political Almanac

(15) For example, women who have undergone hysterectomies generally stay in hospital for ten bed days. Since the advent of 'Hospital at Home' and other similar schemes ("a nurse in the home"), bed days were reduced to five. The introduction of laser surgery may reduce bed days for hysterectomy patients to three. Surgical wards should diminish with the trend for day surgery.

(16) See Parker (1985), Joshi (1985) Halsey (1988) re debate on personal financial costs of caring.

(17) The term was coined by Rimmer (1983).

(18) Source: McKie, D. ed. The Guardian Political Almanac 1993: 122.

(19) Written answer to Dawn Primarolo MP, 20.04.93 HcD col 77.

(20) In 1990, Carrtown's Community Care Liaison Officer was sensitive to the issues raised here and was attempting to address the situation. However, this was before the advent of the Community Health Trusts, before the new joint planning committees for community care had taken off and before the 1993 NHS Act was implemented.

(21) Parker (1986) quotes estimates of 78,000 women eligible for ICA in 1983 at a cost of 85 million. After the EEC ruling from July 1986 married women were entitled to claim. During 1986-87 almost 129,000 claims were received from married women of which some 117,000 were cleared.

(22) Problems with community assessment are not uncommon eg. an old lady living alone who could not dress, wash or feed herself is turned down for nursing care (NDHA: December 93)

(23) Dalley writes, The manner in which individuals care for each other is not simply a matter of personal and practical responses to particular needs. It is permeated by the ideological attitudes upon which other social relations are based (1988: 138)

## THE PARADOX OF MEN WHO DO THE CARING

This chapter seeks to bring the thesis to a close by revisiting the results of the inquiry and the main arguments, and to suggest what policy changes, if any, are indicated.

Feminist research strategy seeks to uncover the different forms of power that secure the subordination of women; with this aim in mind, the thesis seeks to expose and challenge the values and beliefs that hold women to caring. Seven years ago, when I began this study, there were three objectives: to attack the convention that caring is women's work, to explore beliefs about sex roles and health work, and to convince people of the importance of considering the question of who does society's caring. Researching the views and experiences of men and women caring offered a way of tackling these objectives, by showing that caring is motivated by a commitment to care, regardless of sex; by highlighting the mess of essentialist assumptions that brand women as carers and inscribe the unequal status of women's worth; and by considering the current demographic, socio-economic and political context of caring that should force re-thinking on sex roles and health work.

The paradox of men caring makes its impact because of the history and culture of women caring. The force of the image is as great as the contrast which makes it: men look like misfits in the caring role because women have been typecast for it. It is the manifold pressures forcing the sexual identity of caring work that are explored in the thesis in order to explicate the paradox.

First, the thesis argues that fixed sex characteristics to decide which body is which are the conceptual equations of an absolutist archaic biology. The collapse of sex and gender characteristics into fixed biological identities had the effect of prescribing inequalities of sex and race as if they were written on tablets of stone. This kind of specious thinking pigeon-holes "biological" characteristics such as sex, race and age into hierarchical ranking order, forcing the idea of a descending series of subordinated groups who are not white male. It is born of the same imperialist strategy that subordinates feelings and bodies to the supremacy of the mind. Feelings, bodies and women are locked together in unthinking assumptions that have shaped the feminisation of care in western history and culture.

How do these assumptions about sex roles and caring seep through our lives? I have proposed the phenomenon of the feminisation of caring to explain what has happened. Even the words we use for caring picture the suppression of women's worth. The English language of caring symbolises feeling and not the work it entails. Caring has been extended metaphorically in the public domain and in the nursing discourse as feeling - nurses want to own caring as a way of expressing the nurse's moral endeavour on behalf of vulnerable people. Even so, in the nursing discourse there is the repeated unthinking application of

care as a prefix and suffix for work. The poverty of words for caring encapsulates the worth that our culture ascribes to the task. There are no words to describe what we do not choose to see or value however large the enterprise. Caring language is feminised as feeling which signals a moral act that is meant to be beyond value, not without value because it is women's work.

Not just caring words but caring images are feminised. The male regime of sexual inequalities ploughed through nursing with a conspicuous historical wake. Nursing images are made in the cultural image of women that rehearses the biological arguments of men. Women doing the invisible, unpaid or low status work that nursing involves is not unusual. Men performing the same tasks jeopardise their sexual identity in a role that is assumed to be women's prerogative. When men choose nursing, they may have to endure various forms of sexual discrimination as well as ridicule. When nurses are women, they are measured by an invisible system that marks off sexual and social deviations from perfect as a means of testing difference which can be converted to inequality. The image of women nurses is sweet, selfless, brave and subservient. When nurses are men, the biological measuring stick does not apply and compensating forces take over to justify their role. Men nurses are seen as physically strong, authoritative and technically knowledgeable. Men nurses can gain kudos from their special status in women's world and end up being promoted above their female counterparts.

Understanding the difference between shared values of caring and beliefs about sex work roles is crucial to seeing how the paradox of men caring takes shape. The female sex is consigned to caring work by false beliefs about biological

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parts that secure women's advantage to care, whereas the male sex is free to choose to honour caring values in keeping with their culturally constructed authoritative status. The right to choose to care is a male privilege and yet another female injustice. Caring values re-construct and reflect the moral feelings of men who choose to care. The men in the study justify their caring careers in terms of their moral feeling, values and codes of conduct. Women whose sex is credited with caring feelings can also be also prisoners of them if they have no sense of choice in the matter because of their structured dependency. They live their lives in the 'compassion trap'. The moral domain of women's choice to care is invaded by the false belief that it is the biological prerogative of their sex to do so - a belief that the men and women in this research acknowledge exists even if they do not believe it. With these cultural assumptions shaping our lives, caring is more likely to be men's choice and women's destiny.

Men, whose sex invests in a conceptual regime that buries feelings alongside women, help to maintain the authority of their sex by hiding their feelings. The men in this research describe a commitment to care that can be viewed as a changing weave of moral feelings and values and informs their day to day act. They also discuss the most important aspect of caring as a feeling of being in relation to others. Here they are on territory assigned to women, of close relationships, emotional confidences and connectedness. The results suggest the sexes share caring values and feelings and the experiences of men and women caring are not wholly unrelated as some gender relations theory suggested. Because today's concept of care is feminised, it is unsurprising that both sexes associate care with feelings. However, the men and women

interviewees acknowledge the false belief that men should hide their feelings. When men work to hide their feelings, among other reasons, they are also projecting their sexual status as authoritative by staying in control of their strongest emotions.

The feminisation of caring has resulted in the diminution and deletion of various aspects of caring work. The moral feeling that informs the act of caring and is reputedly beyond worth is also without worth because the work is usually carried out by women. The complex knot of unthinking assumptions ties in ideas such as 'caring work comes naturally to women' and women learn to be more skilled at these jobs than men over the course of a lifetime. Women dependents who work for free in the home may do caring work outside the home which is voluntary or poorly paid and women who are economically independent probably use other women to substitute their labour in the home. When men say they do emotion work and dirty work they draw attention to areas of work that have been deleted because of the successful suppression of women's work in a male-dominated praxis. While the men nurses followed the convention that dirty work is taboo and did not discuss it, some of the men carers were able to make moral capital out of doing the dirty work. It can be presented as proof of their commitment to care if they have chosen to overcome their revulsion to cleaning human waste and to risk their authority as men by doing work that is assumed to be below them. Men nurses and carers can gain more prestige from accomplishing emotion work than women. Since women are more skilled at emotion work and more women than men are good at the work, men who are caring for other people's feelings stand out as special. The men and women in the research appear to share the same reasons for doing emotion



work. However, it seems men act to hide their strongest emotions in order to bolster their authority as men. This act helps men to assert their sexual identity in a traditionally female sex role and it may take priority over or interfere with the display of caring feelings that would be expected of women in the role.

The strategic aim of this thesis is to expose the forms of power that promote inequalities for women in caring roles. The outline above suggests that biological, structural and cultural forces help crystallise people's unthinking beliefs about women and ensure the continued suppression of caring. What should and could be done to improve matters? There are historic disagreements about the best way to achieve women's equality, from the liberal feminist incrementalism of successive waves of legislation to radical feminist root and branch politics that put the issues on the public agenda, such as 'Wages for Housework'. In the British feminist discourse on caring, there has been disagreement about the best way to bring about emancipation for women in caring roles while protecting the interests of the vulnerable, frail and sick for whom they care; for example, legislation for equal pay for caring at home and at work (Ungerson 1990) or reducing dependence on the family to do the caring by stressing the need for independence of the cared for and increasing the role of formal care (Finch 1990)? The successful campaign to reverse the decision by the state and allow Invalidity Care Allowance for women carers illustrates both what can be done and the strength of resistance to changing conventional ideas about sex roles and health work. Understanding the reasons for this resistance is key to making some suggestions about what could be done to involve more men in caring and to liberate women from dependent

caring roles they do not choose. The ideas put forward are meant to invite discussion and broaden debate about caring in the new millenium.

1. The nursing discourse should pay more attention to the metaphorical extension of caring as work rather than feeling in order to help blur the image of feminised nursing care. Nurses should research the duration, scope, intensity and complexity of the nursing workload, particularly at the borders with lay care (Robinson 1989). The moral, economic and legal issues raised by 'sharing the care' between lay and professional carers should be addressed honestly and openly in partnership with lay agencies.

2. Lay care agencies (eg. Age Concern) should also challenge the extension of care as sentiment rather than work. It may help to publish more widely the costs of mixed care economies so that more people can judge for themselves the question of who cares and who should pay for it: eg. potential costs to public money distributed by the state against direct and indirect costs to the individual carer, the cared for and any other householders or family members. It may also help to raise the debate about dirty work, and to address the issues such as social taboos, cross sex care, the disposal of human waste from the home and the role and responsibilities of formal care.

3. Any inequalities inherent in the advertisement, recruitment, training and qualification of men and women nurses and their subsequent careers should be avoided at all stages of employment, by demonstrating that all health staff know, understand and apply the law and procedure against sex discrimination.

4. Education, employment and social security planning should examine the potential for integrating policies for pregnancy, maternity and paternity leave, child care benefits and compassionate leave with the aim of promoting the independence and well-being of all vulnerable kin (to the benefit of the state and the taxpayer).

5. The market for lay care should be properly costed, at a rate that recognises the training and/or experience of the carer, that takes into account the length, scope, intensity and complexity of care and is commensurate with the pay for substitute carers in nursing and social services.

6. There should be national body for caring agencies with the aim of protecting the independence and well-being of those people needing care at home through the development of local lay and formal care networks.

7. There should be more discussion in the classroom on the function and purpose of beliefs on sex work roles, such as assumptions that men should not show their feelings or women are nature's carers.

8. The British feminist debate on caring should continue to challenge and publicise inequalities of power in the caring relationship between different groups and individuals including women.

9. The sociological discourse should re-think its prioritisation of the sociology of feelings, particularly the ethical issues opened up by qualitative research among people who may be vulnerable to harm.

10. At the personal level, any man anywhere who wants to be different and equal by doing his fair share of the caring should be given every opportunity and encouragement by any women who are involved.

The responsibilities of care, back in the lap of the community, have not been articulated at national level. There has been more debate about the single European currency than who will pay for all the country's potential grannies and who will care for them next century. The debate has not come about because the state defused the 'demographic time-bomb' by retreating from the problem of caring for granny and pushing it onto the family, so that even if she slides off the proverbial car roof rack, the question of elderly abuse would not arise. What happens to all the elderly whose kin networks have gone and who have no support? Anyone who saw the bleak films of Vietnam war veterans in inner city army hospitals, being hosed down once a week like cars on a car lot, can imagine the human problem that is going to present itself to this country in the next two decades. We have managed to ignore so much human misery in the way of the homeless, the destitute and the mentally ill. Will we ignore the sick, the elderly and the handicapped too? Are we prepared to live in a society where human suffering is mostly hidden, the obvious sanitised and commonplace?

Apart from the moral questions about caring that may touch people in their day to day lives, economic questions are raised for the state. The irony is that the male dominated biologically constructed state could be economically crippled by the biologically constructed chronically sick, elderly and

handicapped, if the new socio-economic woman (and fewer of her) simply cannot manage all the caring that will be required.

Will conventional beliefs about sex roles and health work and modern values for caring support a humane way of life in the twenty first century? The feminisation of caring was a messy historical and cultural process that swallowed women, feelings and bodies into a conceptual vacuum that was not worth thinking about by those with the power not to be affected by it and that was a mute experience for their subordinates. Perhaps the time has come where hearts and minds can be persuaded that we have to re-think sex roles and health work for moral and economic reasons. What is required is the political will to generate a shift in our moral order so that caring is a shared value that everyone has both access to understanding and equal opportunity to act out in order to safeguard the independence and well-being of vulnerable kith and kin.

APPENDIX ONE ;

Recruitment Figures for Nurse Training by Sex in Carrtown DHA (1987-90)

YEAR	MONTH/INTAKE	NO/FEMALE StNs	NO/MALES StNs
1987	Nov	38	0
1988	Feb	36	2
	July	35	3
	Nov	38	0
		---	---
		105	05
1989	Mar	35	3
	July	36	2
	Oct	38	2
		---	---
		109	05
1990	Feb	36	2
	July	36	2
	Oct	66	4
		---	---
		72/66*	4/4

\* During the autumn of 1990 the College amalgamated and recruitment procedures changed to cover two Districts

My grateful thanks to the Admissions Officer for the College for providing me with this data

APPENDIX TWO :

Employment Figures for Nursing by Sex in Carrtown DHA (1988-91)

GENERAL NURSING :

Town Unit	1988		1989		1990		1991	
	Men	Women	Men	Women	Men	Women	Men	Women
Assistants (A/B)	2	96	2	91	2	86	2(3%)*	79
SEN (C/D)	1	98	1	100	2	105	2(2%)	107
RGN (D/E/F)	2	148	3	154	2	144	3(2%)	136
SR/CN (G)	3	25	3	26	3	27	3(12%)	22
Sr Nurse (H/I)	0	10	0	9	0	10	0	10
Director	-	1	-	1	-	1	-	1

\* Figures in brackets are the percentages of men in that grade (1990)

Appendix Two: Recruitment Figures

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Car Unit:	1988		1989		1990		1991	
	Men	Women	Men	Women	Men	Women	Men	Women
Assistants (A/B)	8	254	9	252	7	271	7(3%)*	261
SEN (C/D)	4	238	3	247	1	236	1(0.4%)	224
RGN (D/E/F)	22	445	19	459	20	438	16(4%)	397
SR/CN (G)	2	85	3	83	4	79	3(4%)	74
Sr Nurse (H/I)	1	22	1	21	1	21	1(5%)	18
Sr Nrse Manager	-----						1(20%)	4
Director	1	-	1	-	-	1	-	1

COMMUNITY NURSING :

Comm. Unit	1988		1989		1990		1991	
	Men	Women	Men	Women	Men	Women	Men	Women
Sr/CN	1	126	1	125	1	114	1(0.9%)	110
Sr Nurse (H/I)	1	31	1	31	1	31	1(3%)	28

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Appendix Two: Recruitment Figures

MENTAL HEALTH :

Carrtown Unit	1988		1989		1990		1991	
	Men	Women	Men	Women	Men	Women	Men	Women
Assistants (A/B)	6	110	6	110	7	107	10(9%)*	107
SEN (C/D)	5	33	6	33	8	32	10(24%)	31
RGN (D/E/F)	28	67	31	71	26	60	28(33%)	57
SR/CN (G)	19	20	19	21	21	18	15(50%)	15
Sr Nurse (H/I)	7	5	7	4	6	3	5(71%)	2
Sr Nrse Manager	-----						1(50%)	1
Director	1	-	1	-	1	-	-	-

## APPENDIX THREE

### THEORIES OF FEELING

This section expands on the arguments begun in Chapter Three on the defence of feelings in social research. It reviews some of the sociological literature on feelings, drawn from social policy and social theory fields and describes some of the theories of feeling that give different approaches for exploring caring feelings in everyday life. In general, there are two philosophical views in the discourse on feeling; individuals are autonomous and have the capacity to reason about their feelings and act on reason or they are passive transmitters of cultural constructs of feeling. Social theory would have us believe the person necessarily conforms or on the other hand, behaves individualistically. But the people I talked to in the interviews gave examples of conforming and individualistic reasons for caring. In Chapter Three, I describe Heller's theory of feelings which allows for both human responses. Below I explore some of the other approaches to theorising feelings.

Flam (1990) suggests the model of rational/normative man should also include emotional man because without this additional explanatory mechanism, altruistic acts are inexplicable. Flam's model explains altruism as the unintended effect of people caring on their own initiative, or as the result of social coercion or legal compulsion to give to others (see also Culyer 1985, Hollis

1987). Flam researched reasons for people's conduct in business and distinguished three groups of reasons to do with personal feelings, the emotional etiquette of the social group and organisational rules. Hollis covers similar ground in his book The Cunning of Reason (1987). He criticises the tenets for Hobbesian rationality and Humean sensibilities, and settles for a Kantian version of reasonableness of people's actions, based on an understanding of their motivating desires and beliefs. Hollis argues that the combined efforts of heroic individual action result in unforeseen unintended circumstances for society - hence the cunning of reason. Like Hochschild, he proposes the metaphorical device of actors and role play for researchers to access understanding of people's reasons. In what he terms a messy framework, legitimate reasons for action are separated from real ones. For example, people care for convention's sake, and can articulate legitimating reasons for doing what they do. They may also identify their real reasons for caring, because they have feelings and want to help, perhaps beyond the call of duty.

Hochschild's famous book, The Managed Heart (1983) put feelings in the sociological frame by arguing that they are a hidden form of social control :

Certain events in economic history cannot be fully understood unless we pay attention to the filigreed patterns of feeling and their management (1983: 11)

Her thinking is opposed to Hollis' sense of a person controlling their role. Hers is a functionalist drama of people reacting to messages and behaving in socially acceptable ways. Hochschild borrows from drama theory to make sense of the emotion work accomplished by air stewardesses; in deep acting the stewardesses justify their emotional display with reasons drawn from

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commercial norms of good behaviour. Airlines make money out of delivering superior emotional labour. Thus, Hochschild proposes a new social theory of emotion : she distinguishes someone's inner feelings from emotions to do their job and what she calls the 'feeling rules' for their emotional work. For example, nurses are guided by professional protocol for their emotional behaviour that limits how much they may reveal of their true feelings. Hochschild speculates that feeling rules are felt by people at home as moral injunctions to do the done thing. She suggests that emotional management is as much a part of life in the family as it is at work.

Heller's epic work, A Theory of Feelings (1979), draws on phenomenological and marxist schools of thought, to explore the feeling side of human relations. She raises questions about the significance of the social organisation of feeling. Heller argues that there is a direct relationship between changes in the structure of work and family and what people feel. New types of feeling go hand in hand with new types of re/productive relationships. When society changes, the values that prescribe the old order become redundant, and prescriptions for new orders of feeling emerge: eg. the British welfare state grew up with one order of feelings and its threatened demise is accompanied by another. Feelings go with the task in hand. They are concretised in work, graded by the socially prescribed value for the task and fixed in a hierarchy. For example, doctors are expected to manage their feelings differently to nurses (Gamarnikow 1978). Every age has its dominant configurations of feeling. Society mobilises for the task with normative theories of feeling ... the Dunkirk spirit, the age of chivalry, the caring nineties. Heller's arguments appear determinist. Her theory of feeling proposes the

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internalisation of commonly held values, and links the person with their cultural group, and their everyday feelings with social change. Feelings are historic events meant to ensure the survival of the group by securing the work to be done. Caring could be explained as a modern feeling, generated for society to adapt to the increasing social tensions of caring for others.

Dalley's book, Ideologies of Caring (1988), is about caring rather than feelings. However, she refers to caring as a new ideology, (based on beliefs about the family and the individual), which reveals another approach to theorising about feeling. Dalley argues that whereas collectivism connects the organisation of re/productive work with the social good, the current strategy of individualism ties it up with personal profit, with the result that :

Society dispenses with its responsibility to care for those who are weak and dependent, directing its efforts instead to support those who will be potentially greater value to society in the long term (Dalley (1988), ch one)

Caring is invested with "feeling" that Dalley dismisses as the premise for doing the work. Like Reverby (1987), she argues that society capitalises on women's 'conviction to care', that is really the internalisation of dogma about their status at work. The regime is powerful precisely because its mechanisms are concealed: people sincerely believe women are biologically suited for caring. False beliefs about sex roles generate a false premise among women for doing caring work. Dalley links the everyday concerns of people caring with their political context. She implies the power to generate social values rests with the consensus of the ruling groups. She blows away the puffball of community care politics to reveal ideological seeds to muster people's effort to care for their kith and kin.

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I have tried to argue that the intimate business of caring for chronically dependent people is directly linked to the wider responsibility which society, as a whole, has for all its members; the micro concerns of individuals in the caring sphere form part of the macro concerns of society at large. Thus the manner in which individuals care for each other is not simply a matter of personal and practical responses to particular needs. It is permeated by the ideological attitudes upon which other social relations are based. (Dalley (1988) ch seven : p.138)

Finch (1989) also writes about caring. She does not deny Dalley but she softens the conspiratorial blows of determinism by allowing for free will. Yes she suggests that the caring relationship is shaped by demographic, economic, legal and political structures that surround it. However, she thinks that individual belief systems for caring give rise to expected behaviours not cast iron certainties. Generalising how caring should be is not the same as specifying the particulars for each situation. There are parameters for each caring relationship: kinship ties, bonding, the history of reciprocal giving, independence of the carer and cared for, stages in the life cycle. Finch argues that people are sovereign and negotiate the matter of caring in idiosyncratic ways. Her theory is many sided and softer than earlier feminist viewpoints. Free will is placed in the context of local norms, ideologies and social structures, all of which may influence someone's choice but do not make it compulsory.

This section shows a spectrum of thinking about feelings in sociology. To sum up, Hochschild views feeling as a form of social control. Heller allows for individualistic acts, when people act against the tide of prescribed feelings. Hollis and Flam argue that altruism is really the unintended product of individual acts for the good. Dalley argues that caring by women is

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controlled by wrong beliefs about sex roles for work not feelings. Finch sees caring as a conglomerate of feelings and beliefs that the individual has ultimate control over.

Apparently, the term "caring" can be approached from different ontological viewpoints using the conceptual instruments of rules, values, feelings, norms and beliefs to theorise about sex roles and health work. These are well known troublesome constructs in sociological theory and unsurprisingly, they have become confused in the discourse on caring. The men nurses and carers spoke of many, different and varying reasons for caring for someone - whether it's because they are married to them, they love them, they are responsible for them or they are women and born to it. The fieldwork showed me that people's reasoning changed over time and was not static or certain. I tried to discover the web of reasons that sustain people in their caring roles and how the weight of reason shifts with time according to the difficulties people face and how they feel about them. In Chapters Six and Seven, I try to show that caring is underpinned by a constellation of reasons about feelings and values, beliefs and norms, concerned with caring work and caring feelings for another person.

## APPENDIX FOUR:

### EXECUTIVE INTERVIEW

This interview with an executive member at Carrtown District Hospital was taken down in notes which were written up immediately afterwards. It lasted less than half an hour. The time was granted so that I could ask permission to conduct the second stage of interviews. Permission was given. On hearing that the nurses were to be asked if the most important part of caring was feeling or work, the manager thought it prudent to explain to me some of the ramifications of the new NHS for the nurses.

The re-organisation at Carrtown District Hospital has been on a large scale because of government policy and regional initiatives. The three most important innovations are the Financial Information Package or FIPP, which was developed by Region; the Hospital Information Support Services or HISS, from the Resource Management Project introduced by government, and the new contracting services in line with government policy (for example, the new Medical Management Team, consisting of a consultant, senior nurse and manager, is responsible for overseeing all contracts for 350 medical beds. This follows a trend set by Griffiths to devolve economic management to smaller teams 'at the coal-face'.



FIPP has been on the go as a research project since 1979 with documents in circulation since 1984. Basically it is a software package that turns up financial breakdowns on the utilisation of hospital facilities. It was adopted by Cheltenham Health Authority to develop a complementary nursing activity analysis tool, so that it would be possible to extract information on the hitherto invisible component of nursing labour costs. It is similar to MONITOR and CRITERIA FOR CARE. The point is that since this tool has been in the workplace, nurses are more conscious of being accountable and responsible for the way in they worked because their actions were audited. Some nurses do not think about the relationship between what they are paid to do and actual activity.

For example, this manager stood at the door of the renal unit the entire day monitoring nursing traffic and stopped all journeys out of the unit that were not strictly nursing business; eg. no trips to the laboratory to take bloods because the porter is too busy, no nipping down to pass messages for the doctors etc. Finally the gesture was made permanent by introducing a rule for changing out of uniform for every journey off the unit. This stopped all unnecessary journeys and was a concrete reminder for the nurses of how they use their time and the money they cost.

A second story is about a subsequent power struggle between a group of nurses and a consultant to control the deployment of nursing labour. The nurses started to question the jobs they were asked to do once they believed they were accountable for how they spent their time. They saw no good reason for regularly monitoring the vital signs of elderly ladies who were waiting for

Part Three accommodation and where no one there would take their temperature, pulse and blood pressure every four hours in case they were ill. The consultant saw this as a challenge to his authority by a group of nurses he believed were employed to help him. The officer thought that the introduction of FIPP and its philosophy had two effects on nursing attitudes: nurses were thinking more about what they do rather than how they were supposed to act and were more insecure having discovered what they did do.

I asked about the nurses' view that national underfunding caused difficulties at local level. It was pointed out that that the new market removed the onus from government to manage the allocation of resources and put responsibility on the purchasers of health services to budget effectively to pay for what they need. It was suggested there are two levels of care by providers: the specialities and bread and butter work. Formerly the big district hospitals had offered the facilities for speciality work to smaller hospitals in the region. Base funding for the chronic case load was paid for by the sub regional specialities but if those were now to be contracted separately, there was a risk that general medical and surgical beds could close if they could not be made to pay. Besides big hospitals were rated by their assets and stood to receive fewer dispensations from government than smaller units, even though such assets are depreciating. The problem was how to balance the costs of escalating chronic care against one off specialisms.

The Resource Management Programme is still in its infancy at Carrtown although it had been plugged into hospitals without testing. It is a way of providing data to know if the hospital is on course to fulfilling its contracts

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competitively, in terms of throughput of patients, number of beds and manpower costs.

Carrtown adopted nursing models pragmatically and favoured Orem and Roper. Although such models are meant to be a means to an end, the officer thought some nurses saw them as the end by which the means were achieved. The wards still used team nursing rather than primary nursing because the latter had not been successful in ward trials. This meant that while there was a drift to individualised patient care, there was also a parallel tendency to work to a routine and 'get all the baths done by twelve'. There was also the matter of idealising the written records to fit the nursing model rather than recording the work for the patient. There should be contractual declarations of workload. Money for pay increases had to be found from the budget and had resulted in cuts in service. So it was only right for staff to know where they stand in terms of what they do, who does what and how much they cost.

I asked about the division of caring labour and the difficulties of managing separate budgets for different occupations for work done in one geographical area. The rigid division of work between different groups is very difficult to overcome. For example, ward administrators are responsible for doing work that was formerly part of the permanent staffing role because it had to be done. It is a continuous function that can only be accomplished by someone on the scene and continual prompting was required before nurses would relinquish the work. With one ward budget, senior sisters have autonomy to divide labour and pay for it as they see fit so long as it was justifiable in terms of value

for money. In the long term this could be the prime indicator of the quality of service in the area and not the work of the ward staff.

Finally we touched on the fragmented nature of caring services. Because of so much internal re-organisation, external links have been lost. I suggested that since groups of caring workers speak different professional 'languages' anyway, there could be more pitfalls when people have changed the way they work without having had time to catch up with how they talk about it to other professional groups. This met with the suggestion that all the changes in community care for different groups of recipients as well as acute services may be a potential recipe for breakdown in communication between services.

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