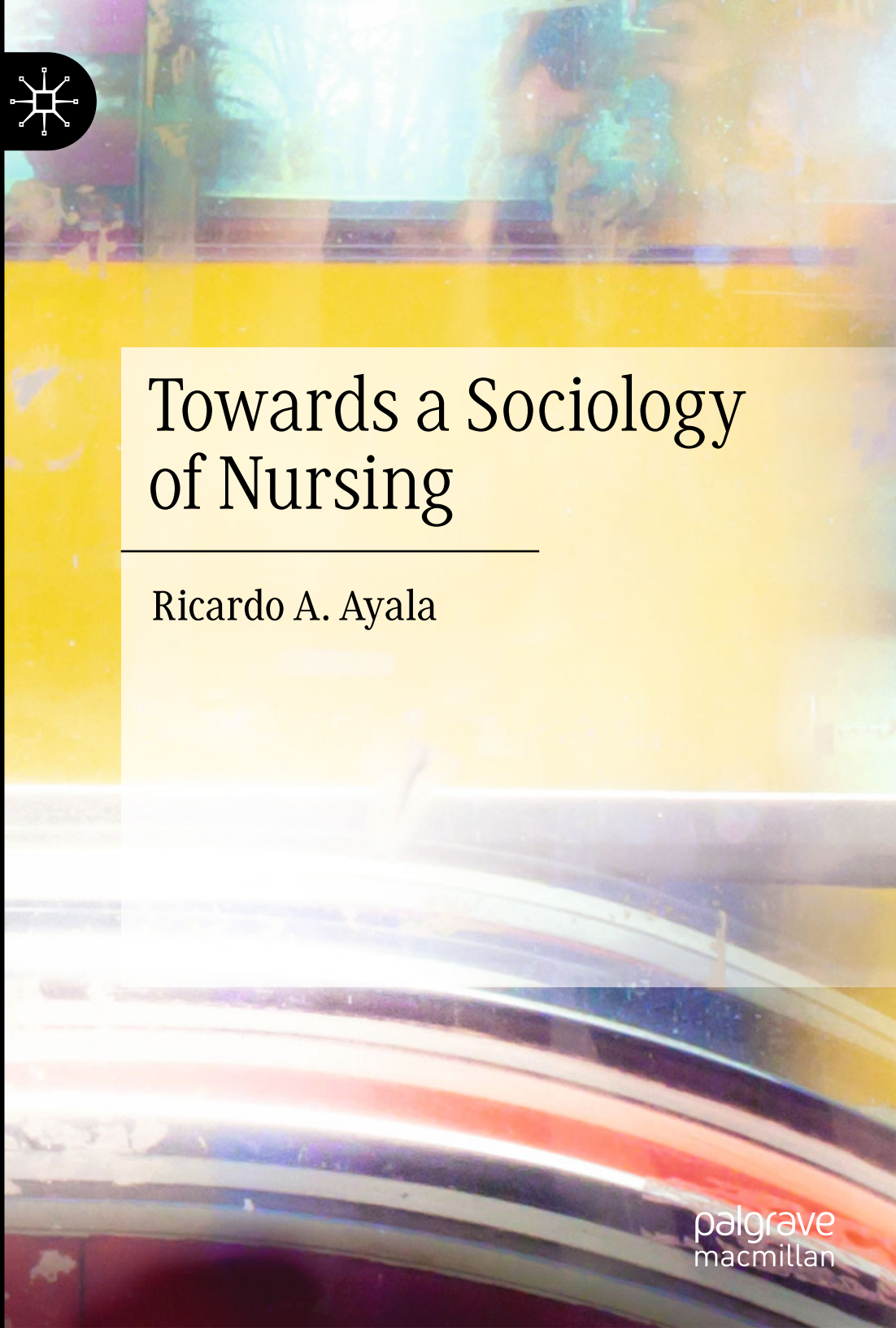
Towards a Sociology of Nursing
Ricardo A. Ayala
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Towards a Sociology of Nursing

"Nursing is often studied as a single entity as if nursing were a single issue untouched by culture, geography and political economy. In fact, it is embedded in the social relations and constructed within different socio-cultural and historical contexts. The body of work presented in this book is formidable and inspiring in its depth and breath. I see the author as uniquely able to contribute to the disciplines of sociology and nursing."

—Professor Karen Breda, *University of Hartford, USA*

"Ricardo Ayala does a remarkable analysis of nursing's professionalization. By using the Chilean example, he takes us on a historical and sociological journey that helps us to understand the progress (and sometimes difficulties) nurses around the world have faced while constructing their social image. This book is a must-read for those keen to learn more about the sociology of nursing and also a great methodological input for systematically exploring the sociology of professions."

—Professor Paulina Bravo, *Catholic University of Chile School of Nursing, Chile*

"Dr. Ayala's book traces the origins and continuum of the nursing profession throughout history as a powerful force on the health, well-being and shape of society. His book provides a useful sociological compass for navigating through the realm of professional and societal issues reflected in nursing. Ayala skillfully explores how nursing transitioned to academia, investigates the cultural schisms between nursing and midwifery and scopes the impact of the profession on modern healthcare. He offers an excellent contemporaneous and timely analysis to the gendered nuances of nursing which is much needed in an age searching for equity and equality between the sexes. Ayala's multi-faceted text appeals to the reader who willingly thinks and reflects about the minutiae, complexity and conceptuality of issues that can influence nursing practice. This book will be valued among those with an inquisitive mind and an appreciation of the rich sociological vein of interest nursing provides. I expect that lay, professional and research-mind people will find this book enriching as it adopts an accessible prose which provides intellectual nutrition that is easily digested by all types of readers."

—Professor Nicholas Ralph, *University of Southern Queensland, Australia*

Ricardo A. Ayala

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Ricardo A. Ayala
Department of Sociology
Ghent University
Ghent, Belgium

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Useful Definitions

Chapter 2

Profession

Generally, a profession is a knowledge-based category of occupation which usually follows a period of tertiary education and vocational training and experience; at least in part, that knowledge comes from science. Professions are also structural, occupational and institutional arrangements for work associated with the uncertainties of modern life in risk societies.[1]

Although distinguishing the professions from other, less complex forms of work is difficult today, oftentimes professional groups either are elites with strong political links and connections or use elites' political mechanisms of market closure and occupational control. The focus of sociological interest lies precisely in the exclusionary devices that professionalisation encourages.

[1]Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology, 61*(5–6), 778–796.

Para-Profession

Arising in the late 1960s, the term para-profession (or semi-profession)[2] refers to 'aspiring' occupations that 'evolve' into the status of established professions, but are characterised primarily by their shortcomings. Beneath this notion lies the mystification and stigmatisation of gendered patterns of the division of labour—such as nursing, teaching, social work and librarianship—which presupposes that all professions share the same value orientation.

Professionalism

Professionalism is used to denote an array of traits such as reliability and trustworthiness, which is expected to arise from the relationship with users. It is common that for professionals to be successful they have access to users' confidential or sensitive information, while users need the insurance that such knowledge will not be used for fraudulent purposes. This is why mutual trust is key to professionalism.

Social Theory

Theory is an assembly of statements of why and how ideas or facts are interrelated. Social theory uses different broad-ranging frames to formulate theory, focusing, for example, on *social structure* (fairly stable behavioural patterns), *social functions* (roles which are regarded as essential to the operation of society as a whole), *social conflict* (a frame that regards society as an arena in which some groups are benefitted while others are deprived) and *symbolic interactions* (an approach that sees society a the result of people's everyday interactions).

Most of this book's contents analyse overt behaviour, struggles and purposeful interaction between social groups, thus using a social conflict stance.

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[2]Etzioni, A. (1969). *The semi-professions and their organization: Teachers, nurses, social workers*. New York: Free Press.

Chapter 3

Social Stratification

This is a system of social organisation based on ladders hierarchically organised. Stratification transcends individuals and persists across generations and societies.[3] Some societies are stratified by castes—where destiny is defined by birth—while others are stratified by classes—where one's position in the hierarchy is rather defined by the dynamics of the economy.

Social Class

Class, as used in this book, is a rung in the social ladder defined on the basis of income, material wealth and lifestyle.[4] Different traditions and agendas of class analysis may lead to different emphasis—material or symbolic. Class coexists with other forms of stratification, such as gender, ethnicity, sexual orientation and citizenship.

Social Class Identity

Class involves not just unequal resources but also different beliefs. Class informs the way people interact with one another both within a single class and across classes, because individuals are in some way conscious of being members of a class[5] (i.e. class consciousness). Often people's actions, preferences and decisions function as markers of social class (i.e. leisure, clothes, food, neighbourhood, accent and so on) and thus reinforce specific forms of identification and relationships.

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[3]Scambler, G. (2013). Social class. In J. Gabe & L. F. Monaghan (Eds.), *Key concepts in medical sociology* (pp. 3–6). London: Sage.

[4]Wright, E. O. (2005). Social class. In G. Ritzer (Ed.), *Encyclopedia of social theory* (pp. 717–724). Thousand Oaks: Sage.

[5]Jones, P., & Bradbury, L. (2018). *Introducing social theory*. Cambridge, MA: Polity Press.

Social Distinction

Relating their social ranks, individuals make categorising distinctions of the world around them, as can be observed directly in their social practices. This creates a pattern of cultural consumption beneath which lies a specific logic: the predisposition to turn taste into markers of class.[6]

Social Mobility

People can change their position within the class hierarchy. Mobility can refer to changes in one's own class (*intragenerational mobility*) or to one's class as compared to the class of the parents (*intergenerational mobility*). Additionally, one can climb in the hierarchy (*upward mobility*) or fall in the hierarchy (*downward mobility*).

Chapter 4

Gender

There is great variation in what constitutes gender by time and culture. Generally, gender is a set of representations about sexual differences, which lead to social positions based on the meanings assigned to sex. Owing to an awareness of the pernicious social organisation based on male dominance (*patriarchy*), gender is a highly politicised concept.

Sexual Division of Labour

Division of labour based on sex is a form of organisation arising from the assumption that bodily capabilities are indicative of one's aptitudes to specific types of jobs. This assumption is socially, politically and

[6]Bourdieu, P. (2016). *La distinction: critique sociale du jugement*. Paris: Les éditions de minuit.

economically problematic; it affects individual beliefs and lived experiences and in the process defines life opportunities and the allocation of rewards. The idea of sexual division of labour helps understand, for example, why established, more prestigious professions correspond to a masculine representation of work, or why within a single profession men and women tend to have different career patterns.

Gendered Division of Labour

This is a type of stratification of tasks and roles based on differences across the range of different genders. A gendered separation implies a complex assembly of meanings and identities, rather than the sexed body alone.[7] Gender division is clearly relevant not just to feminism but to gender studies more broadly.

Chapter 5

Conflict

Individuals and groups face conflict when there are differences in interests. However, conflict is not intrinsically undesirable or harmful. It can, for instance, reinforce communal values, encourage organisation or intensify association. In sociology, conflict theories sustain that social order is based on relations between groups, which in turn are based on an unequal distribution of resources,[8] leading to latent conflict in the form of dominance. Overt conflict surfaces occasionally.

[7]Mills, M. B. (2016). Gendered divisions of labor. In L. Disch & M. Hawkesworth (Eds.), *The Oxford handbook of feminist theory* (pp. 283–303). New York: Oxford University Press.

[8]Collins, R. (1994). The conflict tradition. In R. Collins (Ed.), *Four sociological traditions*. New York: Oxford University Press.

Interprofessional Care

Interprofessional care is a deep level of collaboration between healthcare or social care providers to address comprehensively the needs of their users. It involves not just working together and maintaining boundaries, but a number of practices such as sharing and even exchanging roles.[9,10]

Professional Jurisdiction

Jurisdiction is an area of work, often circumscribed formally by legal rules, which a profession claims as its own. Formal definitions can be accompanied by symbols that highlight the profession's dominion. The boundaries between jurisdictions are constantly rethought, redefined and contested, especially through interaction with neighbouring professions.[11]

Technology

Though often thought of as equipment, technology comprises arrangements that are larger than the machines: ways of living, relationships, organisation, techniques, routines, ideas, values and, notably, property.[12] In this book, technology and technologisation are used mostly in the 'hardware' sense.

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[9]Coyle, J., Higgs, J., McAllister, L., & Whiteford, G. (2011). What is an interprofessional health care team anyway? In S. Kitto, J. Chesters, J. Thistlethwaite, & S. Reeves (Eds.), *Sociology of interprofessional health care practice: Critical reflections and concrete solutions* (pp. 39–54). New York, NY: Nova Science Publishers.

[10]Reeves, S., Lewin, S., Espin, S., & Zwarenstein, M. (2010). *Interprofessional teamwork for health and social care: Partnership working in action.* Oxford: Wiley-Blackwell.

[11]Abbott, A. (1986). Jurisdictional conflicts: A new approach to the development of the legal professions. *American Bar Foundation Research Journal, 11*(2), 187–224.

[12]Gunderson, R. (2016). The sociology of technology before the turn to technology. *Technology in Society, 47*, 40–48.

Chapter 6

Academic Credentials

A degree works as a badge (i.e. a credential) to access the employment market.[13] During the second half of the twentieth century, credentials became increasingly the standard requirement to prove one's skills and knowledge. Typically, that is the case of the bachelor's degree, and in some areas the master's degree. The Ph.D. degree is usually the formal requirement to access the scientific system, although some specific paths are oriented to professional practice.

Central to the theory of professions, credentials also participate in professions' social closure mechanisms.

Credential Inflation

Requirements from employers and wide availability of degree holders increase the level of education required to enter, and stay in, the employment market. In face of an increasing highly educated workforce, employers can afford to be more selective, which in turn decreases the value of the credentials and makes candidates to always look for higher, rarer or more prestigious training. In sociology, this is called credential inflation.[14]

Organisations

Organisations can be understood in a range of different ways. Generally, organising is seen as coordinating activities and actors towards the attainment of certain goals. However, organisation also refers to formal

[13]Collins, R. (1979). *The credential society: An historical sociology of education and stratification*. New York, NY: Academic Press.

[14]Collins, R. (2002). Credential inflation and the future of universities. In S. Brint (Ed.), *The future of the city of intellect: The changing American university* (pp. 23–46). Stanford: Stanford University Press.

social entities such as hospitals, companies or associations.[15] Formal organisations have a certain level of autonomy, are differentiated from their environment and use a range of different resources to attain their purposes, including the way they are structured and rationally organised. In addition, and underlying the central claim of this book, organisations serve as 'arenas' in which multiple external interests and values coexist.[16]

Patterns of Power

Historically, the wielding of power has had patterned ways one can identify. Not all of them are considered legitimate. At an individual level, there is the use of sheer force, coercion and persuasion, alongside many gradations in between. In other cases, power is exerted by the use of legitimate authority (i.e. parental roles, scientific degrees, among others).

At a macro-level, power has three identifiable 'faces': (i) open-face politics, that is, political action that is accessible to the public and considered legitimate and democratic; (ii) agenda-setting, which is more secretive in nature, may benefit some groups but not all stakeholders and can include both legitimate and illegitimate strategies; and (iii) manipulating desires, which implies misleadingly persuading others that decisions are being made in their best interests when that is not really the case.[17]

Some professional collectivities are often wary of power, believing—erroneously—there is something inherently negative about it, and feel more comfortable with some strategies than others, but importantly, this too varies across time and cultures. Using power is not always related to formal authority (i.e. positions, titles and ranks) and does not necessarily lead to domination.

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[15]Sometimes the word institution is used as a synonym, but in sociology institution rather refers to a society's essential subsystems, which revolve around a set of values, and this defines individual action, such as the family or friendship. Another example is the expression 'the medical institution' to refer to Western medicine as an ideology.

[16]Brunsson, N., & Sahlin-Andersson, K. (2000). Constructing organizations: The example of public sector reform. *Organization Studies, 21*(4), 721–746.

[17]Lukes, S. (2005). *Power: A radical view*. London: Red Globe Press.

Attitudes

Social attitudes are evaluative judgements over something,[18] for example one's position regarding the use of power or distaste for strangers. Social attitudes may differ from individual responses and preferences.

Political Alliances

Political alliances are made when groups have complementary interests. Some alliances can be formalised and institutionalised, while others are more symbolic in nature. The aim and strategy of an alliance can change when interests shift, whereas alliances tend to pull apart when interests totally conflict.[19]

Chapter 7

Organisational Reform

Generally, reforms attempt to 'complete' areas of an organisation that are perceived to be 'incomplete'.[20] Often driven by a new rationality, reforms thus involve improvement (or attempts to it) in coordination, efficiency and effectiveness, although reforms also alter groupings and flows of power and influence in the 'arena' that an organisation represents.

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[18]Voas, D. (2014). Towards a sociology of attitudes. *Sociological Research Online, 19*(1), 1–13.

[19]Roskin, M. G., Cord, R. L., Medeiros, J. A., & Jones, W. S. (2014). *Political science: An introduction*. Boston: Pearson.

[20]Brunsson, N., & Sahlin-Andersson, K. (2000). Constructing organizations: The example of public sector reform. *Organization Studies, 21*(4), 721–746.

Organisational Dynamics

Often non-linear, organisational dynamics comprise the system of interacting units and subunits. These dynamics include the flows of information and power as well as sequences, patterns and direction of change.

Organisational Culture

An organisation's culture is a set of shared beliefs and attitudes about accepted ways to proceed and do things. Culture is as powerful a factor as formal rules in explaining the way organisations respond.

Commodity

A commodity is a marketable good. In today's society, knowledge has become a commodity, too, since it is used in commercial exchanges either to produce other goods or services or to create more knowledge.[21]

Expertise and knowledge cannot be obtained solely from professionals. Nowadays, it is also found in guidelines and stored in machines' software, hence produced and consumed as a commodity in a range of different forms.

Social Movement

Social movements consist of systematic action addressing disagreements, undertaken by a collectivity that shares a common goal. This collective action is engaged in by those who are in one way or another excluded from participation or rendered invisible by cultural politics.[22]

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[21]Kendall, D. (2012). *Sociology in our times*. Belmont: Cengage Learning.

[22]Arthur, M. M. L. (2008). Social movements in organizations. *Sociology Compass, 2*(3), 1014–1030.

Chapter 8

Ecology

Like biological systems, social systems relate to one another as in an ecosystem. Although metaphorical, this perspective places a particular emphasis on examining the role of competing group interests within the wider socio-economic order and how resources are distributed. This perspective is useful because one cannot understand a system by looking only at its own internal dynamics.

In studying ecologies, all interrelated systems, institutions and groupings can be relevant units of analysis. By looking at different levels, one can point more effectively to the complex network of forces for change.

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Part I

Differentiation and Structuring

1

Overview of the Study

There was once a time when we thought of nurses as angelical, vulnerable and graceful figures, kneeled, cape fluttering, beside wounded men on the battlefield, pictured gesturing silence for a hospital poster or dressed in a brilliant white dress wrapped in the arms of some kissing sailor. That was a time when nurses seemed to conjure up the best blessings of human existence.

In a world crafted by *mankind*, rather than *humankind*, there remains a place for romanticism and heroism and the aesthetic representation of the nurse; but much as this idyllic image comes to the fore when we close our eyes and recall that prolific imagery, that is not the basis for this research. It may be assumed that although outside the nursing world people think of the profession in this romantic light, the truth is altogether different. It is, at its heart, a sociological puzzle.

A journey to a hospital poses one intrigue after another in every physical corner, from the surrounding roads, where one overhears ambulance sirens and wonders what misfortune may have occurred, to the very bedside where nurses scribble in patients' records. Of course, these thoughts are usually fleeting unless one happens to be a hospital ethnographer. Who are those workers? What do they do? What brought

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them to this hospital? What is life like here? What do they talk about? Do they laugh like the rest of us? Or, in academic parlance, how is the hospital socially organised and what roles do nurses play within it?

Studying society enables tracing the architecture of relations with each piece containing clues to past and present realities. These pieces reflect the conventions and practices of those who enact social roles. Work is an important part of society's functioning and social life. In this respect we ask, should nurses' work be focused on more purposely as a self-styled profession? The fundamental question being, 'is nursing a profession?', and to what extent does the long-standing debate surrounding the professional nature of this occupation hold relevance? While most of our beliefs, assumptions and knowledge about the nursing profession are dominated by the realities, problems and politics of the US society, this research is different in that it is possibly one of the largest explorations of the profession outside the English-speaking world.

In Chile, where only a few occupations are endorsed with such an investiture, the debate about 'professionhood' pointed to the basics of social stratification at work. This became even more confusing during sociological debates in European circles, though much less so in the UK and the USA. This difference pointed to the need for further examination of cross-national scholarships, which differed greatly based on world views and the role of the state in defining professional groups, allocating status and upholding privileges. Whereas in the English-speaking world, with societies oriented to open-economy dynamics, the notion of 'profession' is contested among high-status occupations, in Europe this discussion seems out of place, where the term, rather than an honorific investiture, is applicable to any specialised area of work, and thus the question 'is nursing a profession?' seemed meaningless. In this second tradition, the professions (*les métiers*) are subdivided into *categories socio-professionelles*, whereas the first would primarily dichotomise into professions and crafts—and ranks somewhere in between—which some would call 'semi-professions'. Led by two separate traditions, this divide was most surely crucial to approaching (and explaining) my initial research question.

Engaging the problem in terms of the latter tradition, the answer would have been all too easy. The former, however, offered a more

comprehensive frame for a nuanced interpretation of the construction of professions. The attainment of professional status for Chilean nurses has been a constant theme, a theme that seeps into the international debate. With this context in mind, the question is changed to: To what extent is the construction of nursing as a profession shaped by the transformations witnessed by a society? Such change brought aspects of sociological—and historical—relevance to the centre of the field of inquiry.

There are very few dates marked in my work, and in spite of its somewhat historical scent, this is not an historical study (with the exculpated exception of one of its constituent chapters). As a compilation of narratives, this dissertation tells a story, one possibly known by many but told differently. There are unpretentious reasons why I deliberately developed narratives, rather than simply conforming to the plain, formulaic writing of the academy, creating my own way of scientific expression. One aspect is that important perspectives of knowledge come to us in the form of narratives—as we approach other people's lives through their experiences, their stories bring fresh insights. A second reason is that, while I could not really bring the reader to the actual research field, improving the description of the setting and reconstructing personal stories constituted the most realistic resource to express what I perceived, saw, heard and sensed throughout my field research, otherwise virtually impossible to share in written form. I could also add that narratives modify the mood of the writer (and that of the reader), in ways that facilitate a more intimate connection with the audience, more imagined than visible. Another reason is that, far from being 'epistemologically opaque', narratives are intimately connected with inductive ways of knowing, making the researcher's implicit subjectivity in the construction of data explicit and in the process enhancing the possibilities of an enriched sociological imagination. This is why narrative matters and became central to my writing. With that in mind, I composed the chapters as if they were parts of a conversation with my unseen readers. Unable to refuse these pluses, and aware of the dearth of literary merits in them, I collected the stories fragment by fragment, one fraction of the whole at the time, as I realised that, unlike fictional prose, real settings and real stories are exactly that, *real*. Their lure lies in their realness.

The importance of this work is that we have not really had a substantial explanation or solution to the problem, should nursing be defined as a profession. Most studies addressing the topic are accounts of nurses simply giving their own viewpoint from a vindicatory perspective. This is the major criticism to nursing research—it concentrates more on what nurses *think* than it does on how they *do* things.

My methodology aimed precisely to bridge this gap. It consisted of an extensive hands-on ethnographic exploration of the nursing world, combining what I observed with in-depth interviews, and analyses of the many documents I compiled throughout my field research.

The data from these different sources were then analysed in order to build a meaningful account of the nursing profession as a systemic unit. This perspective enabled an exploration of its interaction with environing occupations, its exchanges with the landscape, its ideologies, its institutions and its internal stratification. Whereas this exploration drew attention to the functioning of the indisputable success of Chilean nursing, it in turn uncovered other problems of sociological interest, such as the detrimental consequences of its social closure project—a social pattern that benefits one group while depriving others.

In what follows, Chapter 2 traces the rise of professions in medieval societies and contrasts a range of sociological approaches to professional work. The chapter outlines the concept given to profession within mainstream nursing literature and then expands the discussion by presenting the systemic approach to the profession presenting a framework for systematic analyses.

Chapter 3 looks critically at the incorporation of nursing education into academia as a mechanism participating in the reproduction of social differences on the grounds of the eliteness of graduate professions; ethnographic narratives are provided for a novel argument illustrating a 'social distinction' sense of status elevation through which university-trained nurses have monopolised the title 'nurse' and the practice of 'nursing'.

Chapter 4 adds to the discussion on gender and gender relations at work. While there is considerable scholarship addressing internal boundaries between male nurses and nurses, little is known about the construction of those boundaries in the early stages of socialisation. Not

only does this chapter highlight the impairments in life opportunities as gender identity is balanced with nursing identity among male students, it also provides the bases for an argument about the underlying political ideology aimed at portraying an empowered image of nurses.

Chapter 5 profiles a long-standing conflict between two competing occupations, the nurse and the midwife, tracing back the origins of the conflict to the technologisation and managerialism of healthcare. While this chapter brings insights relevant to the appeasement of the conflict, it also points to contextual transformations, external to the professions, as a source or abrasive interaction between remodelling professional jurisdictions.

Chapter 6 sets forth the intricacies of health reform and the participation of professionals in it. As nurses gain new credentials and the credentials themselves gain more symbolic value, the reform process has opened up spaces for wielding power and questioning patterns of power. This argument stresses the increasing system of credentials in nursing and, more broadly, illustrates the transformation of hierarchies and relational patterns among occupations.

Chapter 7 takes a look back to the organisational setting of the reform process previously discussed, in the anticipation that bringing the setting to the fore would favour further insights into exchanges between the professions and their ecology, and how the former does not solely adapt to the latter but also manipulates it.

Chapter 8 concludes by putting in perspective the number of relations that the nursing profession has developed within the system of healthcare, and the different devices nurses use to exert power collectively.

Chapter 9 offers an overview of how I investigated the nursing profession. There is an increasing interest in exploring the professions ethnographically, because then researchers may have access to what is implicit and uncover that which participants may not always be aware of concerning their practices and interactions. By doing this, this researcher also furnished them with the opportunity to reflect upon their work.

The fundamental purpose of this book is to contribute to the resurgent body of literature in sociology regarding professions. Nurses should

realise that the aim of critically analysing their profession is, above all, edifying. In the longer term, this work may indeed encourage further thought, debate and research among nurses. The same holds for sociologists.

2

Nursing as a Profession: Old Tensions, New Insights

The professional status of nursing—the starting point of this research—has been a passionately debated issue among nursing scholars with much of the debate resting upon whether or not nursing ranks as a profession. The topic of what a profession is, in and of itself, has also led to much discussion as it can be vague and confusing, with the term often being used in contradictory ways, meaning not only that profession can be treated as a technical label, or a social symbol, but it is often also associated with honorific status. In spite of these seeming contradictions, all of these interpretations can be considered desirable. In order to reach a conclusion in this area, research in nursing has explored several approaches, many placing nursing in the realm of the 'emerging professions' or 'semi-professions' (Cutcliffe & Wieck, 2008; Hiscott, 1998; Hood & Leddy, 2006; Porter, 1992; Reed, 1993).

This chapter presents an overview of the origins of professions and the main frameworks through which sociology has addressed the subject. It begins by analysing the long-standing influence of the theological notion of social order, and the definition of professional bodies and its shaping of state-labour relations. This is followed by a sociological discussion on professional work and expertise in

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contemporary societies. At the end of the chapter, the discussion focuses on the systemic relations that connect the nursing occupation with other system components and the consequences of this interaction in the making of modern nursing.

Origins: Theological Notion of the Professions

This section of the book opens with a brief overview of the theological conception of social order and the way it has influenced the notion of what professional work is. This idea provides a starting point to understanding the social differentiation that characterises a profession, as opposed to other forms of work.

Today, what seems irrefutable is that law and medicine are held up as the symbols of professionalism. Both professions have a long history stretching back to the medieval theological model of work and state (Bouckaert, 2007; Bourdin, 2004). This provides a complex structure of society until well into the twentieth century. This approach is grounded in the dogmatic view that the state is elevated into the category of exclusive universal law guarantor, in ways that defined the political philosophy and the state corporative system. The corporatism was thus transposed from Catholicism to the state structure and extended to an entire conception of politics.

In the middle ages, crafts and professions were at the core of community development (Dubar & Tripier, 1998). At this time, workers were grouped by trade into different neighbourhoods, each trade seeking to carve out, and define its expertise and territory. This was a way of attempting to control their area of influence. The status of the professionals signified both erudition and social standing, becoming a juridically legitimate entity by means of a qualification. This principle is still reflected in such titles as, *Professeur d'État* (State Teacher) and *Diplôme d'État de Docteur en Medécine* (State Medical Doctor), among others. A professional body—that is, a corporative form—echoes such theological notion of social order and public administration (Bouckaert, 2007), recalling the idea of body of Christ (*corpus* = body), where the different members make up a unified whole symbolically. Similarly, a profession,

as in *professio*, implied that one must 'profess' an ideology and engage in it as a life choice, under oath and by means of ordination, becoming an expert in certain matters and allowed to profess a *ministerium*. The first non-theological disciplines to take on this standing in medieval universities were medicine and law (Carr-Saunders & Wilson, 1933) with which they would begin an endurance tradition. Work, in turn, would become an issue of increasing importance in civic life as well as in spiritual life.

In line with this idea, under the Catholic doctrine, a person who is not working losses a part of themselves, it is considered shameful to have no work, a reality magnified through increasing church-state integration. This structure would be further broken down into work spheres; liberal arts pertaining to professions, and mechanical arts remaining without this status. The reason is that liberal arts were considered intellectual, sacred, theoretical and abstract, whereas the mechanical arts were empirical, practical and popular. This stratification reflects the hierarchical, masculine Roman religious view not only of labour, but also of life and society, whose influence would be widespread all over the Christian world.

Despite the rise of an Anglo-Saxon alternative model of professions—as a result of the Reformation in Germany and the detachment of England from the Roman Catholic Church—the same structuring elements were used, though in a different prism. For instance, the vocation, the sine qua non-condition to aspire to a higher, professional dignity can spring as a personal calling with no intermediaries, and the labour activity supported and regulated by a community of equals, a fraternity. These elements are at the core of the Germanic dogma, a *völkisch*, worldly order that contrasts to the hierarchical Roman, sacred order (Hahn, 1995; Thornhill, 2006).

This religious origin has had a substantial impact on the separation of the professional and non-professional workspace. Separation has created a division that claims non-professional workers as the uneducated and professionals the educated, and a divide between the orderly structure of professions and the disorder that comes with the non-professional structure. Almost claiming the profession as a vocational calling underpinned by a person's ideology. Aspiring learners thus were not allowed to prepare only by themselves but by following a master who assisted

in accepting the calling and developing abilities, values and beliefs. This would give legitimacy to knowledge and practices, but would also provide disciples a uniqueness and exclusivity which, in the long run, would create lineage. In this way, a profession would become a community and a social symbol, underlined by means of a rite of transition, the oath, bringing together two components that are important for this perspective: the admission into the lineage and the adoption of a set of values, to become consecrated into the profession.

While this analysis is relevant as far as it goes in the theological-political arena historically, it brings to the fore old-fashioned ideas framing the professions, which have had a privileged position in nurses' self-interpretation, undermining greater legitimacy and empowerment, as they have long been socialised into the idea of vocation and abnegation, and in the process creating a culture of selflessness. This perspective was important in approaching my research problem and formulating further questions.

Conceptual Turns in the Sociology of the Professions

Sociology has largely been concerned with the construction of professions (i.e. Abbott, 1988; Dingwall, 2008; Dubar & Tripier, 1998; Freidson, 1970; Friedman, 1973; Hughes, 1958; Parsons, 1939; Sciulli, 2005; Vanderstraeten, 2007). Analysis of sociology points to different applications in the formation of professions, from analysing the concept as a social symbol to analysing its application. In earlier stages, sociological thinking strived to find a proper definition, identifying the professions with the privileges of male-dominated social elites. Most contemporary theorists, however, would regard a profession as 'the knowledge-based category of service occupations which usually follow a period of tertiary education and vocational training and experience' which help deal with 'the uncertainties of modern lives in risk societies' (Evetts, 2013, p. 781).

The literature shows four conceptual turns. These are the historical perspective, the structural perspective, the functionalist perspective

and the systemic perspective. These turns have driven the study of professionalism. In order to highlight them further, some features of these perspectives will be analysed while critiquing their limitations. Following this, a framework approach for analysing nursing in this context is put forward.

The historical approach. This first approach, or turn, the historical approach, focuses on how occupations develop or 'evolve' into full professional status through a common pattern or professionalisation process. Established professions such as the legal profession and the priesthood were raised to an elevated social position in medieval societies (Bouckaert, 2007; Bourdin, 2004; Dubar & Tripier, 1998) and also became a social symbol inferring on them a desirable status. Brante (1988) argues that these defining values did not define a natural process for all occupations. Additionally, the presumption of similarities between the medieval civilisation and contemporary societies leaves this approach limited, as the focus is on the idea of an underlying professional ideology. Thus, assuming a set of patterns of development to all the professions becomes misleading.

The structural perspective. The structural approach emerges from the rise of industrialisation. Flexner (1915), one of the first authors to voice views on professional work, inspired a number of authors transposing his claims into other disciplines. Drawing upon his observations on professional behaviour, he proposed what came to be the professional cornerstone. He put forward a number of traits as making up the 'ideal' prototype of a profession. These traits may be summarised as: intellectual expertise seeking to understand and master complex problems of human existence, a set of learnt practical skills, vocational orientation to social ends, self-organisation, and selective and specialised training and licensing. They are repeatedly thought of as the organising principle and the standard 'requirements', with occupations in a race for seeking fulfilment and prestige. Even though nursing authors (Bixler & Bixler, 1959; Gomm, 1996; Jones & Stewart, 1998) also assimilated this perspective motivating the forge of a structural foundation, there is a major problem at the heart of its conception, which has implications

for nursing—namely the assumption that erecting a given profession depends on internal forces only, the capacity to build an institutional form that fits those criteria. This is not to say that structural concerns are not important, nor is it to say that structure does not provide usable resources for improving nursing.

The analysis highlights the need that the 'nursing-as-a-profession' problem is a subject that needs further consideration: (i) most likely to reinforce the status quo, structural concerns depict semi-professions as caught in a static sociopolitical limbo between non-professional and professional categories, without the possibility to move into the 'protected areas' of the established professions; (ii) given that most occupations have today embarked on a similar institutionalisation trajectory, it seems limiting to see structural achievements as strong support for a professional project in the long run—if this be a process of 'professional status for everyone', then the notion of 'profession' would no longer be a distinctive category, becoming thus a superfluous word; (iii) analysing occupations in a vacuum, detached from the system, ignores mutual modifications that the system components exert on one another through their interaction, focusing the argument on internal forces only and preventing nursing from controlling its environment.

Despite how well constructed the nursing profession may be it is evident that the structural approach does not raise challenging questions so as to support analyses of nursing development. Professional groups in reality face much more complex steps in reaching the status of professionalism than merely achieving a set of traits. What is needed are frameworks that encourage new trajectories for change in their disciplines' course.

The functional perspective. The rise of modernity came to be a turning point in post-war sociological analyses pioneered by Carr-Saunders and Wilson (1933), who emphasised the 'function' of professionals in industrial societies.

Carr-Saunders and Wilson investigated the use of the term 'profession'. They highlighted the traits that would symbolise a professional group,

traits which would include prestige, social manners and lifestyle. These findings were undermined by a lack of methodological rigour and their own view of what is a profession (Abbott, 1988; Prest, 1987).

Parsons, on the other hand, views that the evolution and specialisation of labour is a facet of the complexity of modern society—by which is meant capitalist economies. The specificity of function, in turn, refers to the rationality (as opposed to traditionalism) of a profession (Parsons, 1939). While professional specificity on critical problems of human life is used in a tacitly 'functional' exchange to receive in return large freedom and privilege, rationality operates as a means of building authority, insofar as knowledge prevents doing the work just in the way the predecessors have done it.

We found that while functionalism brings some insights to nursing—especially regarding specificity and rationality—an analysis stressing functionality within nursing could lead to misleading assumptions. This is because the functional approach may highlight the necessity of a degree of 'functional' stability in the structuring of the healthcare system. This in turn may lead to the legitimisation of asymmetrical relationships and inequalities.

The systemic approach. This approach focuses on what occupations do, moving away from a focus on how they are structured. Also offering to a greater degree how occupational categories relate to one another socially within a labour system (Abbott, 1988, 2005, 2010). This approach has become enormously influential and raised provocative questions as it conceives occupational settings in an interactive perspective. This allows for a system that reflects the multidimensionality of ecological interactions showing how the system as a whole strives continuously to reach a balancing point.

While other turns focus on the internal structuring of a given profession in isolation to that of others, one of the key roles of the systemic approach is to see how external forces have relevance in shaping the professions. This looks at the system within which a profession functions and how this system affects it. As Abbott, an influential theorist on this topic, holds: 'Prominent in this interaction is competition […] Knowledge experts compete with one another through redefinition of

each other's work' (Abbott, 2001, p. 137). Further, 'there is no list of structural qualities or given functions that defines a profession. Rather, a profession is any occupation that competes for a work […]' (Abbott, 2010, p. 175).

Within this approach, are three central ways to approach nursing. First, while change is the fundamental force in an interacting system, such change is not unidirectional. Thus, the current state of a profession cannot be regarded as a definitive reality, meaning that although practitioners may gain status they could also lose it and therefore possibly lose its privileged position within established professions. Thus new emergent professions may gain increasing status and prestige becoming recognised as ethical and trustworthy.

Second, within this system, the development of a given profession depends on that of others. Understanding this, professions would take the topic no further forward insofar as the case-by-case logic keeps acting as blinkers; alterations in the zones of interaction are what moves the professional status into upward or downward directions. Third, structural claims and prerogatives of vindication are not as powerful a factor as the actual occupational activity professionals perform. Recognition is often claimed by the deployment of rhetorical resources, although how roles and functions are performed in the field is what defines professionalism and acknowledgement. Attaining control over an area of work is the key element of a profession and therefore induces in its audience a sense of loyalty and exclusivity towards the profession—a monopoly—that ultimately engenders legitimation among its clientele and establishes conscious awareness of its powers in the society at large.

Summed up, this turn points to the fact that, as societies develop and increase in complexity, work tends to follow this trend. There is an increase in specialisations, and the sophistication of work carried out. This leads to an increased number of professions and professionals within each sphere. With this in mind, it is logical to take the analysis further than strictly structural standpoints, reduced to a profession's efforts and achievements. With the dimension of systemic complexities prompting thought and debate, nursing may well widen its perspectives concerning its forthcoming phase of advancement.

The Ecology of Nursing

Abbott's (1988, 2001, 2010) ideas show the need to understand all forces that shape the nursing profession. It is not isolated labour but rather is influenced by and influences the system within which it acts. This can be likened to ecological systems and evolution. Competition and cooperation act to constrain or enhance the profession's boundaries. Of course, some may object to comparing human systems to those that occur naturally, considering the complexity of human ecologies. This is an important concern, and human ecologies are certainly much more complex than that; one cannot fully address this approach without considering nursing's built environments and their sociocultural constructs. Again, the dynamism of this approach has represented a promising step to study more adequately the evolving functioning of nursing work in its social context.

As shown in Fig. 2.1, the ecology of nursing involves the mechanisms of control that define its practice, which are symbolised as 'milestones'

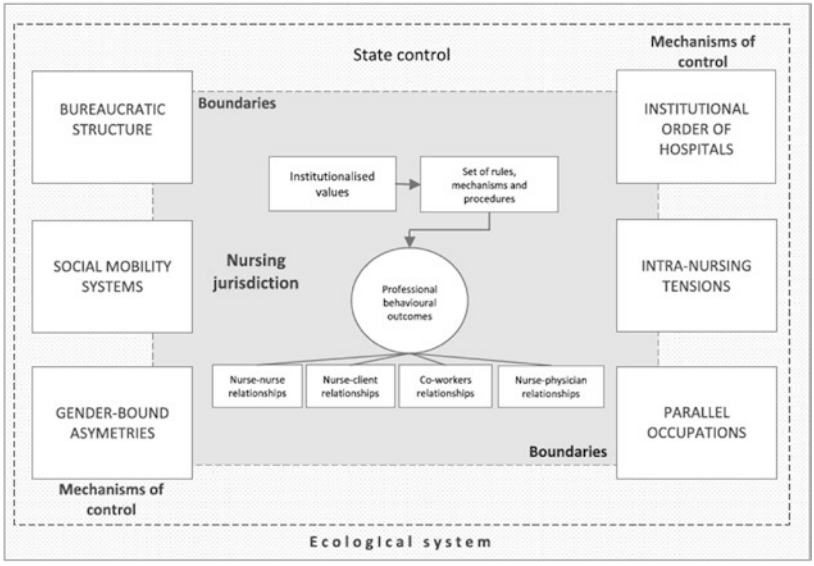

Fig. 2.1 The social ecology of nursing

on its boundaries (Nancarrow & Borthwick, 2006), enhancing or constricting its area of work, its jurisdiction (Abbott, 2001, 2010). The modes in which healthcare organisations are socially organised (Godwyn & Gittell, 2011; Handel, 2003) configure the ecology, embedding institutional values, assumptions and beliefs. This range of representations is transformed into and indeed is legitimised by means of rules, mechanisms and procedures informing relationships as professional behavioural outcomes. The system is permanently recreated insofar as the balancing point is as fragile as it is difficult to reach, given the always-changing environment. Understandably, these interactions and mechanisms, which I will elaborate presently, may be unnoticed by analyses oriented by earlier approaches.

(a) State control: The state certainly has an influence on the labour structure, the governmental apparatus having influence in almost all aspects of its structure. That being said, the prevailing literature in nursing has developed in the Anglo-American cultural context. This culture promotes the market-oriented professional functioning above that of functional contiguity between state, universities and professions that occurs in other cultures (Evetts, 2002). Countries like France and Germany embed the essence of the Continental model of state, centralised and controlling, and as such, influences public universities, defining the actual professions and favouring and establishing in the process a strong minority of 'free' professions (Evetts, 2002; Neal & Morgan, 2000). Neal and Morgan (2000) have also shown that supranational entities, such as the European Union institutions, have favoured a regulatory approach based on greater degrees of centralisation and in the process have diminished the power of national professional bodies. This approach can be challenging for nursing as those occupations with less privilege tend to become 'proletarised'.

Bearing this in mind, it is understandable why nurses in less centralised, more free-market-oriented environments, such as Chile (Jara, Behn, Ortiz, & Valenzuela, 2009) enjoy a rather respectable reputation. This esteemed reputation does not follow countries which have a strong dependence on funding from states, such as many on the

continent of Africa (Mpevo Mpolo, 2012; Obong Oula, 2004). At the same time, countries in South East Asia, such as Thailand (Jetin, 2010) and Vietnam (Anh & Winter, 2010), have witnessed an increase in the number of universities with nursing schools. To some extent, this can be explained by societal demands and universities needing to think strategically. Due to increasing uptake, it is feasible that these strategies will open up access to scientific degrees in nursing.

The increasing importance placed on nursing in emerging economies could be used for the promotion of nursing, allowing for increased status and a greater level of societal recognition.

(b) Bureaucratic structure: The structural component is another fundamental component of the nursing environment. In the post-war period, there have been two major shifts in the healthcare sector—one is the evolution of the hospital into an organisational entity, a 'professional bureaucracy', and the other is its internal planning as a 'divisional structure' (Gourdin & Schepers, 2009).

The influence of bureaucratic structures on the autonomy of the major health professions is a topic of increasing interest (Traynor, 1999; Traynor, Boland, & Buus, 2010). Hierarchical control within organisations leads to discretionary decision making rather than any real autonomy. Organisations function within a structure that dictates responsibilities (Evetts, 2002). This structural hierarchy is not a system that is set in stone and should be open to analysis and questioning. Johnson et al. (2009) and Levay and Waks (2009) speak about the move towards delegated power and mechanisms to improve professional freedom. These approaches threaten traditional modes of managerial authority, resulting in cultures that combine auditing ideas with professional criteria.

Unionisation may work towards this end. Giving workers in all parts of the organisation more say and greater participation can lead to more autonomy and discretion in terms of decision making. If not managed properly, however, this shifting dynamic could create tension and become a source of conflict. As Collins (1994) and Dahrendorf (1996, 2011) suggest, a certain amount of conflict should be expected in order to bring about change allowing professional groups more

self-determination so as to define their scope and judgement, with negotiation abilities playing an important role in holding professional interests.

Changes in the bureaucratic structures are therefore possible and can be reconsidered and relativised with regard to specific organisational patterns. Bureaucracies, too, tend to vary and evolve (Clegg, Harris, & Höpffi, 2011), and that implies the chance to incorporate the nursing political agenda into boards of management and organisational definitions.

(c) Gender-bound asymmetries: There is extensive literature on gender and how it informs nurses' relationships in both obvious and subtle ways (Davies, 1995, 2004). Women who work outside the home are disproportionally grouped in the services sector, which comprises several non-fully established forms, namely self-employment, part-time, temporary and sporadic jobs (Acker, 2011; Adkins, 1995). It can also be said that nurses deal with and perform a considerable amount of unpaid work within their salaried jobs, even non-nursing work, arguing that it is required for their task organisation and their patients' good (Allan, 2001; Allen, 2007), which in the end represents an invisible, cumulative burden.

Adkins (1995) and Grunig, Toth, and Hon (2008) show that the labour relations have links to perceived/historic family roles. These roles put women in a sphere of exploitation and show them as subjects of work. These working roles take on the patterns of domestic interaction, which although placing women in a central role sees them as objects of their environment.

Focus on these gender inequalities is important due to their prevalence and social class are ties that in nursing tend to operate simultaneously (Weston, 2011), and are among the main concepts underpinning the social transformation of the professions. Even in the social sciences, gender, class and ethnicity have been treated in separate traditions and theory bodies (Acker, 2011; Andersen & Collins, 1995), though how inequalities operate requires a conjoint, thorough analysis, as they are intertwined and embedded in organisational regimes. This perspective has also become important in Asia, developing specific

frameworks regarding gender inequalities (Ueno, 1996), including those concerning nursing (Ushiro & Nakayama, 2010).

(d) Social mobility: Hospital roles are often split between medical and non-medical roles. These roles offer different conditions and salaries depending on their perceived level of importance. This in spite of the fact that in today's society organisations tend to be democratic.

Today's hospital organisation combines caste logics and meritocracy mechanisms, producing a highly stratified reward system. Regulations are often categorised by medical and non-medical professions, a divide that explicitly includes different salaries, conditions—or even limits—for promotion, fields of practice, privileges and social constructs such as status, freedom and authority. This somehow illustrates status consistency for 'categories' of professions, reducing social mobility to the limits imposed on those categories. This part of the social landscape refers to a dimension of inequality, as the distribution of resources is fundamentally structured on a basis of academic titles rather than personal talent, clinical performance or commitment towards the organisation—a committed, experienced and talented nurse may certainly receive wages lower than, or at best equal to, those assigned to newly graduated members of dominant, established professions.

By regarding this system a fair, nurses risk allowing themselves to remain unrecognised in terms of professionalism and as a result of that underpaid labour. Due to a lack of perceived professional status, even when a nurse goes above and beyond his/her duties to ensure a patient's well-being they may still go underpaid. In order to analyse this fully, we need to look at and evaluate the prospect of high employability for those embracing a career in nursing and the extent to what nurses may maintain the status quo through embracing the hierarchical order. Again, in the best interest of nursing it is important to develop a political consciousness, consolidating in the process the nursing agenda in the organisational cultures.

(e) Institutional order of hospitals: In a sense, hospitals have been expropriated to nurses; what was once a place to care is today a place to cure.

The biomedically oriented institutional order is perhaps the greatest constraint for nursing to develop its mission. This constraint comprises three problems for nursing.

i. Imbalance: Within the medical profession, the traditional structure places nurses at a disadvantageous position. A proactive approach is often curtailed by the necessity to ensure doctors approval as they are considered more knowledgeable and able to provide definitive answers.
ii. Even when the ethos of nursing has been agreed as the human care (Watson, 1999), modern hospitals are places conceived to cure, which subsequently informs nurses' roles as well as expectations from other members of the system. As a consequence, the actual work required from nurses (Allen, 2007) poses a menace to the independent professional ethos, triggering internal ideological contradictions.
iii. Systematic stagnation: it will be difficult for shifts to have any real impact if it is concentrated on nursing's position alone. A new health paradigm would have to be put forward to have any real impact on changing nursing's position within the system. The aim would be to create an alternative system within which nursing would be both recognised more fully as a profession and a move away from what is considered its traditional role, which would consider nurses to have less autonomy (Group & Roberts, 2001). Influencing the system at large would thus seem more meaningful, so that detecting and forming coalitions with relevant political counterparts becomes vital in this systemic transformation.

(f) Parallel occupations: Medical practice has historically offered niches for nursing practice enhancement. Nurses have developed technical as well as personal abilities to cover what physicians have disregarded (Dreher & Glasgow, 2011; Fealy, 2006; Greiner et al., 2008; Shi & Singh, 2009). This same enhancement mechanism has been utilised by midwives and physiotherapists, among others, making up a process of constant redistribution of tasks and responsibilities.

With the aforesaid landscape conditions, the interplay with coexisting professions, both vertically and horizontally, is what

ultimately defines the area of work, the jurisdiction—the construction of a profession is, in other words, the identification of problems, the conceptualisation of those problems, the development of problem-solving strategies, and eventually the appropriation of the area of work, building and establishing in the process a settlement in that area (Abbott, 2010). Similarly, defending its domain from potential competitors and invaders, and adjusting its jurisdictional scope to environmental changes is how a profession becomes established. Although a relatively young profession, nursing has not only defined its settlement, but also continually adapted to landscape transformations. Without adaptation effectiveness, nursing would have fallen out of the evolutionary loop of the healthcare ecology, opening up room for other occupational categories to take on nurses' roles.

Any analysis of nursing development may thus begin with a close inspection of these areas of contact with other occupations to explore how their systemic interaction defines and redefines one profession's success, and to what extent that is affected by the success of that of others.

(g) Intraoccupation tensions: Finally, in doing systemic analyses, one needs to bear in mind that the forces within nursing may not be equally strong—practitioners, scholars, union leaders, they all look at the profession from a different angle. Nursing scholars consider nursing practice critically and thus lean towards the improvement of a scientific reasoning in the practice of nursing and the adoption of nursing terminologies. Conversely, practical nurses may tend to consider that nursing theory is somehow unrealistic, and therefore scholarship may be relatively neutralised by practical knowledge.

Additionally, several views and trends may be found within the nursing discipline, which represent interacting components not necessarily equally emphasised—human care, healthcare management, delegated medical roles, among others, each of them stressed as differing versions of professionalism, becoming competing interpretations. On a nationwide scale, nursing associations represent another intra-nursing force, as they advocate for legislative and regulatory initiatives to negotiate with the states politically and to protect nurses' interests.

Worldwide, nursing organisms forge the projection of a global perspective on health issues and policies (D. Benton, pers. comm., October 19, 2011) which brings nursing into a more visible and influential position (Cody & Kenney, 2006).

Bringing it all together, these dissimilar versions of what nursing is and what its vector of growth should be required an exhaustive examination of the nuances and interpretations of the intraprofession system as well as an authentic discussion on the future of nursing as a profession.

Conclusions

In this analysis, I have discussed the construction of nursing as a profession, based on the major theoretical frameworks in the sociology of the professions. Whereas analyses inspired by historical, structural and functional approaches may threaten to confine nursing through static definitions, the systemic-ecological approach may more fruitfully raise helpful questions concerning status construction.

By analysing nursing in a systemic perspective, it becomes evident that social ecology informs the areas of contact between nursing and those coexisting professions, resulting in reciprocal implications. Similarly, environmental conditions, such as landscape transformations, require changing and rearranging the constituent elements of nursing as a subsystem in order to adapt to those external transformations. As explained, the ecological logic of the professions is characterised by the instability of the system, and therefore establishing a profession cannot be regarded as a definitive, invariable reality. Rather, change is the fundamental force of occupational systems. Although there are a number of social milestones defining nursing performance, the relative success of nursing lies heavily on its ability to adapt to that continuous transformation as well as to protect its jurisdiction from competitors; this behaviour is in fact more compatible with that of fully established professions. Having change as a constant, the current status of established professions cannot be regarded as a definitive reality either, and

this is anticipated as a vector of evolution for a wide range of emergent occupations.

The present analysis also sets the bases for comparative nursing studies, proposing a framework for empirical applications of the systemic-ecological theory, with a view towards the consolidation of a 'sociology of nursing'. Analysing the nursing occupation in any given country might begin by examining the milestones that define occupational boundaries, either the environmental forces or the interacting comportments. Additionally, this sociological prism may broaden descriptions of the nursing profession into more articulate definitions, considering the particularities of cross-national differences, their social realities, and their evolving nature, uncovering in the process problems of a social nature informing nurses' work such as class, social mobility, ethnicity and inequality.

In using the ecological approach, this discussion invites readers to reconsider an old debate about professional building in nursing and to expand formulations of professionalism, which accounts on structural achievements cannot move further forward.

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3

Nursing the Status: The Construction of Work and Social Class Identity

Building on ethnographic data, this chapter brings fresh insights into the academisation process of nursing education, which highlights social transformations as a more comprehensive focus for examining the development of nursing. The results point to class consciousness patterns in nursing academisation that participate in the reproduction of social inequalities and, importantly, show that class identity formation is as powerful a factor as gender identity in the development of modern nursing.

Literature on nursing tends to focus on two main concepts: gender and academisation. On gender, there is extensive literature analysing the way it effects nurses' relationships, showing how power dynamics shape forms of control and exploitation of women as subjects of work (Acker, 2006; Adkins, 1995). In relation to academisation, a higher degree of learning is considered as a crucial factor in the evolution of simple trades into occupations. Full professional status materialises in advanced research, an evolution of theory, postgraduate studies and social mobility.

Analysing the results of the academisation of nursing, however, one can no longer disregard its relations with social reproduction, i.e. the replication

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of institutions and structures that perpetuate social inequalities (Bourdieu & Passeron, 1970). Hospitals are the places where nurses most often perform their core occupational activities. Here, nurses are connected with other occupations within a socially organised setting, and as such, the hospital represents a field of large cross-class interaction that provides valuable information concerning social reproduction and social mobility.

Abbott (2005) shows how most of the discussion regarding professional development has focused on structural achievements while disregarding the ways in which professionals are socialised within an occupational system. Occupations within a system interact, meaning that they form relationships and that the actions of each have implications on the others. Abbott (1988, p. 33) states: 'the professions make up an interacting system, an ecology. Professions compete within this system, and a profession's success reflects as much the situation of its competitors and the system structure as it does the profession's own efforts'.

The aim of this chapter is to highlight the impact of academisation on social mobility. This focus is not readily available in the current literature and thus has afforded minimal discussion. To address this issue, we will analyse the extent to which social mobility in nursing is shaped by social transformations and by nurses' interactions? The examination of this focused on two concepts of critical importance in social reproduction theory: social stratification and social mobility. These concepts in turn are analysed in four sections: (a) the academisation of the nursing occupation; (b) social aspects of Chilean nursing; (c) socially based tensions among nurses; and (d) socially based conflicts of a fractured occupation.

In conclusion, the chapter poses a discussion on the particularities of the academisation and social mobility in nursing, especially though not exclusively in Chile. The aim being to show how changes could lead to policy implications for nursing in that country and for individual nurses.

Academisation of the Nursing Occupation

Within the last twenty years, there has been a push to gain full professional status in nursing. Following the structural approach of professional work (Flexner, 1915), nursing has focused on the traits that

were thought of as the bastion of autonomy and status. Accordingly, much attention has been paid to intellectualise the practical activity they perform, to improve self-regulation of practice and to gain entry into the academy.

Models of training in nursing have changed from the earlier apprenticeship model to a movement towards a more academic-based model. This is confirmed by the growing number of scientific degrees in nursing. Despite this shift, the link between organisational patterns and the academic training seemed to remain quite unchangeable. That is to say, that although nursing schools moved from hospitals into universities, the training remained fairly similar. That which was taught now reflected previous hospital procedures, which in turn was mirrored by a new generation in the hospitals in which they worked. Whereas teachers bring experience, students reproduce it in a practical exercise. This is a circular idea that may be conceptualised through the social reproduction theory; Bourdieu and Passeron (1970) argued that the educational system is an instrument of social reproduction, not of mobility but of replication of a social space of quite stable patterns of domination and inequalities.

Although it is difficult to obtain precise measures of the social class background, nursing is considered as a helping female vocation and a middle-class occupation (Callinicos, 1983; Erikson & Goldthorpe, 1992; Weston, 2011). The notion of class refers to the distribution of capital, or 'the set of actually usable resources and powers' (Bourdieu, 1984, p. 114). In a productive setting then, class interaction is crucial for a critical appraisal of the distribution and actual use of powers among occupations. Such setting is a system (Abbott, 1988), by which is meant a complex set of mechanisms that outline expectations, as nurses coexist with other occupational categories. The distribution of resources and powers thus depends largely on the reciprocal relationships within the system components.

Empirical research into nursing performance can build on class analysis and help in the analysis of nursing dynamics. Wright (2005, p. 22) argues that one of the consequences of class is that 'what you have determines what you have to do to get what you get'. This knowledge and a shift in this approach could lead to a change and more open access to life opportunities for nurses. It may also lead to a more open

dialogue within the work structure and improved channels for nurses to voice their views on health policy. This, in turn, leading to nurses defining their role within the system and negotiating their position within it.

From a structural point of view, the link between healthcare organisations and nurse training is important. Then, we must look at how the academisation of nursing can help in changing the process of social reproduction. But, is academisation a turning point in redistributing resources and powers to nurses?

From here I provide some background information on how nursing is shaped within the Chilean context. This is presented along with the methodology and findings of an ethnographic study. These are discussed with the tensions that were highlighted within the occupation that surfaced during this study.

Social Aspects of Chilean Nursing

During the twentieth century, the philanthropic role religious orders and institutions were central in the areas of education and social welfare in Latin America. This role was also taken on by central governments. Both groups along with religiously inspired people from the bourgeoisie managed the provision of basic services (Guarda, 1978; Sanborn, 2006).

Healthcare groups helped to organise the rise of charity associations among the 'female' elite class. This leads to the appearance of a type of proto-nurse. Organisations and societies, like the Drop of Milk Society and the Chilean Red Cross (formerly Chilean Red Cross of Ladies), organised services to meet the poorer population's needs concerning health and nutrition (Alvarado, Cheetham, & Rojas, 1973; Illanes, 2006; Subercaseaux, 2007).

The organisations and charity association activities brought women into 'circulation through the extra-domestic space' (Ossandón & Santa Cruz, 2005, p. 98) and also into contact with other classes. This contact was a pivotal factor in the integration of women into the public sphere. Well-educated ladies migrated from these charities and organisation to the employment market. Due to the type of work being done in these organisations, teaching and nursing were the most eligible occupations.

As the status of nursing was one of the upper class, nursing became an element of class distinction (Bourdieu, 1984). This was especially visible among those sitting on hospital boards of management.

On the other hand, a medical assistant known as *practicante* arose from both the hospital as an ally of the physician and the army's organisation. The *practicante* was similar in scope to the nurse, but more focused on surgical matters. The nurse was quite subordinated to the doctors' will and had more responsibility for taking care of the sick. Whereas the *practicantes* had a rather practical knowledge, nurses earned university training by the second decade of the twentieth century (Muñoz & Alarcón, 1999), by which time dispersed institutions providing nurse training had merged into a single university.

The entry of nursing into the academy brought two results that are important to the present analysis. First, nursing was raised to the status of a graduate healthcare occupation. From this, the *practicantes* began to disappear gradually from the sanitary scene. Their occupational role was slowly taken over by the auxiliary nurse. Second, access to university education was intended to overcome highly selective entry requirements. Entry requirements were at that time difficult to achieve, without further recruitment from outside the educated elite, creating a process of exclusion and segregation.

Educated women became more and more attracted to occupations that offered better conditions and salaries, such as law and medicine. This helped to open up nursing to the emerging middle class.

With the foregoing historical backdrop, this analysis now examines the place of nursing in the social structure of the early twenty-first century, including the way it shapes the relationships to other occupational groups and defines its function within the system.

Compiling Nurses' Stories

Apart from the structural details of hospitals, this analysis also looked at how nurses' narratives of their work bring fresh insight into both status and occupational identity. In this reconstruction, I isolated and used nurses' stories as the master cases to illustrate the emerging

categories. Five individual nurses' stories constituted the narratives with which to construct a more nuanced picture of what nurses do.

i. Millaray is a recent graduate nurse. She has a short-term contract in the internal medicine ward. Millaray originates from a family of peasants in the Andean foothills, with which she keeps up a relationship via her widowed mother. Millaray's personal motivation is to increase her salary to be able to help her mother financially.
ii. Like many others, Roberto is a fireman who decided to become a nurse. A father of two, he works at the emergency department and in his time off he takes extra shifts as an ambulance nurse and, occasionally, gives some lectures on resuscitation techniques. He is known for his charismatic personality and his efforts in getting close with the assistant personnel.
iii. Pia has been working shifts in the intensive care unit for five years. Recently married, she is seeking a job with normal office hours. Thanks to her vision and personality, her colleagues regard her as a good candidate for the chief nurse position.
iv. Diana works in palliative care and wants to further develop her career by doing a master's degree in administration. She graduated a few years ago and appears to be in her early thirties.
v. Marta is both the chief nurse of the surgery ward and an exceptional person. She grew up as a nurse as the hospital grew. She became an assistant in the late 1980s and became a nurse in the 1990s, thanks to a good deal of family sacrifice, a bank loan, and what she said was 'God's help'.

There are some similarities in the professional paths that these nurses have taken and in their personal lives. Certain personality types and people with specific personal preferences gravitate towards certain occupations (Chusmir, 1990; Huntington, 1974). However, resulting from the rise of the middle class in the late 1970s and 1980s in Chile, today's nurses are coming increasingly from low- or average-income families, with very few or no professional referents. A trend that is visible in other areas of health care probably stemming from 1960s

reforms which lead to the expansion of public health measures in the 1960s (Szot, 2003) meant that many people looking for a better life turned to health care for employment opportunities. This is highlighted by how few nursing students come from private schools. Ministry of Education figures show (Ministry of Education of Chile, 2012) that only 7% of nursing students and about 1% of nursing auxiliaries come from these schools which serve the elite (Arum & Velez, 2012; Gauri, 1999). These figures are in stark contrast to the level of intake for medical courses arrived from these schools (over 50%).

There is a notion that nurses are driven by an overwhelming desire to help people. Yet in the Chilean society of the early twenty-first century, this thinking is more clearly related to how working-class people help each other by sharing basic subsistence goods and performing selfless acts. Rather than the symbol of distinction that it used to be (Alvarado et al., 1973; Illanes, 2006; Subercaseaux, 2007), helping seems to reflect a mutual system of support on which the social relations of low-income families are based (Happe & Sperberg, 2003).

I identified Pia's social background as a 'negative case' because it stood in contrast to the general pattern. An evident manifestation of such contrast was her recurrent talks of leisure and cultural activities as a subject of interest, with apparently no counterpart to share this interest satisfactorily, together with an accent uncommonly heard among nurses that makes the others refer to her as 'the posh one'.

While at the hospital, observing, it became clear that nurses appear to share a middle-class consciousness, patterns of taste and language, when compared to the culture of 'ordinary people' in the street who understate manners and protocols but embrace effort and honesty. Thus in the hospital setting, a sense of class integration—the assimilation of values, beliefs and behaviours considered appropriate within a community—develops. This takes place during social interactions and is extensively reinforced throughout academic training especially because the majority of nursing instruction is provided by other nurses, who agree on approval requirements and safeguard community values. Nurses' individual origins and the notion of social class then become central in nursing identity.

Caught in a Dead End

One of the key focuses of my analysis was the extent to which a nurse's values and attitudes helped shape his/her professional and social relationships with other nurses.

One of nursing's core duties is taking care of people. I would argue that this sense of responsibility to others permeates their personal life and the construction of nursing's professional ethos (Watson, 1999).

Expectation of the workplace environment for nurses may be one of tranquillity and understanding, surrounded by a caring community. Fieldwork data, however, suggest that this expectation may be very different to the reality. One of the reasons for this can be the high-stress work environment that tends to exist in a hospital, where time can be the difference between a life saved or lost (McMurray & Clendon, 2010). Added to this is the reality that nursing is, for reasons I shall outline below, socially speaking, an arena of severe competition.

Aware of the necessity to develop her career and reflecting on her experience in doing administrative arrangements, Diana stated:

> When someone [nurse] wants to make progress, there appear obstacles, obstacles and more obstacles. It's like, when I said I wanted to study a master's and I got enrolled, none of my colleagues were willing to cover my shifts.

This reiterates a tension that, as the fieldwork progressed, became clearer:

> We, nurses, should be closer and more united to each other. (Marta)

> Some colleagues here give themselves airs, you know, like a centrepiece. They consider they should become chiefs, and that's why they want to study further. They say they want to learn more and change things. I also wanted to study last year but they said it was not my turn, that there was someone else before me, but eventually nobody studied. On my second attempt, nobody 'could' change my shifts. (Roberto)

This tension is created due to a lack of enthusiasm for the encouragement of the progress of individual nurses. One reason for this may be that it does not seem to be congruent with their socially ascribed identity of selflessness. Added to this is the fact that social mobility is a scare resource, and so the tension builds. Becoming a qualified nurse represents a kind of upward intergenerational mobility, through which a low- or middle-income person may substantially increase his/her employability and earnings, but individual social mobility remains limited. Lacking the power to change the way hospitals are organised socially, the tendency is to inhibit channels for individual progress. Although it is rare, there are exceptions in personal social mobility:

> Pia married a doctor. I believe it was a disaster for her career: the other colleagues are unfriendly with her, and it's because she's changed … she dresses differently now, she's changed the way she speaks and has other friends … Have you noticed that nurses who are doctors' wives only join with other doctors' wives? (Diana)

> I guess that's not for who I am, but rather what my husband, an important doctor of this hospital, symbolises to the rest of my colleagues… that's why they take distance. Also because I don't actually need as much money as they do… jealousy you know. I don't find them bad persons but the relationships between them and I were somehow broken off. (Pia)

The struggle seems to be really in terms of a class struggle rather than a competition for professional places. The aspiration is thus not just in terms of professionalism but also an aspiration for class advancement. This quest for social mobility involves interprofessional relationships too:

> The thing is, thirty years back we're trained to get the attention from junior doctors. Today that doesn't happen anymore but there is an implicit competition between nurses and doctresses. (Marta)

The social transformation of nursing as an occupation and the subsequent competition for status and mobility generate tensions that can result in hostilities, difficult validation experiences and contradictions that need to be relieved:

> If one of us [nurses] gets into trouble no one will help her or protect her, except a friend… but no colleagues. We aren't close to each other, not really. Doctors protect each other and auxiliary nurses protect each other… but we don't. (Millaray)

> This is not politically correct, but I always tell my students, 'to a nurse, there isn't any worse hazard than another nurse'. (Marta)

An analysis of this may use Marx's (1976) concept of 'superstructure' as a microscope—a class is the base on which the social consciousness, the superstructure, is built. What is necessary is to rethink the academisation of nursing, not just as an abstract concept but as one with practical implications for nurses as individuals. Moreover, organisational parameters for social mobility can influence the impact that nurses can make as a collective group. These parameters include conditions for promotion, collective privileges and development policies, disregarded since nursing attained and consolidated academic training.

We Don't Belong Together, Nurse

Previously, in Chile nurses were categorised into different roles, either nursing auxiliaries or university nurses. The latter category, as one can tell from its name alone, was given more prominence and putative privilege due to its higher social class origins, with which it was anticipated would garner a more professional status for the nurse.

In turn, it was the nursing society which decided the role of nursing auxiliaries. This means that their duties were to a large extent, determined and delegated to them. In 1995, this was ratified, when the Paramedics and Nursing Auxiliaries Association accepted that, in a clinical setting, nurses' instructions are a part of their routines (Ministry of Education of Chile, 1995).

A concern of auxiliary nurses has been the way they are referred to, since in practice they are not permitted to use the title 'nurse'. From the outset, they were grouped under the collective title of 'Nursing Auxiliaries' rather than 'Auxiliary Nurses'. However, there was an

attempt to remove any trace of a relationship of dependence which the former title suggested by changing their collective title to 'Paramedics'; with this, it was clearer that their orientation was related to health-care systems rather than to nurses. Nevertheless, their 'nursinghood' remained quite unalterable.

Another important move came at the beginning of the twenty-first century when the Paramedics and Nursing Auxiliaries Association succeeded in attaining an enhancement of their training. Courses were extended for up to two and a half years, meaning that Nursing Auxiliaries could now pursue the degree of Higher Education in Nursing Technician, also known as TENS (*Técnico en Enfermería de Nivel Superior*). One of the reasons for this move was to ease access to university education. It also required a group of nurses to provide the training.

The advent of TENS training has helped to narrow the technical gap between nurses and TENS-trained auxiliaries. TENS training is similar to how nursing education had been, ensuring that practical knowledge and how they are perceived in society has narrowed the cultural gap between these groups.

Additionally, there is a relation of contiguity between the two groups, since they coexist together in a special symbiotic dyad, because of the strong similarities in their social origins, and the intimacy developed during their 'seclusion' in the wards. This may explain why both groups attempt to show how they differ from one another. With this background in mind, it is easier to understand nurses' concerns when an auxiliary is called 'a nurse' by the public, as the following extracts from my data illustrate:

> She is not a nurse – Millaray said while looking over her glasses inquiringly – she is an auxiliary nurse. The clarification sounded absolutely precise. The patient did not respond. Maria, the auxiliary, serpentined through a crowd in the hallway and vanished. (Field notes)

> When I was a newly graduated nurse my mentor taught me: 'Auxiliary nurses are the maids of hospitals. You see? You order, they obey'. Only recently did it occur to me that it may be worth considering the extent to which this is true. (Diana)

> We watched in disbelief. The word maid returned hundreds of references and flashbacks of tense situations we had witnessed between nurses and assistant nurses. (Field notes)

> When I started dating with an auxiliary, it was terribly criticised, you know. They said that I'm a professional and she's an auxiliary… this is not well looked upon. I knew it, but we insisted. Later on our chief nurse realised… the meetings were the only moment she was not looking only at me. (Roberto)

The attempts made by nurses to perpetuate this difference to nursing auxiliaries, and ensuring the idea of two distinct groups has origins in the 1940s. Through women's magazines, nurses tried to educate the public to the fact that they must not be confused with auxiliaries, as the following extract from Revista Eva illustrates:

> There exists only one type of nurse: the professional nurse, the one who holds her title and diploma after pursuing a 3-year training in a nursing school. She is recognised for her uniform and her work, which is to watch always the patient [… and] to control her subordinates' work. […] Girls of hospital rooms: these are not nurses and will never be, unless they undertake training in any of the schools. (Revista Eva, 1948, p. 37)

Nursing auxiliaries' identity has been built on the idea of a labouring class, contrasting with the 'professional class' claim of university nurses. Referring to this, Maria's colleague explained:

> We are called by our first names. Nurses, instead, must be referred to as 'Miss', for real! They are women who keep their distance. There've been very few cases in which a nurse and an auxiliary have become friends, but this is censored by both nurses and auxiliaries, so in public they have to pretend they aren't friends. (Maria's colleague)

Yet this detachment seems to be at a more discursive level than the cultural practices domain:

> I've noticed nurses share social behaviours with auxiliary nurses, rather than with doctors. The sense of humour they enjoy, the vocabulary they use, the kind of music they listen to, they are all connected by these things. (Field note)

> Barely possible to be ignored and above all the background noise, we could hear lively music and shrieks of laughter coming from a staff room. The nurse who was writing at the nursing station lifted up her head and looked at me saying with a tone of embarrassment, 'Do you see what we have turned into? Professional form-fillers!' Music went on. (Field notes)

My fieldwork has shown that an idea exists which holds the nurse as the only indispensable member of a team. This does not include auxiliary nurses. This ideology highlights the view that nursing is considered superior to auxiliary nursing. The view put forward is that nursing is vital due to its role as a 'connecting' piece within the hospital's functioning. It is hard to gauge just how dispensable or indispensable a given occupation really is. Power structures are set up in such a way that those who are in positions of power wish to maintain their status. Groups want to ensure that they hold onto a position that allows the potential to social disruption should they withdraw their labour thus ensuring a position (Parkin, 1979).

Apart from this, reference to auxiliary nurses in Chile had tended to focus on how they are not nurses or to state that auxiliaries' training was handed over to nurses (Chilean Nurses Association, 2012; Chilean Society for Nursing Education, 2012). Almost to the extent to where a researcher may say they have been systematically excluded from any analysis of Chilean nursing. Their attempts at setting up programs in higher education have also encountered difficulties (Mönckeberg, 2007).

From this analysis, the following three insights concerning the relationship of nurses and auxiliary nurses may be inferred. First, the title 'nurse' and the practice of 'nursing' have been monopolised by university-trained nurses, although it is evident that auxiliaries as well as other healthcare providers perform certain nursing roles and functions. Second, the exclusion of auxiliary nurses from the analysis of the nursing occupation in Chile has resulted in an incomplete picture of the

history or development of Chilean 'nursing'. Third, a power dynamic exists within the nursing occupation in Chile within which nurses are dominant and auxiliary nurses are subservient. This relationship is almost a mirror image of that which has existed historically between the doctor and nurse—an asymmetrical relationship which leaves nursing as a whole with minimised political power.

Despite this however, it seems clear that the development of auxiliary nurses will continue to grow. It is difficult to be certain if this growth will help lead to the merging of the two groups, but nursing could be significantly strengthened with such a merger.

Social Reproduction of a Middle-Class Occupation

Having reviewed the creation of boundaries between nurses and auxiliary nurses, it is necessary to revisit the internal boundaries of university-trained nurses. Confronting these boundaries, it is possible to see a duality between an old-fashioned idea of elite ladies who became nurses and middle-class people who 'should' adopt a professional class identity despite their cultural closeness to auxiliary personnel.

Conversely, these values are in fact internalised across the organisational grounds; outside the hospital organisation, auxiliary nurses and university nurses appear to experience greater degrees of freedom, with both adopting exchangeable nursing practices and building closer relationships. The most valued rule of nurses' identity, 'do not allow them to call you by your first name', is easily broken.

Has the social identity of nurses become stronger than a professional class identity? It would appear so. According to Larraín (2001), contemporary Chilean identity has been strongly influenced by both social class and occupation. Thus, as society's middle class grows, it seems reasonable to discard the old-fashioned ideas of 'eliteness' of professional groups. This has import for the construction of the professional discourse, so linked to exclusiveness and distinction, and in

the case of nursing, a mystification of 'ladylikeness' in the social imaginary as well as in the academic discourse, as our data illustrate:

- *Senior lecturer*: Nurses don't have to just call themselves as professionals, you know, they also must behave accordingly.
- *Interviewer*: I'm not sure I understand…
- *Senior lecturer*: I mean, nurses must not look like their own maids.

This discourse reinforces the status quo of the social order of hospitals, which remain very hierarchical and stratified on the basis of social class origins. In time, this discursive production leads to the reproduction of inequalities:

> Nurses rarely, if ever, marry auxiliaries. That's uncommon, even weird. They rather marry doctors …or male nurses but this is also uncommon, not that weird but still uncommon. I see it's more common that an auxiliary nurse dates with a male nurse, but not in the other way around. Same for doctresses, they never date with male-nurses. (Diana)

Bourdieu's notion of social reproduction offers a framework for understanding these practices and behaviours among nurses and their co-workers. The academic training that the nurse acquires not only reproduces a body of technical knowledge but it is ultimately political for society at large, as it reproduces social institutions and structures:

> What attracts our attention when leaving the field and comparing our notes? Millaray continues to work extra time on weekends, typically 12-hour shifts, not for time off but for extra bonuses. Roberto, the fireman, broke up his hidden relationship after six months of being pressured to do so. Thanks to her husband's influence, Pia eventually got out the night-shift system and has a normal life. Diana remained within what has always frustrated her, the difficulties to find support to go back to college. On the third floor, Marta is striving to find the right words for a presentation before the Ministry of Health. Ironically, as we stepped out of the hospital, the air smelt pure and sterile. (Field notes)

Conclusions

I have made a case for and analysed the nursing occupation in Chile, based on two major components that emerged in the analysis, namely the social transformation of nursing which shapes nurses' relationships and the singular academisation process and its ineffectiveness in preventing the reproduction of social inequalities. Although this case study is limited to a single institution, as a field of large cross-class interaction, a hospital reflects many of the features of the broader society.

In using academisation as a key factor in professional development, authors usually refer to the access to full professional status. However, class consciousness and social behaviour may more usefully provide a focus for examining the development of nursing in a given country, as professions are connected to the social transformation of society. Any analysis of a country's nursing system might begin with the following question: How has the nursing occupation been shaped by social transformations? This does not imply that structural concerns are not important, and it is recognised that it is not possible to write histories of single occupations in isolation of histories of other occupations. Accordingly, I have analysed two parallel occupations, the nurse and the auxiliary nurse, socially similar, but different through detachment, resulting from a socially constructed 'otherness'.

As explained, the process of class identity formation is as powerful a factor as gender identity and gender relations in the development of modern nursing. The social identity of nurses, qua university-educated professionals, constitutes their cultural capital and their power. If the academic credentials that nurses gained have eased access to employment markets, these same credentials may be used as a means of critical analysis of social stratification in nursing, namely the asymmetries and inequalities that are reproduced through nurses' socialisation into organisational cultures that are supported actively by nurses as social actors in these same cultures.

The setting of a Chilean hospital provided a case study of the social impact on nursing that has resulted from the academisation of nursing, resulting in the reproduction of earlier historical class differences

that have existed in nursing. These class differences are manifest in the socially constructed distinction between the nurse and the auxiliary nurse, resulting in a schism within the nursing family in Chile. The analysis illustrates how university-educated nurses have appropriated the notion of nursing, and in the process have excluded non-university auxiliary nurses despite their own academisation. A critical part of this analysis will be how the political power of nursing as a whole would be increasingly improved.

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4

Redoing Gender in Nursing

In Chapter 3, I discussed the social evolution of nursing education in academia. In a sense, that discussion also sought to shed light on the growing number of men interested in a previously considered 'female' occupation. This chapter will present paradoxical results of nursing education in what concerns to its development, focusing on its ineffectiveness in preventing gender-based inequalities. An increased number of men entering nursing may help to facilitate male students' progress along with an increased interest in empowering nursing politically.

As previously stated, nursing has often been considered a 'female' occupation. This became a core concept of its identity. The academisation of nursing education affords an opportunity to reflect on and move away from these gender stereotypes allowing an increased awareness and raising understanding around the reproduction of gender inequalities.

In the literature, there is evidence relating to inequalities at workplace; there is little focus on how these inequalities may originate earlier, during nursing training practices. The aim of this chapter is to discuss this overlooked area in the literature on nursing education. The key question being, to what extent are nursing gender relations shaped by the socialisation process within the academy? The hope is to review

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the idea that the impact of academisation on gender inequalities has been taken for granted; meaning the conventional assumption that the access of women to scientific degrees reflects the development of a given society.

This problem was analysed using a corpus of interviews. The analysis focused on two concepts of relevance: masculine identity and gender relations. To conclude, the chapter invites a discussion on social equality and the particularities of nursing education.

Gender-Based Social Inequalities in Chile

Chile has seen major political reforms over the past five decades. Despite this, and ongoing development of the Chilean economy, as well as its integration into the global market, social inequality is still a blight on society. Substantial income differences (Castillo, 2011; Morley, 2001), as well as geographical (Bicudo, 2011), health (Ewig & Palmucci, 2004; Fuentes, Sánchez, Lera, Cea, & Albala, 2013) and educational inequalities (Levin, 2011; Mizala & Torche, 2012) have framed the making of the early twenty-first century's Chile.

It is argued by Castillo (2011) that the concentration of income in the wealthiest segment of the population seems to be intertwined with an 'existential argument' that justifies and legitimates social inequalities. This suggests that the legitimacy of social differences is ultimately embedded in cultural self-interpretations of social groups.

Upon the gradual move of women from domestic work to employment, they became disproportionately employed in the service sector, typically in areas like teaching, social work or nursing; highlighting social differences. Nagl-Docekal (2004), calls these 'helping' vocations and is in one sense explained by this. Another reason is presented by Ridgeway (2011) who points out how conventionalisms often favour men for authority representations, a process that can structure rather rigid patterns of career choice.

By international standards, 37% of the labour force that women make up is quite low, even by Latin American standards. Though encouragingly, the proportion of women working has been steadily

increasing, while the proportion of men working has remained stagnant. Contreras, de Mello, and Puentes (2011) and Contreras and Plaza (2006, 2010) have put forward the belief that this low figure is perpetuated by conservative attitudes that influence all areas in the country.

Next, we shall analyse to what extent these figures have implications on the nursing occupation and demonstrate figures of men employed in the nursing occupation. These figures are followed by an analysis of the main findings of this part of the study, and a discussion of patterns that consistently surfaced during the production and analysis of the data.

Men in Nursing: Masculinity at Workplace

Pullen and Simpson (2009) reveal how the role of men in what are generally thought of as 'female occupations' has often been overlooked and garners little focus in the study of social inequalities.

Figures from the Chilean Nurses Association's (2013) records and the public statistics on education and employment (Ministry of Education of Chile, 2013) show us that nursing in Chile is also a predominantly female occupation. These figures show that the percentage of male nurses in Chile is in the region of 6–10%. However, although once perceived as a female domain within which the presence of men was an intrusion, male nurses are today an integral part of the nursing family.

There is a common belief that male nurses have shown positive results in their careers. This prominence may be understood through theories of a 'monopoly' of attractive positions (Budig, 2002; Williams, 1993), resulting in higher rewards for male nurses. Assumptions that males possess a greater propensity towards leadership and competitive nature have seen male nurses benefit within the system as they may be considered to take their work more seriously (Floge & Merrill, 1986; Heikes, 1991), reaching strategic positions in hospital boards (McMurry, 2011) or grouping together in high-technology specialties (Connell, 2012; Evans, 1997; Simpson, 2004; Williams, 1995). It is without question that this ideology upholds the idea of women as emotional and fragile, while men are strong, rational and able to control their emotions (Evers, 2010). Other authors (Brown, 2009) find that

male nurses are placed in a dilemma of identity, battling between their masculinity and the nursing role, which seems connected to a pattern of professional specialisation. Some authors (Heldens & Schilling, 2010; Kelly, Fealy, & Watson, 2012) have pointed to the womanly qualities in the public image that nursing is associated with, portrayed by the prolific imagery in the media market (Almodóvar, 2002; Brixius, Wallem, & Dunsky, 2009; Harding, 2007).

These claims and ideas have, while shedding light on gender inequalities in nursing at workplace, given little evidence in relation to nursing students and the extent to which nursing education may play into this engendered phenomenon. The aim is thus to integrate this process and analyse the early stages of the socialisation process in order to reflect on these and gain useful insight.

Male Students in Nursing: Stories from the Field

When I felt a part of my research needed a strong focus on gender, it helped that I was acquainted with many nursing students who were willing to participate in interviews, both individually and in groups. Because their accounts varied, some structure was needed, and so they were grouped into beginning and advanced students (separately) with the aim of balancing viewpoints. These viewpoints are namely the 'ideal nursing' communicated to beginners, and the 'real world' nursing experimented by advanced students. More importantly, the discussion conveyed male and female views and included males and females separately to contrast their views on gender interaction.

As elsewhere, there is a stereotyped image of male nurses that pervades in society. This idea of nursing has an impact on the view of nursing as a fitting career for men, as these views disseminate into the public arena and family environment. Due to this pressure, nursing is seen as a role for women rather than one men can also excel at. Very early in the interviews/conversations, and across the categories of participants, this idea surfaced without even asking direct questions, as the following passages reflect:

> In the media, the male nurse scarcely stands out, because it's still not a job for men. It's sometimes difficult to find male nurses, and when patients are being seen by one they call him «doctor»; he is the doctor to them, it is hard to call him «nurse». (Pedro, 5th year)

> If you are a male nurse, you are automatically labelled as gay-ish, something like that. In short, really that's the image projected by a male nurse. (Anita, 5th year)

> I have [nursing] classmates who studied in men schools and they have alumni gatherings. Then, they are asked: «so, what are you studying?», «Nursing» and they are like: «No! What the hell! What happened to you?» (Pamela, 1st year)

These passages are very telling of generalised social attitudes about men in nursing. And yet, a turning point in the discourse was a very insightful story told by a male student as a first-person narrative, framed as a conflicting story of family disappointment and individual frustration. Here is an excerpt of his story:

> When I told my father I was going to study nursing, he was like 'Pedro, I raised male kids: sons, not daughters.' And therefore I entered this school having my doubts… when mum and dad said to me that I'm studying a career that is for ladies, I felt disappointed. Ok, let's be objective; it's true, there are almost only ladies here. (Mario, 1st year)

Although this information has been well documented, its relevance here is the important input such stereotyping has to the central question underpinning thesis—the male students' position within a female environment. The participants told me repeatedly about male students having very few or no masculine referents—for example, practising nurses, lecturers or nursing theorists—which has import for professional identity formation. Apart from this, male students tend to pay little attention to the feminised academic discourse in nursing, or pretend it does not happen, a discourse that often references 'her' or the female nurse. This discourse is also reinforced through Spanish language translations that mirror this language (i.e. *la enfermera*), the end result being the invisibility of men and the male gender.

On the one hand, the social environment informs self-interpretations of masculinity, which is in conflict with the selfless, feminised identity of nursing. And on the other hand, nursing training participates in the socialisation of nursing students by using female referents alongside gendered language:

> It's annoying that the lecturers always speak in gendered terms: 'she, the nurse' but never of 'he, the nurse'. And when we study nursing theories, we realize that there're no male authors! (Francisco, 1st year student)

With this background in mind, it is easier to understand how a discourse of self-compassion—'poor me'—develops among male students. Additionally, female nurses develop a compassionate discourse towards men in the occupation, focusing on the supposed difficulty for men to be sensitive, and engage with the emotional needs of patients. A discourse that separates 'us' from 'them', as shown in the following passages from interviews:

> It is considered difficult for men to relate to the caring dimension needed for good nursing practice. "One is very protective towards the guys, even selfless sometimes. We give them advice, lend them our notes and photocopies, and in the end they get higher grades than us!" (Veronica, 5th year student).

> We try to look after them, because we know they're not used to these things. (Magdalena, 5th year student)

Reinforcing this view, I witnessed the following conversation between two students during a group interview:

- *María*: nursing teachers are mainly women, and at the clinical campus nurses are usually female, too. The role they play is very maternal. Their favourite one in a group of students will always be him, the guy. And it tends to happen to us too; if we're a group of 5 women and 1 man rotating in clinics, we girls will want to help him.
- *Antonia*: Yes! Definitely! ….he is like our number one.
- *María*: As if we weren't aware of this issue, of the maternal role we take, we're always helping him.

- *Antonia*: It's because we know they've more difficulties in handling things.
- *María*: yes.
- *Antonia*: we want to protect the guys, 'cause they are clumsier at the compassionate part…. (Group interview, 5th year student)

Interestingly, the conflict the male student is in—the nursing identity and the notion of masculinity—is ultimately resolved in ways that all gender scholars are familiar with:

> Girls worry about us. And we just let them love us. (Pedro, 1st year student)

These discourses of compassion engender a special symbiotic dyad between male and female students. This dyad may be analysed in reference to a pattern of gender relations built upon roles of a 'mothering woman' and a 'needy man'. However, the focus here is not how male students are or become dependent on their female counterparts, but rather the perception of them as such by supervisors and lecturers. This reality enables the reaffirming of discourse and gender roles.

Throughout the field research, I found there are a positive attitude and general agreement that the entrance of men into nursing would be beneficial for the future of the occupation, and its move towards professional status. It is hoped that increased male participation will lead to a furthering of political power.

Findings from participants' discourses have suggested lecturers' positive attitude towards male students, including at times a preferential treatment. This may be seen as part of a subconscious but active effort to masculinise nursing, or at least to increase male to female ratios.

Interviews and observation have also suggested that male students enjoy a greater degree of autonomy, and freedom to be proactive and take initiatives in clinical settings. This may stem from confidence trickling down from positive attitudes from superiors. (These findings however need to be further documented, as academic records were not accessible for this study.)

And yet, a finding that consistently surfaced in the corpus of the interviews is the perceived differential treatment given to students on the basis of gender relations. Here is a series of pieces of data taken from female students' narratives:

- *Student*: just to give an example, instructors make us, girls, suffer very much, it's really stressing! However, they allow men to pass with no difficulties; they let them be who they are.
- *Student*: Maybe, it's because it's more personalised, he is «him», and to him everything is given differently. We, girls, are «students», but a male student has a «name». (Group interview, 5th year students)

The problem is, among so many women we cannot be distinguished. We are so many. But the man will always be the man, he'll never be overlooked. (Anita, 5th year)

- *Student*: nursing teachers are mostly women, and in the practicum nurses are normally women, too. So nurses adopt a very maternal role with students, therefore the favourite student in a group will always be the man. (Group interview, 5th year students)

There's even a competition among female students, but not against men. Actually, we couldn't see them as opponents. In clinical practicums men definitely have better results than us, although sometimes we see their marks aren't necessarily correlated with their efforts, nor with their skills. (María, 5th year)

Men have a privileged relationship with instructors. They feel closer, more confident and more relaxed than us. (Nadia, 5th year)

- *María*: We aren't questioning men's knowledge, it's their attitude. They're more… they're lazy. It's like, if they get one thing done in the whole morning, that's it. Then they go away, snooping around in the emergency room in case there's a heart stroke, things like that.
- *Nadia*: Yes. And after that they'll have a coffee break. We, instead, are working all the time. Men constantly come out with pretexts, they always have good pretexts. [laughter] (Group interview, 5th year students)

With all this taken into account, it may seem reasonable to infer that nursing teachers may facilitate male students' orientation towards a more 'masculine' practice, adapting approval requirements to their interests. It becomes apparent that male nurses' expectations for a masculine performance echo early exposure to 'hero-like' roles that are perceived as complex, hazardous and challenging.

Here, once again, the stereotyped idea of nursing as a 'female' work surfaces through males' interest in high-technology units, exploring roles they may consider more attractive, likely a way to withdraw from a caring role as their main duty. Similarly, male graduate nurses tend to concentrate in such units as well as in administrative posts. In this scenario, the choice of post becomes more suitable to traditional sexual roles, relegating the care to the perpetual notion of femininity, largely rooted in the country that served as a setting. The literature has long emphasised this aspect of nursing careers (Connell, 2012; Evans, 1997; McMurry, 2011; Simpson, 2004; Williams, 1995). However, my findings shed light into the early construction of gender segregation during nursing studies, which may well correlate with mechanisms of inequality elsewhere.

Issues for Further Reflection

It must be highlighted that this particular study was limited to a single institution, and still the aim was to raise awareness surrounding the issues addressed, namely the linkage between the nursing education machinery and the reproduction of historical gender-based inequalities which have undermined the nursing profession. A systemic approach arising from the sociology of the professions was used in this analysis of inequalities, focusing the analysis of internal stratification (Abbott, 1988, 2005, 2010).

This analysis has shown that the phenomenon is twofold. Firstly, men who enter nursing are often thought to be declining in status (DeCorse, Benton, & Vogtle, 1997), and because of this, male students tend to, or at least it is imagined, look for a mechanism to counterbalance that perception. In addition to that, the educational experience stresses their

male identity as they are expected to assume a nursing role, a result aligned with Brown's (2009) claims describing this as the male-nurse's dilemma. Whereas this dilemma has reportedly hindered retention of male students elsewhere (Jeffreys, 2012; McLaughlin, Muldoonb, & Moutrayc, 2010), in this study I uncovered a mechanism aiming to overcome that dilemma—a pattern of differentiation in the educational system.

Following this, there is also a need for strengthening the image of nursing. It is thought that an increasing masculinisation of the occupation would add another layer to the movement calling for nursing as a profession in a setting of severe income and educational inequalities (Castillo, 2011; Levin, 2011; Mizala & Torche, 2012; Morley, 2001). It is thought that this increased male presence within nursing can help to vindicate this movement.

Discourses of compassion emerging from the invisibility of men in nursing development (Roth & Coleman, 2008) may threaten academic integrity, and in the process reproduce those same inequalities in question (Bourdieu & Passeron, 1970), both in the educational practice and at nursing workplace. However, it needs to be recognised that the growing interest of men in the nursing profession must have tangible benefits for nurses as individuals. Any gains in political standing cannot be considered a victory without ensuring real gains for individuals and more egalitarian gender relations.

Conclusion

The dilemma faced by male students seeking to enter nursing is thus one that challenges society's ideas of a masculine identity: Would they be able for the caring role that comes as part of the occupation, and are they comfortable enough to take on this role despite societal misgivings? Previous research has dealt with identity issues among male nurses, though this study brings new insights on gender identity construction in nursing students.

In the setting of my research, a culturally feminine profession tends to be considered as a rather supporting activity. Male students,

accordingly, learn how to pursue socially respected nursing roles as a channel to conciliate both personal identity and professional identity. As this analysis illustrates, such a process may be facilitated by a differentiation pattern embedded in educational practices, leading to a form of gender stratification within nursing from a very early stage.

While the increasing number of men embracing a career in nursing may have a meaningful resonance with the transformation of contemporary societies, opening up nursing to men, if not handled judiciously, may lead to the reproduction of earlier historical inequalities. There is a genuine reason for nursing itself and the whole healthcare community to celebrate the benefits of the academisation of nursing, though this same academic rank may be used as a means for critical appraisals of how nursing education meets key challenges, such as the forging of a fairer society.

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5

Red and Blue: Competing for Jurisdiction, Losing in Power

This chapter draws on historical data, despite the fact that it arose from observations through which I problematised visible features differentiating nurses and midwives. This led me to explore historical disputes between them. And although the conflict itself may not be at the heart of my inquiry, it was important to gain an understanding on the construction of professional fields, the mechanisms for the definition of jurisdictions and the disputes for knowledge ownership. Together with the socially constructed otherness I elaborated on in Chapter 2, the conflict between midwives and nurses served greatly to illustrate how social closure dynamics operate in profession construction. While the masculinisation of nursing seems to be used as a means of improving public image, closure dynamics permeate interprofessional relations with parallel and subordinate groups.

Nursing and midwifery in Chile, despite their similarities, have developed as distinct and in some ways opposing occupations. People who enter either stream undergo their education in separate schools and develop opposing identities. This process put them in competition, and conflicts arise periodically. This conflict develops out of overlapping roles in healthcare management, projects aimed at relieving nurse shortages by enhancing midwives' nursing skills and attempts of state entities to homogenise nurses' and midwives' competences.

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In this section, historical and contemporary literature is analysed and discussed in order to present a rationale concerning nursing/midwifery jurisdictional conflicts. These findings are then used to approach this phenomenon in an analytical way to ensure a greater level of insight. The aim of this research is to bridge the gap that currently exists in the literature focusing on nursing/midwifery development, which to present has received very little attention. The overall aim of the discussion is to analyse that extent to which socio-historical processes shaped the identities of nurses and midwives in Chile.

In order to conduct an unbiased analysis, the study was conducted as a comparative study. This allowed previous data and documents to be drawn examined and thus enabling research informed by prior studies while integrating contemporary research findings. These data were then broken up and grouped into five main themes for discussion. The chapter then finishes by presenting the two occupations, nursing and midwifery, within Chile, discussing the case for policy changes and its implications for more coherent and integrated care.

Background

The movement towards more defined roles within the healthcare professions in Chile has seen a growing momentum over the last four decades. Discussions and academic analysis have sought to characterise the professions in terms of how they are viewed or imagined, but much less so in terms of how they are conducted. The focus therefore has not only been on providing more legitimacy to the professions but also seeking a greater level of autonomy within the professions. This, it can be reasonably inferred, will ensure increased scope of practice legally.

Previous literature has discussed the histories of occupations in isolation. Although it is clearly important to reflect on a common pattern of professionalisation and the internal forces that enable development within one's profession, this pattern should also be analysed in terms of interaction with other professions and the environment within which they exist. An isolationist perspective neglects mutual implications that cognate professions may have. In the setting of my field research, those

implications may be understood with reference to the concept of 'social closure' (Evetts, 2013; Larson, 1977; Reeves, McMillan, & Van Soeren, 2010)—professions develop market-oriented schemes, exclusionary mechanisms to gain monopoly control of an area of work, assuring self-interests in terms of power, salary and status, so as to thwart the interests of competing occupations.

A review of the growth of nursing and midwifery in Chile showed a level of competition between the two fields. Increased interaction between workers in the two fields increases both the amount and level of competition that is visible. Overlapping areas, such as the care of the newborn, further magnify conflicts over jurisdiction. Other areas of overlap are roles in healthcare management that nurses and midwives often share. This overlap is, to a certain extent, due to midwives' education which in some measure is rooted in a nursing background. Organisation and common spheres of practice also influence this. Glouberman and Mintzberg (2001) highlight the interpretive role of nursing and midwifery as being one of the reasons for competition as nurses and midwives generally run the wards, coordinate workflows and look after the patients. This is different to the doctors who normally take on an interventionist role prescribing medicines, removing organs and so forth. Understanding this is crucial to interpreting boundaries in such a shared domain.

In recent years, according to the Chilean Nurses Association (2012), there have been increased efforts by state bodies to relieve nursing shortages. Conflict begins when state bodies try to use a perceived midwife surplus to upskill these workers in terms of nursing competencies. Continuing in this manner will homogenise nurses' and midwives' competences blurring the lines between occupations.

These tensions did not form from nothing but due to an historical context within which these two occupations have often coexisted. In the following sections, however, we will demonstrate how, despite the similarities of the two professions in Chile, midwifery and nursing have embarked on significantly separate trajectories. For this, I draw upon socio-historical circumstances relevant to professional development while delving and demonstrating in depth the actual role nurses and midwives have taken on within the healthcare systems.

Studying Two Professions with Very Little Contact with Each Other

While most of the chapters in this book use ethnographic observations as the primary materials, this chapter is different in that it looks at historical sources. The reason for using historical documents rather than ethnographic data here is that there is no actual interaction between nursing and midwifery.

In order to conduct an analysis with relevance to long-standing interprofessional conflict, this research was done through a social history approach (Burke, 2005). The aim of this type of approach seeks to research history from the view of those who are normally excluded from official historiography; focusing on the lives and struggles of people who have been largely excluded from texts up to this point. In this case, the focus is on the history of medicine and health care in Chile. And although there is no actual interaction between the two professions at the workplace, some visible futures of nurses and midwives (Figs. 5.1 and 5.2) were at the origin of these ideas.

This is important to keep in mind, because it changes the way in which the data are looked for and compiled. In order to keep an open and non-restrictive approach, the search terms I used in addressing my question on specific databases were left open. This enabled wider access to conceptual recurrences in the twentieth-century and early twenty-first-century literature. The process included gathering disparate sources—books, journal articles, theses, conference proceedings, technical reports, legal documents, newspapers and institutional websites—tracking their annotated bibliography, classifying the content, creating thematic families, and organising and reorganising the findings until pieces of data cohered together in a meaningful way to answer the question of interest.

Some of the main sites used in the search for relevant historical documents were: the Library of Congress of Chile, the digitised archives collection of the Chilean National Library, the San Francisco-based Internet Archive, the Latin American newspapers section of the Centre for Research Libraries, the Medical Heritage Library, digital newspaper

Fig. 5.1 Chilean midwives (University of Chile)

Fig. 5.2 Chilean nurses protesting in defence of their jurisdiction

collections, Chilean universities' libraries and relevant professional association's websites, which comprised documents written in Spanish, English, Portuguese and French. Background literature was retrieved from searches on the Web of Science and the Latin America-based Scientific Electronic Library Online (Scielo), and from tracking reference lists. In an attempt to ensure that important sources were not overlooked, senior researchers in the fields of health care and history were consulted so that they could lend their expertise.

In total, the search yielded a compilation of 6 historical books, 17 contemporary books, 3 dissertations, 23 research articles, 121 newspaper articles, 87 archives (magazines, letters, minutes, study programmes and reports), some of which were discarded after judging conceptual and methodological relevance and validity, or not cited here due to content repetition.

In analysing professional interaction and cooperation, it was important to focus purposefully on the emergence of historical processes and patterns that consistently surfaced throughout the exploration of the phenomenon, so as to reconstruct and develop a historical-narrative account (Roberts, 2001; Waldman, 1980) of the conceptual themes arising from the included sources. In order to scrutinise the validity of the data sources I was using and aim to ensure the reliability of the analysis, my period of analysis focused on the same period as that of the data sources being used. The resulting categorisation was organised in a number of themes and contents that were reduced, refined, rethought and adjusted as new information surfaced, using the cross-disciplinary assistance of close colleagues, who were either historians or sociologists and midwife/nursing researchers, to compare and discuss the data. Arising from this process, I developed themes that comprised key socio-historical processes illuminating a discussion on jurisdictional conflicts, such as those highlighting the early origins of the caring professions as a source of diverging identities, the progression of two seemingly distinct disciplinary traditions and academic-training paths, struggles concerning the division of labour and mechanisms of boundary expansion, and the increasing utilisation of law in defining demarcations between professional fields. Taking into account recent developments in nursing identity in Chile, it also seemed meaningful to enhance the analysis by including a last theme on social-class consciousness and social mobility.

Early Origins of Nursing and Midwifery in Chile

The role of nursing in a Chilean context owes its origin to philanthropic work in charitable areas, social work and the area of education. Until relatively recently basic services were conducted by religious organisations or groups from the elite class inspired by religious activities; these services would be later taken over and managed by the State (Guarda, 1978; Ponce de León, 2011; Sanborn, 2006). One of the first groups to take on this role of service provider was The Sisters of Charity. This group began their work in the early days of post-independence Chile, in the early nineteenth century. They were known to be skilled nurses and teachers and began by taking over responsibility of hospital administration and care work. These nuns brought their *savoir faire* into the hospitals and legitimised and dignified an activity that would become increasingly secularised (González & González, 2008; Yeager, 2007).

This rise in the number of charitable associations among elite ladies occurred due to a gap in basic nursing services. The appearance of these services to meet the poorer population's needs concerning public health and social security (Alvarado, Sheetham, & Rojas, 1973; Illanes, 2006; Subercaseaux, 2007), evolved steadily from volunteering into the employment market. The transition from a volunteer-led base to an occupation's employment was critical in the formation of a new group, the social worker. Out of this emerged the figure of the visiting sanitary nurse (Illanes, 2006; Mooney, 2009). The status of nursing was associated with the educated elite (Ayala, Fealy, Vanderstraeten, & Bracke, 2014), and the nursing profession became an element of class distinction, reinforced by the centralisation of training in a university by the second decade of the twentieth century (Muñoz & Alarcón, 1999).

The history of midwifery contrasts to that of nursing. Midwives, or birth attendants (*parteras*), have a long history in Chile prior to independence. During colonisation, however, their work became thoroughly discredited, judged, intervened and regulated by the royal authorities (Zárate, 2007). Besides the influence of religious views at the time regarding the notions of body and healing, the extensive control exerted over the *parteras* was facilitated by a number of characteristics

surrounding their figure, namely illiteracy, poverty, ethnicity, gender and a supposed connection with the supernatural.

At the outset of independence, one of the main concerns of the new state was public health. What was a long story of political constriction over the *parteras* came then to be one of medical domination, for that increasing development of science and the interest of medicine in pregnancy and child delivery (Zárate, 2007). Occasional bouts of formal midwife (*matronas*) had begun to be offered by the 1830s; the teaching was undertaken largely by obstetricians. Newly built facilities which served as both maternity home and residential midwifery schools were important in providing maternal care and ensuring a foundational landmark towards women's professionalisation (Zárate, 2007). Midwives acted as nurses but also served as a means to vulgarise scientific knowledge on childcare into a popular language (Illanes, 2006), structuring in that way an incipient discipline of infanticulture.

Nurses, during this period, were usually unskilled workers who took on the role of hospital assistants. This began to change with the organisation of maternal wards within hospitals (Zárate, 2007). Midwives and nursing personal came into contact more often as they began to share the same workspace and environment; it can be inferred that this close proximity led to an exchange of ideas and knowledge. It was this change, and the probable isolation endured due to lack of 'professionalism', which would lead to the formalisation of nursing training in the early 1900s.

This movement should not be considered completely in isolation of the national context at the time. The bitter massacre of the War of the Pacific (1879–1884) fought between Chile and the allied nations of Peru and Bolivia seems to have been a turning point. The many casualties that needed to be treated during that war showed that, while nuns were expected to help the poor, there was no organised nursing service to assist the war wounded, only the willingness of the civilian population (Sater, 2007) as in reality the 'paucity of medical personnel included an absence of professionally trained nurses and field medics' (Sater & Herwig, 1999, p. 120). The large amount of causalities during this war and the civil war of 1891 highlighted the need for an organised service. The end result of this need was lobbying for nursing reform and a number of medical doctors educated in Europe (Cruz-Coke, 1995)

who, in turn, were interested in opening nursing schools and providing training to nurses.

By that time, the sanitary principles attained by the British during the conflict of 1854–1856 were becoming increasingly popular, in ways that gradually influenced nursing training in South America (Bullough & Bullough, 1979; Sánchez, 2002).

The historical backdrop puts into focus three important realities that are central to the present analysis. The first of these is that the humble social origins of midwives were certainly challenging and perceived by the science as a threat (Zárate, 2007). The number of nurses, however, grew organically as hospitals grew. This was due to the influence of Roman Catholic sisters and actively supported by scientific medicine. Meaning that nursing gained a certain level of prestige and became an occupation that garnered the interest for well-educated women.

Secondly, while midwifery was essentially meant to assist a natural process, namely pregnancy and delivery, nursing emerged to face what was considered an unnatural one, namely taking care of the poorer population's needs and assisting those who had experienced the horrors of the war. This seeming polarisation of the occupations was a turning point in their development, marking them as being near opposites rather than complimentary. Thirdly, looking more carefully at each occupation, it becomes clear that some of the elements of nursing are entailed in midwifery. Midwifery has also developed over time; no longer is it solely an occupation involved in assisting in childbirth and caring for newborns but also in taking care of the sick or the wounded along with being recognised as caring to women across their lifespan, becoming clearer that their ethos is thereby one of a caring profession.

It may appear acceptable to argue that the two groups drew upon two different points in history divergently, and therefore, they cannot merge into a single occupation. However, the notion that ideas and institutions do originate and evolve at several points simultaneously may have a meaningful resonance for the caring professions. Nonetheless, the connection of this historical backdrop—largely unknown—with the identity construction today is rather blurred, given a major historical gap. Further evidence is needed to understand how their origins might contribute to exploring the processes of differentiation more closely.

The Academic Training of Nurses and Midwives

Formal education for midwives began in Chile in the 1830s. Nursing schools, on the other hand, did not emerge until about a century after. This nursing training emerged with the central involvement of both the sisters who had run the hospitals since the 1850s, and helpers who worked in those same hospitals (González & González, 2008; Zárate, 2007). During the development of both midwifery and nursing education, and the increased length and sophistication involved in courses and university training, both occupations remained distinct from one another and developed rhetorically antithetical identities. This separation has been a central and constant feature of their parallel evolution. My analysis of the historical data and recordings of this proved that a gap in knowledge exists; however, some crucial writings relating to an integrated project proposed by some universities in the twentieth century did emerge. In the 1960s, a merger of nursing and midwifery into a single occupation—namely the nurse-midwife—began to emerge (Florenzano, Romero, & Alvarez, 1991; University of Valparaiso School of Nursing, 2013). This came out of the epidemiological circumstances that faced Chilean society at the time in terms of child malnutrition and mortality. This particular training, offered only by a few universities, was then expanded to five years. Its aim was to improve services and professionalism provided by the workforce in relation to child and maternal care (Murray & Veraguas, 1996). One would be right in wondering then how a merger in occupational duties and a greater level of integration between nursing and midwifery did not emerge. It has been suggested that two main reasons led to a schism in the previously near symbiotic atmosphere. The first reason was the failure of the public health system to organise specific positions for the newer occupational figures meaning that nurses–midwives worked more often than not as nurses (Murray & Veraguas, 1996; University of Valparaiso School of Midwifery, 2013); the second was the length of the programme discouraged prospective students from applying.

On first review, the continued separation of the occupations seems a reasonable approach. An analysis of the history, however, shows that an

alternative agenda working towards a fission existed. This is supported by Murray and Veraguas (1996) who point out that schools offering a united study programme were fiercely opposed by prominent members of the Chilean Midwives Association; the reason being the purported need to protect midwifery as a 'separate profession' (p. 99). The trade agenda to destabilise the nurse-midwife project was reinforced by the figure that the midwives saw in nursing, which prompted antagonism: Murray and Veraguas (1996, p. 99) point out that 'as a profession Midwifery is competing with both medicine and nursing for space and status'. A fear of losing not only prestige but also work itself existed. Other evidence suggests that the fruitlessness of such a project was addressed on both fronts: that of midwifery and of nursing (University of Valparaiso School of Midwifery, 2013).

That being said, although midwives do make up, to a certain extent, a different discipline, midwifery education is at least partly rooted in that of nursing. Subjects are taught from a nursing approach; therefore, problems are defined through nursing taxonomies and vocabulary. Professional activities are also organised within the nursing-process frame. Due to this similarity in terminology and how it reflects educational practice, it is difficult to determine just how different the reasoning in both occupations is.

While the back-and-forth of this nursing/midwifery duality is relevant with respect to the technical arena, it becomes problematic to visualise the place and relevance of the patient in this discussion. The argument rather points to the disputes for a jurisdictional field with which the discourse of distinctiveness can be justified. If the challenging scenario of child and maternal health was important for the inception of an integrated project, the subsequent debate does not seem to have followed from it. Whereas the earlier historical backdrop seems of little relevance in identity structuring today, the fears of a technical overlap appear to gravitate towards antagonist relations and detachment. The 'counterproject' of separate schools has then resulted in very little contact and a lack of opportunities to identify and valorise each other's knowledge and skills, and therefore, the opposing identity would instead rest upon an unawareness and the discourse of differentness, hardly upon a fundamentally different educational ground.

Division of Labour and Boundary Expansion

Apart from looking at the social history of nursing and midwifery in Chile and the separation of these occupations enhanced by the movement towards further academic training, we must also analyse the internal boundaries of healthcare system and look at how these parameters can lead to jurisdictional conflicts. These boundaries can be understood in reference to the concept of 'division of labour'. Drawing on an ecological notion, division of labour in its most optimistic sense reflects cooperative interdependence on the basis of systemic dynamics (Hughes, 1993).

Hospitals have witnessed some dramatic changes over recent years. They have had to adapt and develop as organisations. This is shown through the division of roles into a structure founded in a process of rationalisation and bureaucratisation (Gourdin & Schepers, 2009). It is within this divisional structure where nurses and midwives find themselves working within a common sphere. Glouberman and Mintzberg (2001) describe this sphere as being 'organisationally-oriented' meaning that its fundamental purpose is ensuring the structure itself. An understanding of this structural rigidity lends itself to a greater awareness of the jurisdictional boundaries such an organisational/interpretive domain creates. The organisational reality in with nurses and midwives function carries a certain degree of 'flatness' in terms of development and movement within the structure. Thus, should this remain the defined structure of the medical domain, nursing and midwifery would have no option for vertical expansion, and therefore, there is no solution but to strive for horizontal expansion. Nonetheless, the non-medical occupations have also experimented varying degrees of medicalisation as health technology evolves, which responds to mechanisms of Taylorist rationalisation and delegation of work from one profession to subordinated ones (Dingwall, 2008). This is, in other words, a vertical expansion, which again brings professionals into a competing logic.

Any context of expansion is considered to be an important strategy in achieving professional development. Abbott (1986, p. 195) has emphasised the need for expansion to ensure that clients are not poached by others in the business. Chilean nursing has experienced a

bolder medicalisation over the last decades, taking over responsibility in procedures such as echography, extracorporeal circulation, electrocardiography interpretation, preventive screening tests, and even rewriting prescriptions and extirpating certain veins. Although not at a large scale yet, these roles are often seen as an advancement—alternatively said, 'expansion'. This increased role and diversity of the occupation has also led to the short handing of other areas that would have traditionally been considered part of the nurses' role. Areas such as ambulance nursing, sterilisation divisions and nosocomial infection departments are to a certain extent being performed increasingly by non-nursing professionals.

This increased sophistication and diversification in nursing has been mirrored in the occupation of midwifery. It could be said that to some extent midwifery occupation has undergone 'nursification' and seen the interventionist side of their role increase. Ordinarily, midwives' role would entail the handling of female organs, implement surgical techniques, diagnose, prescribe medicines and certify births and deaths (Ministry of Health of Chile, 2010). This phenomenon has been labelled by the international literature as 'an assimilation phenomenon', and relates to both nursing and medicine, to survive the earlier vilification from the medical profession and prevent falling out of the evolutionary technologisation of health care (De Vries, 1996; De Vries & Barroso, 1997).

Due to midwives frequently working independently in hospitals or in private surgeries, they are perceived as being closer to the ideal prototype of profession. Murray and Veraguas (1996, p. 99) have discussed in their work how historically Chilean midwives have been associated with a 'parallel relationship to medicine'.

With this in mind, horizontal and vertical expansion becomes as powerful a factor as the divisional nature of hospitals in the analysis of conflict sources. This structure has led to the increasing levels of competition within the structure as a way of preserving and attempting to enhance one's position within it. This could also have repercussions on collaborative relationships among workplace groups which thus may need to be appraised thoroughly. Both boundary expansion mechanisms and mutual unawareness may threaten a genuine search for integrated care.

Jurisdictional Conflicts and the Struggle for Legal Demarcations

In terms of jurisdiction, nursing's strategy in Chile has been to monopolise the notion of 'care management' (*gestión del cuidado*). There is evidence that midwives and other professionals perform certain nursing roles and functions, but in legal terms, it is the nursing strategy to manage these areas. Legislation covering this area came into force in 1997, which, along with the historical context, reflects society's acknowledgement of nurses' mandate and that the aspects in dispute become acts that are 'exclusive' of nurses (Milos, Bórquez, & Larraín, 2010; Milos, Larraín, & Simonetti, 2009). A number of researchers have concluded despite these assumptions that the role of nurses remains fairly unknown among the general population in Latin America (Gomes & Oliveira, 2005; Holmqvist, 2009; Samaniego, Cárcamo, & Frankel, 2011; Zapata & Alcaraz, 2008) and that the self-interpretation of nurses may differ from the constructs associated with them in the social imaginary.

The legal support afforded to nursing may therefore be more a result of support for nursing representatives in political circles combined with their negotiating abilities in representing the crucial function of reform in health care. Those claims may thus be regarded as a discourse of a persuasive type. Since Chilean nurses have traditionally had a predominantly biomedical role (Poblete & Valenzuela, 2007), the notion of care management can create a channel for detachment from the medical practice and also for gaining access to hierarchical posts, excluding in the process other disciplines under the umbrella term of 'caring sciences'. Inadequately, the laws have been largely utilised to form delimitations between professional fields, rather than uphold areas of conjoint action.

The fact that several occupations provide care and that their responsibility also involves management tasks embeds the inconsistency of those claims on the gravitation of the concepts 'care' and 'care management' into a single profession. Such inconsistency has indeed been the object of allegations before the Chilean National Audit Office (*Contraloría*

General de la República), a State authority allowed to discern and apply a common interpretation of administrative laws. This organism has ruled that the concepts of 'care' and 'care management' are wide in nature and therefore apply to several health professions (Contraloría General de la República, 2008). From a legislative perspective, nurses cannot thus abrogate ownership on them.

A common state exam for access to public service work in nursing and midwifery illustrates this conflict even further. The exam was met with stern opposition within nursing circles. A common framework was thus seen as an affront pushing two occupations under a single jurisdiction. Activists protesting the premise of duality obtained media coverage, with some boycotting the examination as a form of rejective protest. The protestors argued that the authorities had disregarded self-regulation of and disciplinary differences between the two professions. Nursing activists stressed that an examination of this kind would target the enhancement of midwives' skills over those of nurses leading to a equalisation in competencies, fear that a zero-sum game would mean a loss of prestige. The result of this was the Chilean Nursing Association's campaign to defend nursing-discipline-oriented certification, provided by the Chilean Society for Nursing Education, as being the only valid examination for practical nurses (Castellano et al., 2011).

In the light of the jurisdiction theory (Abbott, 1988), we can interpret from this situation that, insofar as a common examination fed fears of invasion, revoking such enforcement obstructed any possible evidence of midwives' nursing skills. My position becomes clearer when contrasted to those stances claimed by the two professional organisations, arguing on one hand an aspiration for illegal incursion of midwives in the field of nursing (Chilean Nurses Association, 2012), and the non-existence of an 'exclusive' disciplinary training for nurses, on the other (Chilean Midwives Association, 2012). Likewise, a two-year training proposed to midwives to become nurses was firmly opposed by nurses and eventually withdrawn.

Rather than try to imagine ways of ending this dispute, it seems that the real key to understanding further the grievances of each group is to investigate further the nuances of the conflict. This approach, it is hoped,

would help promote theoretical agreement and inspire a greater level of cooperative practice. While the advances in legislation on the healthcare professions cannot take for granted a solution for earlier historical differences, the greatest challenge that midwives and nurses will be facing is the indivisibility of the subject of practice, the human being, long disputed by the caring professions rhetorically.

Social-Class Consciousness and Social Mobility

As previously discussed, following the rise of the middle class in Chile during the late 1970s and 1980s nurses and midwives were mainly recruited from low and average income families. Recent statistics back this up showing how only about 7% of nursing students and about 4% of midwifery students come from private-paid schools (Ministry of Education of Chile, 2012), those serving the elite (Arum & Velez, 2012).

The identification of nursing and midwifery as helping vocations within Chilean society may be related to the solidarity principle developed on the basis of performing selfless acts and sharing basic subsistence goods.

This vocational aspect of the occupations seems to reflect the system of support which is often demonstrable in low-income families and is founded on symbiotic ideals and coping mechanisms which enable them to deal with the financial challenges of unemployment (Happe & Sperberg, 2003).

Ayala et al. (2014) have provided evidence that there is a class consciousness, which opposes that of medical doctors and suggests instead a sense of class integration.

From this, we can appreciate how one group might feel under pressure from the other group's advancement. As both occupations are essentially in a competing environment it is understandable that each wishes to protect their precious place within the labour market structure and increase their own level of social mobility. That is to many low- and middle-income workers becoming a healthcare provider in Chile is

a chance at upward mobility and a way of both increasing employability and earnings (Ayala et al., 2014).

Reflecting upon the historical and social background of nursing and midwifery we see each in an unfavourable position to reach greater legitimacy. As they are considered 'genderised' occupations—they are typically viewed as being below a male-dominative profession, adding to this is the structure of hospitals which reflect class ideology and social status. As shown in the present discussion, nurses and midwives represent middle-class women and this seems to be at the core of their social identity. As mentioned earlier, contemporary Chilean identity has been strongly influenced by both social class and occupation.

A case can be argued that nurses and midwives have been written out of official histories, meaning that their sudden appearance in the public sphere has flared up not only a crisis of identity but also a process of class-based competition as a struggle for not only social recognition but also uniqueness in their sphere.

Conclusions

This chapter has made a case for and analysed the socio-historical development of conflicts between midwives and nurses in Chile. This analysis is based on two major components that emerged from a reconstructed history. The first was the social construction of relationships and second the historically disconnected identities. This analysis then looked to shed light on the consequences of these on the professional projects and how likely they are to impact how nurses and midwives interact in contemporary care settings in Chile. The research further illuminates how a leading example of professional development of nursing/midwifery in Latin America implies a struggle historically constructed.

In using historical data to study a given profession in the contemporary ground, authors usually refer to the turning points embedded in a professionalisation process. However, reconstructing the picture of systemic interactions may more usefully provide a focus for examining the development of the caring professions, as occupations are linked to social-historical transformations.

The analysis of a country's healthcare system might originate in the following question: How have the healthcare professions been shaped by social-historical transformations? This implies that it is not possible to write histories of a single occupation in isolation of histories of other occupations. Accordingly, I analysed two parallel occupations, the nurse and the midwife, technically similar, but different through a socially constructed otherness.

As I have elaborated through the preceding analysis, there are a number of reasons that endorse strongly opposing identities between the two groups. It is crucial in any identity construct of two parallel entities that one entity has properties that the other has not. The findings of the reconstruction elaborated presently, however, suggest influential similarities that relate the two professions to one another, namely patterns of enhancement through assimilation mechanisms, an organisationally oriented division of labour, a legally shared domain of care and care management, 'genderised' relations, and social-class consciousness. These similarities represent a great prospect for potential empowerment. The differences seem borne out of misconception, and they may rather be a topic for theoretical, disciplinary discussion, one that prevents conflicting reactions in the trade arena.

International discussions tend to bring midwives and nurses working together more than ever before, given the challenges of peoples' needs and professional understaffing, recognising the commonalities and the various paths for nursing/midwifery professional training. It would be meandering to benefit from the social closure project of the professions—that of professional competition for market and status—at the expense of the necessities for care. Whereas the closure project seems to be preponderant in similar nursing/midwifery tensions in other countries of the region, such as Peru (Arenas, 2012), that quality care can best be met by cooperative efforts has been repeatedly reinforced elsewhere in the globe (Ament, 2007; International Council of Nurses, 2007, 2011; Jasper, Rosser, & Mooney, 2013). We have to entertain the possibility of an eventual fusion of the two professions, an evolution witnessed earlier by occupations such as barbers-surgeons who joined the physicians (French & Wear, 1991; Prioreschi, 2003), a wide variety of technical specialists merging together in a large engineering fraternity

(United Nations, 2010), and the legal occupations in the field of law (Clark, 2012). An important part of this analysis will be how the political power of the caring professions as a whole would be progressively enhanced, conceivably focusing on global, comparative analyses.

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Part II

Influencing the Environment

6

The Time Has Come: Changing Patterns of Power

This chapter draws on notions I have addressed in precedent chapters, such as the social structuring of health organisations and the social closure mechanisms that have been, and are being, used in the making of the nursing profession. Certainly, the chapter evolves out of further engagement with sociological literature and reviewers' comments on my earlier manuscripts, and as such. Here, I examine nursing credentials as an institutionalising mechanism interrogating the notion of medical dominance as a relational pattern.

Over the years, nursing in Chile has gained a respectable position among healthcare professionals. This reputation has also extended beyond the country's borders and to the wider Latin American nursing community where Chilean nurses are held in high esteem. This solid reputation has grown out of the longevity of nursing academisation in the country. This process, as we have seen, began in the early twentieth century and has continued uninterrupted since then. This uninterrupted process has also been strengthened through increasing levels of sophistication and diversity offered in nursing courses, and the expansion into different areas. This longevity and constant evolution of nursing training has allowed for the ever-increasing development of the

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courses and enabled improved and increased recognition of the academic credentials. This system, although often brought into the discussion on education planning, has not been the object of analyses with regard to whether it has led to a redistribution of 'usable resources and powers' (Bourdieu, 1984) among professions, and whether such credentials have served to interrogate established ideologies and structures that legitimise traditional patterns of power in organisations.

This research has sought to use an increased level of empirical data to conduct the analysis. As while the central debate about professional development and academisation of nursing has been well researched and readily available in the literature, research using empirical data as a way of offering greater insight into theoretical arguments is less common. Often, the empirical data available is limited and pays only lip service to the political influence on professional power building. The main concern of published studies relating to nursing in Chile focuses on nursing credentials; the overall concerns are academic aspects—the rapid proliferation and content of degree programmes and the national standards of quality for these programmes (Behn, Jara, & Nájera, 2002; Castellano et al., 2011; Jofré & Paravic, 2007; Rivas & Osorio, 2005). Although three major works (Jara, Behn, Ortiz, & Valenzuela, 2009; Núñez, 2012; Urra, 2004) have devoted attention to the link between the two concepts—academic credentials and power—they do not go far enough to advance a discursive shift in the scholarly debate. Urra (2004), on the one hand, points to the lack of regulation on paths and requirements for specialised practice after degree studies, while Jara et al. (2009) and Núñez (2012), on the other hand, discuss the historical lack of recognition of postgraduate qualifications in the labour market and recall some underlying ideologies for the continuous transformation of the nursing curriculum.

This lack of recognition of postgraduate qualifications in the labour market is one of the central themes of my analysis. Collins (1979, 1990) and Rivera (2011) both highlight the importance of credentials as devices for controlling occupations and appropriating their wages, building privileged positions, and for this reason are central to the modern social stratification. Credentials ought not to be seen as solely

a rough indicator of a certain understanding in a given area or occupation or a 'passport' for the trained workforce to access the employment. Accreditation and academisation also have an important role in how society is structured. Credentials symbolise cultural capital—status, standing and power—and therefore credential holders become not only members of the 'knowledgeable society' but also of a defined professional group driven by particular ideologies.

Relationships and relational patterns in organisations archetypally develop from ideologies. This chapter looks at what ideologies lie beneath current patterns of power in nursing. It also explains what institutions have been used as legitimation devices, and how both, ideologies and institutions, have shaped the ongoing processes in the making of contemporary nursing in Chile. The main focus of discovery is on whether academic credentials make power shifts possible, and on what credentials make nursing thrive.

Drawing on ethnographic data, these concepts are addressed through five major sections: (a) the established patterns of power in the Chilean society and in organisations; (b) the struggle for nursing validation in a current scenario of reforms; (c) the construction of partnership with bodies becoming allies; (d) the structuring of credentials in nursing; and (e) the attitudes arising from context and nurse training. The purpose of this chapter is to open a debate around the use of academic credentials in shaping ideologies and power relations in the making of contemporary nursing in Chile and elsewhere.

Established Patterns of Power in Organisational Settings in Chile

In order to frame the common structuring that shapes organisations as a social and cultural space, I first discuss relevant background information concerning the *latifundio* as a dominant model of land administration in Latin America since the colonial period and the impact it had on sociopolitical relations. The structure of the latifundio resulted not only in a specific form of land tenure but also in the development of a specific model of production and work relations. The logic behind this

structure was rather conservative, as for much of the nineteenth century and early twentieth century families of landowners kept control of the economy. This allowed them a powerful role in shaping political relations among classes, in many cases resulting in oligarchies.

Even to the present day, the *latifundio* model is considered an influential pattern in Chilean cultural identity. It marks what Herrera-Sobek (2012) refer to as a *criollo* (creole) traditional identity. In Chile, most of the population lives in the central area. This being the largest agricultural zone, here we find that work relationships are often based on ties to the *hacienda* stratification (Keen & Haynes, 2012). This structure puts landowning families on top of the structure, and *campesinos* (peasants) or *inquilinos* (tenants) in lower strata. Generally speaking, the landowning families originate in the European-descendant aristocracy in Latin America, while *campesinos* derive from local indigenous peoples and their mestizo offspring. This means that in Chile skin colour is often considered an important trait in determining a person's social rank (Forment, 2003). Structured as a 'microsociety with a social life on its own' (Barr-Melej, 2001) and sometimes perceived as a 'feudal society' (Austin, 2003), the *latifundio* is characterised by verticalism and a 'sacralisation' of and, consequently, an attachment to this order, to authority, compliance and obedience to the established structure (Bucciferro, 2012; Hojman, 2006). This principle has been repeatedly reinforced for generations through textbooks used in official public education on the basis of nationalism (Barr-Melej, 2001; Illanes, 1991).

Although the *latifundio* in Chile was largely confiscated in the 1960s and early 1970s, its labour-repressive functioning remains at the heart of the cultural and political organisation of state administration and public service institutions. These institutions have retained the rigid and paternalist traits that generations of *latifundio* have embedded into the model of society. Other institutions and organisations have also influenced cultural processes, namely the armed forces and the Catholic Church. At a cultural identity level, these forces have meant a strong Eurocentric class and ethnic stratification in the contemporary society at large and within organisations. This is not to say that this research uses a culturalist lens; it simply reports the regularities between setting and context which were insightful.

Patterns of Power in Healthcare Institutions

Healthcare organisations are not solely service institutions. They are also cultural realities configured around a set of organising values; in the case of interest, those enacting the *latifundio's* hierarchical system. Gómez and Rodríguez (2006, p. 47) illuminate these matters, stating: 'Based on the historical perpetuation of this [latifundio] model […] even with the changes and the process of modernisation of the State, which resulted in the opposition to paternalistic authoritarianism, individuals still seek to establish paternalistic relationships in all aspects of their civil lives, with bosses, union leaders or whoever is considered to have/represent power to them'. In this light, it becomes apparent that the established pattern of power in organisational settings is one of linear subordination logics, preconceived upon a tacit understanding of 'what this is all about'—who is 'above' and who is 'below', regarding family background, social-class consciousness and ethnic self-ascribed identity.

This relational principle of Chilean organisations is equally embedded in hospital cultures, reported earlier, for example, as the great might of the medical profession (Cerededa & Hoffmeister, 2008), the social-class struggle among nurses (Ayala, Fealy, Vanderstraeten, & Bracke, 2014) and the institutional paternalism towards patients (León, 2008; Myser, 2001). This picture ultimately represents hospital functioning as tied to a unidirectional flow of power and authority.

Given this picture, which could be thought of as an unbridgeable chasm in nursing's quest for recognition, it is no wonder that an increasing proliferation of universities offering advanced degrees in nursing fuelled expectations among nurses, which in turn was perceived as a promising political platform to challenging and remodelling established institutional structures.

From here, the findings of my ethnographic study will be discussed to highlight the tensions that surfaced consistently in order to analyse them and their linkage with the development of a credential system in nursing.

Further information on the methodology used in this study can be seen at the end of this book.

Striving to Validate a Domestic Metier

State reform in Chile in the 1980s lead to a major reorganisation of the healthcare system. These reforms have led to hospitals facing market constraints in response to pressures for survival strategies. Increasingly the need for these survival strategies is becoming a managerial responsibility in order to promote the hospital's self direction. These changes have led to a highly specialised bureaucratic structure, namely a growing number of high-rank posts and coordination bodies, and a number of goal-oriented control mechanisms. The focus of hospitals has thus begun to change somewhat, shifting from a medically centred domain, to one that has witnessed the increasing rise of hospital management. This shift in hospital management and structure is opening up potential niche for nurses to reach detachment from medical dominance. However, while this project proved to be appealing to the nursing community, questions arise about how the nature of nursing might differ outside the formally vertical, medically dominated conception of health care. This will lead to nursing being considered more than a helping occupation. If this is the way nursing is heading then questions need to be asked, how significant will it be in the future and where is nursing heading to? What are the underpinning ideologies of the nursing project? Could it possibly hinder the healthcare reform process? How would hospital governability be still conceivable without medical dominance?

> Nurses begin to feel uncomfortable with the bystander role. Nursing representative.
>
> There is no such a thing as a divide between curing and taking care of the patient, as nurses want to show. The reality is that doctors know best their patients' situation and lead the team accordingly. Chilean Medical Association's (2013) public statement concerning nursing divisions of 'Management of Care' in Hospitals, extract.

Charting nursing's course is charting a carefully constructed plan basically aimed at validating their centrality as a connecting piece in the organisation and coordination of services (Ayala et al., 2014). This idea of nurses' domestic centrality is also of political significance as research

has shown a certain amount of male dominance in the area of medical authority. This political significance led to the assigning of vocabulary to the nursing organising activity, a vocabulary which in part represented the legitimatisation of a particularly 'female' type of wisdom. This, in turn, is being translated into a particular set of abilities, modifying in the process self-interpretation and aspiration of nurses:

- *Interviewer*: nurses have more ambitions than any of us thought imaginable.
- *Nurse representative*: yes, but the difference is that our struggle flag is the patient's flag.

The move by nurses to take on a greater level of responsibility and gain a more prominent political position has meant a challenge to the socially constructed barriers. These social barriers may include all of the following ethnic background, gender relations and social class, and thinking another way it may be said that nurses' mobility defies a long-standing social stratification tied to the social structure that existed under the *latifundio*. Aware of this move that was perceived as a threat, the Chilean Medical Association (2013) would delegitimise the nursing stance as if reaching high-rank posts would violate the social order of the organisations as much as the cultural expectations on what it means to be a nurse. This reactionary phenomenon would eventually creep into the public sphere, depicting an image of nurses as a nonconforming group, whose detachment will allegedly have rather damaging repercussions on the provision of care services and on doctors', taken-for-granted, leadership.

Allies: Call and Response

While the nursing project has been strongly opposed by medical leaders, validating its organisational role has been a crucial move in nursing's attempt to become a freer occupation. This achievement owes its success to a number of forces and alliances. This reform scenario has opened up organisations to analyse more carefully the rare climate that is the political history of nursing.

The State's distant relation with nursing has turned into a tacit pact of cooperation greatly rewarding for the latter as the State's support enables a greater level of validation and leads increasingly to legitimacy within the societal structure. This greater level of legitimacy and validation will in turn lead to definitive rights within the structure. Of State entities with importance for the nursing's political endeavour, two have been decisive in the current scenario: the Ministry of Health and the Legislative Body, one wanting administrative expertise and the other granting authority and privileges in return.

> We have reached a number of landmarks in such a short time. First, making our management of care official by law and as a responsibility exclusive of nurses. Then an agreement with the government on implementing high posts for nursing offices in every hospital as a requirement for accreditation. And now this new law regulating nurse education. Yes, we have done many important things. Junior nurse.

Constructing such a pact and adding to the level of responsibility in nursing would ensure that the valued collective input of nurses was recognised as an important asset in realising practices that are in the best interests of public health. This reality has only being enabled through greater awareness by nurses of their significance in terms of both policy design and implementation. Without this level of awareness, it would be impossible for nurses to gain the benefits of their increasing collective power within the healthcare system. The importance of this increased political power within health bureaucracy (Molina, 2005) should not be understated. In some contexts, nurses outrank doctors in terms of key policy-making positions, allowing themselves to be more confident in their role, and add to the esteem of nursing shifting the power balance from a hierarchy to a more linear structure.

Nursing is also benefiting from an alliance with the National Federation of Public Healthcare Professionals, non-medical university-trained workers. Through this group, there has being a push for improved conditions both in work and outside of it. The achievements of nursing in building momentum towards a greater degree of social mobility and symbolic rewards have been cheered by the association for increasing their overall visibility.

> Our Federation also rejects the Medical Association's claim on the new nursing offices of management of care. It sees these roles as being fluid and therefore should not be ascribed to one particular title as non-medical professionals have long performed these roles. Extract from the National Federation of Public Healthcare Professionals' (2013) public statement concerning the position of the Medical Association on Nursing Management of Care.

Another important factor in the growing importance of nursing is its relation with its clientele. Nursing's ethical mandate, namely to defend the best interests of its patients, has helped to develop an enduring sense of loyalty towards the profession and an awareness of its importance. The ethical integrity through which the profession acts and is viewed provides genuine reasons to uphold its mandate which in turn leads to the patient-nurse alliance. The Chilean Nurses Association (2012, p. 39) dictum '*I* take care of you' highlights the importance of communicating this sense of vocation into the public sphere.

These three alliances set a new code of symbolic capital, which surfaces in the form of a shift in the use of nurses' collective powers. Whether this shift results from the acquisition of further credentials in nursing is unclear at this point, though nurses could significantly shape rules of organisational governance as newer disciplinary developments can be used to wield power.

The Structuring of the Nursing Credentials

The influence of healthcare reform has not been the only factor in influencing educational credentials in nursing. The broader reorganisation of state structures and educational reform steaming from the State's embracing of open-economy dynamics also had an impact.

During the 1980s, public-oriented universities in Chile were affected by budgetary restrictions and new administrative approaches. Between 1980 and the end of the decade funding had been slashed from over 4.5% of the total public spending to 2.8% (Lehmann, 1990). This reduction in funding, in both public and private universities, was combined with a policy of self-funding, increasing levels of deregulation

and higher fees. This new format can be seen in several other countries in the region converting universities into 'university companies' (Cancino, 2010; Sotelo, 2000). Other non-university institutes could be best described as 'factories of educational goods' (Donoso, 2009). This changing dynamic led to universities creating brands and building mechanisms of publicity to seduce their targets. These policies resulted in an open race for credentials for those outside the educated elite. Although certain programmes of study may cost between U$3'330 and U$7'930 per year (Ministry of Education of Chile, 2013), it should be said that the vast majority of the subjects studied at university level have positive returns on the investment (Meller, 2010), with nursing ranking among the top five careers (Ministry of Education of Chile, 2013).

The curriculum in nursing has also changed over the years, extending the course length to up to five years, with the programmes becoming increasingly theoretical. Practical experience is combined with an introduction to managerial approaches and methodologies for research and the application of scientific research to nursing.

> We were told that getting the degree of *Licenciado* by increasing the number of years of training would allow us to pursue other degree programmes if we so wish, but also to acquire new knowledge to get better positions once graduated. Not many study postgraduate degrees but I feel that training was a good thing for our management role, perhaps we do need to learn more, I don't deny that, but at least it gave us more confidence. Clinical nurse.

Recently a debate, started in 2005, on whether legislation should be introduced to ensure university-based education as the sole route of entry to the practice of nursing reached its culmination. It seems that although detractors of the law project presented more significant and compelling arguments it was those advocating in favour of 'universitisation' of nursing that won the day (Chamber of Deputies, 2014)—the vast majority of deputies voted in favour of the new legislation. The lopsided nature of the result may further emphasise the ability of nursing representatives to lobby actively and effectively. It seems that without this growing awareness of nursing's current position

in the market and its strengthening voice in policy-making circles this favourable outcome, in terms of professionalisation, would have been unlikely. In the political arena, there must be agreement on the values to be exchanged between the parties, along with views on a range of acceptable concessions that equally protect particular interests. More importantly, it is necessary a consciousness on the various machination strategies that each side could eventually implement in a given case scenario.

Along with these, demands in relation to nursing postgraduate education have also changed. At the non-degree practical training level focusing on management skills, theorising nursing's core occupational activity might still remain an applied field. The changing nature and growth of these types of third level credentials are best explained through the prism of social processes and mechanisms for expansion of professional jurisdictions (Abbott, 2010). This thinking can help to explain the separation of areas of work under control, in our case of interest the managerial detachment of nurses from the curative aspects of the medical practice. Another explanation is the constant shifting of job market requirements over time. Increasingly more demanding skills and more diversity are required within the workplace environment, and sometimes to even gain entry into it. To these norms nursing is no exception, and as such, nursing has begun to place administrative and leadership skills at the core of the nursing professional project. Such differentiation, as relevant as it goes in the sociopolitical grounds, may be understood with reference to the concept of 'social closure' (Abbott, 1988; Evetts, 2013; Larson, 1977; Reeves, McMillan, & Van Soeren, 2010)—professions develop market-oriented schemes, exclusionary mechanisms to gain monopoly control of an area of work, assuring self-interests in terms of power, salary and status, so as to thwart the interests of competing occupations. In this light, closure, as opposed to openness, draws attention to the differences between related professions, with the notion of 'ownership' of knowledge and expertise (Collins, 1979; DiMaggio, 1982; Heller & Wilpert, 1981; Larson, 1977) amalgamating the acquisition of legitimisation and authority.

Postgraduate degree programmes, however, have not necessarily seen the same fate befall (Jofré & Paravic, 2007). An apparent lack of interest may be enlightened by Collins' (1979, p. 192) view on credentialing:

'education is part of a system of cultural stratification […] the reason most students are in school is that they (or their parents on their behalf) want a decent job'; this means that the interests of the proposed students may not always match those of nursing academics. Rather than focusing on the requirements of employment, academics may instead focus on their own narrower goalposts to satisfy their personal academic goals. To this extent, a master's or doctorate qualification may not add much to the individual's employability in nursing as they do not seem to be regarded by employers as a valuable contribution to nurses' skills.

> The problem of nursing postgrad schools is that they're disconnected to the practice and that there is a mismatch with organisations' requirements, as they need a nurse 'to do', not to overthink things. Manager nurse.
>
> A nurse is a nurse, with or without postgrad schooling. Hospital Manager.

It seems that postdoctoral and master degrees are mainly used for mentoring new faculty nurses for the limited number of academic positions. Nursing is considered more a job-oriented environment and therefore nursing scholars often must combine their intellectual interests with technical teaching. This reality in terms of how academic qualifications are viewed in line with more practical experience usually leads to stalemate, especially in proposing and managing large research projects or acquiring a researcher identity. That is to say that a research career in nursing is limited and may begin and end with a dissertation:

> Lack of time has been for ages the argued reason – "nurses don't have time to do research." Equally, here at the university, nursing scholars have long argued the same. It is my personal belief though that even postgraduate nurses lack confidence to do research autonomously, and even to imagine themselves dealing with complex research projects and large budgets. Senior Lecturer.

The lack of marketability of postgraduate credentials in terms of employment in nursing should not take away from the importance of nursing postgraduate schools in building a stronger identity for both

nurses and the nursing discipline. Before the formalisation and push for a greater academisation of nursing, postgraduate training had been fragmented into the practical aspects of the profession and those values embedded in the paradigm of health and illness. Jara et al. (2009) highlight that until the 1960s most nursing scholars in Chile had no postgraduate credentials and that training was broken down into specialisations. This began to change, however, in the 1980s as some nursing schools begin to organise master's programmes, and following this, in the 1990s doctorate programmes. Even if the full benefit of these movements is yet to be seen, they were important steps in the movement towards a greater level of recognition for nursing. Nevertheless, it is believed that they may signify an important influence in the rise of a more critical thinking among nurses, counterbalancing old, tired ideas of precedent currents of thought, those relying on values such as selflessness and abnegation as the driving force of the nurse identity.

Changing Attitudes

Having reviewed the institutions, processes and ideologies that lie beneath the making of nursing credentials, it is necessary to answer the main topic of concern, that of whether this machinery has served as a means of interrogating old-fashioned patterns of power.

Most mid-career nurses recall that 2004 was an *annus horribilis* for the nursing community. A number of newly promoted director nurses were forced to vacate their only recently acquired posts. The Medical Association played a key role in destabilising a project which sought to allow nurses to become hospital directors. No consideration was given to the nurses' credentials who had acquired the director posts and an abrupt end was brought to this project not for reasons of meritocracy but stigmatisation of the nurses' role. As one of my interviewees stated:

> - It was all over the press. We all perceived that as a hit below the belt; we didn't really know those colleagues personally, but we felt so much empathy for them, they represented the end of a long, long struggle of nurses to get rid of doctors' yoke. It somewhat revived the memory of old strains

> with doctors and there was some tension in the air. For them, it was just distressing that someone with a rather 'housekeeping role' could get the highest position in the hierarchy and be at the helm. Senior Nurse.

This reflects an old pattern of working relations in hospitals, as explained by another nurse:

> - Some doctors behaved like 'awful landlords' and were in fact referred to as such, 'the patrons of the parcel.' It wasn't uncommon that some of them would come up the stairs and, as stepping in the ward, they would shout their head off: 'Where is the nurse?! Nurse!' almost as if they were calling their personal servants. Senior Nurse.
>
> - That's undeniable. It used to happen. Some colleagues abused their position time and time again, I know. They played the despot over the nurses. The junior doctors now learn that professionalism and despotism cannot possibly flourish together; the one has its roots in our best reasoning; the other grows out of our worst moods. Senior Doctor.

It seems that there was another reason for the undermining of the nursing role, namely that of attempting to be a leader in a male-dominated domain. Health care has long been a domain of male doctors and as such male-dominated hospital boards. This is particularly striking in the building of political networks, and how hospitals are usually given the names of former director doctors, which have become more a homage-paying pattern surrounding the medical patriarchy.

It should be stated that although gender differences cannot be the sole explanation for this conflict, they are an important one. It was in 2011, after an open call for applications, that a nurse would win a tough competition and become the director of one of the largest and most symbolic hospitals in Santiago de Chile. In 2012, a nurse would gain a director post in another metropolitan hospital. This seemed to highlight a sea change in terms of appointments of directors with nurses no longer being overlooked. Most nurses saw these appointments in this way, as both the pinnacle of a nurse's professional career and a foolproof demonstration of their political latitude. It would, however, be

unjustifiably deterministic to assume that the reach and impact of nursing credentials are the sole force of nursing's collective ability, ignoring that other type of credentials may equally contribute and that individual candidacies rely heavily on personal trajectories and interests. Indeed, both directors had obtained further training after graduation, though not postgraduate degrees in nursing, and both were male-nurses. To whatever extent gender might have been decisive, the figure of a nurse sitting on top of the hospital board could become a sign that belies common assumptions on nurses' capabilities.

Despite this political transformation, my observations uncovered what may be considered as a subtle incongruity between discourses which nurses have taken on and the actual relations at a non-political level:

> – Why don't we augment the fluid rate for this patient? – as if the doctor wished to disguise his order in the shape of a request. The nurse, at the other end of the desk, wraps up her duty with a tone of agreement. – Yes! Field notes.

These words represent a broader picture of the interactions I witnessed between nurses and doctors. The type of discourse used almost became a predictable mirror for the working relationship: reporting for deciding and dictating for implementing. Relational patterns have changed, and yet working logics seem to remain as a counteracting burden for nurses. It can be argued that this logic only affects the clinical dimension of nursing, though this is its core occupational activity which engrosses a considerable part of a nurse's day.

Taking all these observations into account it becomes clear that a change in the way nurses experiment and exert authority and approach the political sphere is shifting. These new patterns are influenced by the emergence of nursing postgraduate programmes promoting new ideologies, a result potentiated by the transformation of the curriculum and the acquisition of extra-nursing skills. In the end, 2004, the *annus horribilis*, may have benefited nursing's interpretation of power and a better understanding of how to manipulate it to their advantage.

Conclusions

Since the early 2000s, a number of publications have analysed the possible impacts that the changing nature in nursing credentials may have on its position and the role of education in achieving this. These publications have, however, failed to offer real insight on how exactly credentials are used to wield power.

This chapter approached this key issue from an ethnographical standpoint in order to better explore what ideologies, structures and processes have informed and developed credentialing in nursing. This approach enabled a focus on the extent to which credentials have and may continue to serve as a means of adding insight into those established patterns of power which have historically undermined the nursing profession's course.

Chile was chosen as the setting for this study as it is regarded as the leading example of nursing development in Latin America. This allowed a study that was based on some of the highest standards in the region, drawing meaningful insights into the nursing profession. A focus was placed on transformations witnessed in the country with an emphasis on going state reform and how credentials are considered a means of social stratification in health care.

As the system was established as part of a larger colonisation project of governance, organisational patterns often reflect the repressive means implemented to maintain an authoritarian rule. This is reflected in the class, gender and ethnic stratification that has been analysed. State reform has, however, led nurses to adopt a more open attitude towards power, often being seen as a group lacking the desire to exercise it.

At a political level, with the objective of transforming the future, there are signs that represent an important rupture with the past. Firstly, by focusing on external social dynamics produced by the State reform, it becomes evident how operationally induced political changes have made an implicit pact possible, through which it was foreseen would garner a greater position for the nurse in the doctor–nurse power interplay. Secondly, the transformation of the State has promoted the rise

of hospital management and with it a policy of individual candidacies for high-rank posts, disregarding family ties and elite professional titles. Thirdly, the materialist, technical component of the nursing credentials has moved gradually into a more symbolic, cultural component (Wright, 1998) which, alongside a modification of the curriculum, has greatly shaped sociopolitical processes concerning upward moves and cultural expectations, process facilitated by strategic alliances. Fourthly, a social closure project has successfully precluded the interests of other professions, such as midwives, gaining monopoly, rights and privileges, and eventually a new code of power for nurses.

While these changes signify advances in the political sphere, observations at a non-political level suggest a persistence of asymmetries, though there may exist a discontinuity of old patterns of relations—although there are discourses of autonomy that might fuel a mass mobilisation of nursing labour force, nurses have not been liberated in the clinical domain; yet we could not expect a completely new beginning despite the manifest ongoing process of renewal.

While some authors elsewhere have contended that nurses' taking of power may result from a process of liberation from oppression and linear hierarchies (Daiski, 2004; Roberts, 2000), it would seem that this also represents a crucial dilemma for fully established professions, due to processes of democratisation in organisations and society at large. This argument becomes increasingly plausible when contrasted to the transformation of the nurse curriculum which has espoused larger social reforms opening up organisations for wider representativeness.

Finally, that increasing representativeness in Chile bodes well for non-elite professions collectively and will continue to challenge dominant positions more openly, leading to rotation in power and ultimately forging a significant transition into more commensurate relations. Irrespective of how consolidated the credential system may be, the perspective of credentialing as a social process offers a unique window of opportunity for further scrutiny of historical patterns of power shaping relations in the country.

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7

The Organisation, the Background, the Landscape: Navigating the Reforms

Most of the precedent chapters developed from revisiting field data and reading the findings across themes. That is, reflecting on the commonalities among them. This particular chapter, however, arose from the missing parts of my writings. Not that there should not be 'missings' in research reports. For, in fact, that can be a permanent regret while taking a look back at the cumulative progress of one's discipline—in the writing, more than in researching, eventually everything makes sense and ends up well.

Nonetheless, at some point I began thinking of the setting of my research more purposively and looked at the organisational transformations and the intertwined dynamics of profession building. And that is what it became, a piece that looks at the ways in which nurses interact with the organisations they are in.

The aim of this chapter is to emphasise the organisational setting's impact on health reform. It is important to spend time on this as the majority of today's healthcare practitioners perform their activities in organisations, although most research analyses the professional development from the viewpoint of a professional's role and thus findings are examined as detached from their social environment. This type of

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research therefore neglects the importance of the organisational landscape and functioning in shaping profession building and atmosphere.

To conduct this analysis, the ethnographic data and institutional documents were drawn upon to enable the examination of institutional change within the hospital setting while taking into account what demands and supplies take place in the actor-environment exchange and how coexisting interests also shape ongoing processes of modernisation.

Health reform is often seen as solely an economic and technical process, but this study also focuses on the parallel social process that is evident. These social processes form part of the changes that are witnessed and affect internal organisational dynamics. The end of this chapter highlights through discussion the organisational culture and organisational capital in the workplace allowing greater understanding of professional development and the application of expert knowledge.

Nowadays most professional work in health care is performed in organisations. Although healthcare organisations have been used as settings for numerous studies regarding professional development, and analysis of the same has been put forward, researchers have disproportionately focused their analysis on the roles and skills of professionals using the organisation as just the 'background' where activities occur. Indeed, professions and organisations have normally been researched in two separate traditions. Not only do organisations exist on the basis of technical tasks coordinated to obtain expected ends, but also of social relations among the actors intervening in organisational processes. Organisations become interacting environments where varieties of interests coexist and such environments are shaped by social forces with reference to those interests.

Bringing the organisational background, or landscape, to the fore of the research and making it the focal point of analysis (Abbott, 1991) allows for a greater level of understanding of its impact. It also enables an analysis of the nuances of the dynamics of institutional change where social actors interact with the landscape. Approaching the research in this way also enables perspectives to be drawn from the ethnographic data and personal working experience through a reform period. This chapter looks at (a) what supplies and demands take place

in that actor-environment exchange, and (b) how coexisting interests shape ongoing processes of modernisation—or, rather, reorganisation—of hospitals. These concerns are addressed in terms of organisation, disorganisation and reorganisation. To add further insight, a discussion is posed to conclude the chapter. The discussion analyses health organisations as the embodiment of social processes and cultures, and how disorganisation-reorganisation developments may contribute to the application of expert knowledge, qua organisational capital, in the continuous transformation of both the professions and the organisational landscape.

Since much of the book's contents rely on my observation process and reflective engagement with workers, this account provides a wider perspective on the day-to-day practices of porters, clerks, clinical professionals and others working in the healthcare environment. As they shared these practices, interviews and casual encounters, and stringent note-taking allowed for a later analysis and questioning of their narratives.

Initially, as I began the study, it was difficult for the participants not to regard the observation as a form of supervision or assessment. This suspicion soon lapsed as a greater rapport was established and our presence became normalised and thus non-intrusive. My assurances that content from both the observations and interviews would be confidential also contributed to participants' willingness to participate.

Organisation: The Hospital Stays Afloat in a Social Sea

A hospital can be understood as organised flows of specialised work: stretchers are pushed here and there, carrying patients, crashing into and going through restricted-access doors, heart monitors beep, blood samples are taken away, papers are printed, signed and archived, and telephones ring. Voices, rings and beeps mingle into a constant background noise; the noise of work comprising a large number of complex activities coordinated timely in a year-round occurrence on a twenty-four-hour

basis. Their unifying feature is that they are *organised*. Coordinated action is the principle of how users can have their injections injected, their records written, their wounds dressed and their tumours removed. Any interruption in these flows might threaten the provision of care.

These hospital activities do not take place independent of one another. Hospital personnel work within a system that becomes part of a daily routine, allowing for the seemingly chaotic atmosphere to function effectively. As my notes read: 'Hordes of workers rush into the hospital near 8 o'clock to register arrival on a fingerprint scanner'. Within this system, however, demeanour of individuals can allude to what group they may be placed in. Doctors often have the walk of a cavalier, stately in the centre of the main corridor, matrons that of a strict housekeeper overseeing activities, and nurses that of a busy maid. In nursing stations, auxiliaries murmur at a supervisor while going over union pamphlets. From the research observations, I was able to pinpoint that it is here where most of their social disputes are put up. It is clear that the organisation has symbolic relevance for the professionals working here, and that their interacting dynamics are as much cultural as they are technical, and that this cultural dimension is the driving force behind the organisational life of the hospital.

But most workers also enter the hospital to pursue their career and not simply do their work; this in itself is a 'repository of social forces or social choices' (Clegg & Cooper, 2009, p. 18). Skilled acts, as performed by professionals, are not only compensated monetarily but also afforded a special recognition which gives a greater level of status and, almost always, ensures a certain wage. This reality exists as a consequence of collective connections, affiliations, influences, tensions, competitions and struggles.

As a bureaucratic structure (Gourdin & Schepers, 2009), the hospital also assigns each actor an 'office' (Weber, 1982) with certain parameters of jurisdiction. This means that each role is confined to its own specific rules governing function. These rules, however, are not the only parameter that governs jurisdictional boundaries. A tacit agreement also exists whereby individuals and groups from different 'offices' ensure that these rules are adhered to so as not to cause conflict and to create in the process interdependence, stability and certainty within the environment.

At this point, it is important to note how large hospitals can be. Indeed, many are among the largest public institutions in the country.

Hospitals are often regarded as slow-responding organisations; icons of public service's senile lassitude, best described through the metaphor of a heavy cargo ship difficult to alter direction quickly and stay afloat when challenging obstacles arise, as opposed to nimble and light sailing boats. Hospital managerial boards are thus often handicapped by the mere scale of managing such large organisations. This inevitably leads to desperate measures due to not having full control over the helm or simply resigning themselves to do 'as much as and when the circumstances allow them to'. The difficulty in changing directional approaches seems to be embedded largely in historical cultural practices: groups' interests and willingness (or lack thereof) to change, along with a long-standing belief which holds that, once acquired, a job post becomes inalienable (Blöndal & Curristine, 2005). The result of this cultural influence is that the organisational structure grows rigid. Challenges for improvement go unanswered, or worse, are never even brought to the table to question the current organisational approaches (Abbott, 2009). Overall, this leads to a barrier to innovative approaches and a restrictive interpretation of one's own scope to put forward new approaches or attempt to implement new ideas.

This neither suggests that a hospital is a wholly monolithic entity, nor is to say that it is a fixed ordered system. Unravelling of organisational dynamics shows a perpetually changing flux moving along various paths. While technical and social activity may inform one another in ways that define the organisation's own interior logic, the counterbalancing effects of their forces seem to keep the system stable.

The pertinent question is whether a setting with these characteristics can eventually avoid the 'Titanic's fate' with a 'reform ahoy', but at this point in the analysis this understanding is still unclear.

Disorganisation: Reforming Winds Blow

A major State policy reform in the early 2000s set out to drastically rearrange hospital organisation. This news put healthcare workers on guard and sparked a politically fuelled confrontation between them and politicians who sought to implement these new measures. This drastic

'shock' approach to hospital reorganisation unleashed a level of disorganisation—otherwise bureaucratic irrationality (Hummel, 1994; Weber, 1947)—of hospitals.

For example, one key aspect of the systematic rearranging sought to impose universal health coverage. Universal coverage, it was felt, would interfere with a consolidated private health insurance market. This in turn would lead to a backlash from conservative sectors (Lenz, 2007; Pribble, 2013) and certain professional groups. Lenz and Pribble have highlighted political ties between the medical profession and the Parliament, as being an obstacle to the reforming initiatives put forward. This opposition has been further strengthened by collective activism and a concentrated media campaign aimed at garnering support from the general population and influencing their perception of the proposed reforms. It is important to recall a divide that emerged between professionally minded and scientifically minded doctors, as their scientific societies had an active role advising the government (Lenz, 2007), an atmosphere that created a large level of public distrust. Arising from this, and possible even more intrusive on the aspirational reforms was the level of internal uncertainty that grew which pointed to inadequacy in organising care, a key facet of healthcare organisation.

The modernisation of hospital management was another key instrument put forward for reform as historically it is an area which has been criticised for its amateurism and ineffectiveness (Lenz, 2007). Along with the introduction of specific management training, thinking of the future of the hospital strategically also meant posing some basic questions across the institution, such as: Who are we? What do we do? What are our fundamental values? Where do we want to head into? These seemingly innocuous though fundamentally important questions uncovered a slew opinions and cross-organisational input that highlighted an ideological fragmentation that exists across departments while at the same time representing a significant impediment to ensuring that aspirational reforms are delivered in a timely manner.

Much of the antagonism comes from cultural power dynamics such as medical doctors' fear of losing control over a system which they considered themselves to be the leading force. These doctors thus envisaged any remodelling of the sector to be a threat to their position within the

organisational structure. Any redistribution of resources or imposed algorithms and deadlines would, they considered, be an affront to their position at the top of the organisation structure. In this atmosphere of suspicion and fear, hospitals were used to continue to perpetuate medical dominance over health problems, advising patients not to support the State's initiative while adopting an apparently indifferent attitude towards change. This seemingly indifferent approach later turned to overt antagonism and mass mobilisation leading to industrial action as the reforms progressed.

Other health practitioners, it was seen, were more open to a number of the proposed reforms and a number of commodities (Abbott, 1991). New guidelines, standardised operation procedures, protocols and high-tech equipment it was envisaged would enable an improved application of knowledge and professional judgement that would lead to dispensing with close medical control and therefore a greater level of professional autonomy. This new scenario would also encourage a moral rhetoric holding that, unlike doctors, their mandate was to protect their patients' interests rather than their own. The organisation, conversely, became a platform for their political action and a channel for voicing historical claims of vindication:

> We are determined to get the recognition gap bridged. We know, and society should know, that our function in hospitals is absolutely indispensable. Recognition and respect for our autonomy is, at least, what we deserve. Nurse representative.

Another group that has chronically being excluded from both discussion and the decision-making process is that of blue-collar groups (Arthur, 2008; Grossman, 2005). For these groups, taking more responsibility could be implemented through technological training that would result in an increasing delegation of technical tasks:

- *Auxiliary representative*: Our struggle ain't over. Since 2007 we've been presentin' our demands for legitimation of our new roles in the reform to get rewarded accordingly.

- *Interviewer*: you, guys, have more ambitions than any of us thought imaginable! (laughs).
- *Auxiliary representative*: We hate to be bystanders. Like I said, mister, our struggle ain't over.

The proposed reforms also put forward a framework to redistribute authority. This meant the creation of new national entities that would oversee and inspect health processes and results, meaning that health-care services should then act as care providers only and relinquish their managerial role. Such a change in organisational structure would also have an effect on the internal hospital logic, undercutting symbolic power structures that indicate 'who reports to whom'. Although change may attenuate medical dominance, it may also create internal confusion as to the vertical flux of reporting and hierarchy.

> That was a chaos [sic]. Things were really messed up and nobody seemed to have the answers. What was written in the guidelines seemed to find no place here. Doctors were responsible of admitting the patients into the new programmes, but they didn't do what they had to; they just didn't want to; many lost their rights because of that. We sent reports regularly to the coordinator of each programme and we were requested to… force things silently, such as filling the forms ourselves and persuading the doctors to sign them. Now I take a look back and I simply can't understand how we're able to overcome such a torrid chaos [sic]. Senior Nurse.

The greatest challenge to the reform, however, was the apathy with which it was viewed by doctors. Advice was given not to use new guidelines or new algorithms that were aimed at supporting patients' treatments throughout the course of priority illnesses. Given this opposition from doctors, it seems that there is little opportunity for reforms to succeed. Just how crucial a resistance this proves to be is uncertain. Could managers keep control over the organisation despite this opposition to reforms? Is there a way of ensuring that reforms thrive?

The doctors' apathy is contrasted by the optimism of nurses. Nurses, who were afforded increased responsibility in office work, were later inspired by a sense of improved status. This would allow them to delegate most of their direct care duties to auxiliaries and allow

them to garner an air of white-collar professionalism (Ayala, Fealy, Vanderstraeten, & Bracke, 2014).

While office work meant a larger number of professionals reporting to nurses, the emergent implementation of new care programmes also opened an entirely new window of opportunities for other non-medical professions intending to validate their participation in processes definition and control. What is relevant to emphasise here is that those professional groups' interests would conflate technical control with social control, as their centripetal role in a period of inoperative fragmentation and distrust—for want of a domination apparatus—would garner higher recognition within this new scenario. Extra-organisation interests reflecting a wider social movement (Arthur, 2008) indeed unfolded as fieldwork progressed and tracked back the different professional groups reporting the upheaval of the process to external parties (Arthur, 2008), such as their respective professional associations and trade unions. These associations, in turn, endeavoured to introduce their political agenda in the government board.

Putting organisation at the forefront, as a cultural platform for political interests, has allowed changes to put non-medical staff at the front line and with them a fresh 'disruptive potential' (Parkin, 1979; Wrong, 2003). This is a cultural shift that would enable non-medical to, upon suspending their activities in industrial action, for example, bring the system into a halt. Medical professionalism and altruism appeared to experiment a status downward while being questioned by both State and society at large, as expressed by the now ex-Minister of Health:

> Their attitude separate medical representatives from society, affecting their credibility (García, 2004) Public statement, extract.

It has become evident that in all this jockeying for position among social movements, that is professionals who supply the organisation with technical wherewithal, these skills were used as bargaining chips (Burstein, Einwohner, & Hollander, 1995) for their collective interests, scheming how to seek greater rewards as confusion and distrust grew (Seo & Creed, 2002). The organisation, in turn, suffered the strains of a ship that has just collided with an iceberg on a foggy, moonless night.

Reorganisation: Stronger Hands Hold the Helm

No review of this period would be complete without an analysis of how this process leads to the re-stabilisation of the system's functioning. That is, despite the complex nature of the reorganising cultural reform, there was in the end a move back to equilibrium and stabilisation.

During this conflicting period, nurses and other professionals attended training sessions on the new processes which dealt with both patient response and functionality. Doctors meanwhile attended their own private gatherings:

> When people begin to murmur instead of actually talk, you know there's something going on out there. And then you see them all getting themselves to the meeting room behind closed doors. No premonition was necessary to know something was being plotted. Senior Nutritionist.

The initial optimism towards the new order and reimagining of the organisational approach seemed to vanish in the wake of a medical strike convoked by the Chilean Medical Association across the country towards the end of 2002. This ebb in positive attitude was seen again repeatedly in subsequent years within the medical association, claiming that a reform of the sort was untoward and awkward (Lenz, 2007). It was not until several years later that it would be demonstrated how the medical profession's claims had been disregarded by the legislative body, commanding to proceed with the reform as planned, at both organisational level and bedside level. That intervention, which came to be known as 'a process reengineering', may well be considered as a defeat for the reform detractors.

The hospital where this research was conducted was rearranged by 'responsibility centres' which would provide more accurate and trustworthy accounting on hospital managing, diluting medical specialties as its organising principle. This is a similar approach that was taken in most of the major teaching hospitals in the country. The main focus of these responsibility centres was on rather curative aspects alone. The progression included a two-pronged external intervention aimed

at altering the organisational regime—one up-down legal instruction imposing procedures and deadlines, and down-up exigencies from the citizens, empowered by media advertisements promoting rights and benefits, reported elsewhere as monitoring performance of public services (Milewa, Valentine, & Calnan, 1999), this in spite of internal resistance offered by dominant groups.

Even though analysing the technical, therapeutic side of the reform is not pertinent to the present discussion, it was noticeable a decentralisation of decisions along with the establishment of coordination mechanisms, often supported by fresh clinical personnel brought form the private sector serving as consultants.

During the process, a policy of adopting strategies that resulted in less attention was taken on by non-medical groups (Arthur, 2008; Creed, 2003). These groups sought to take this less confrontational approach or path of least resistance in order to minimise the possibility of strikes, which were felt, could feed fears of invasion from competing groups. An awareness of the overlapping roles among healthcare workers helped avoid perceived threats to one's profession's specificity of function and ensure any animosity, or suspicion between groups was kept to a minimum. Lacking a domination apparatus and discarding the choice of a forcible progression, they had no means other than adopting persuasive and manipulative tactics to handle their environments, which would eventually lead to an internal balance. Modernisation therefore leads to the deconcentration of authority and a redistribution of collective power (Davis, 2003; Scott, 2004). New organisational and power dynamics have emerged, meaning that formal training in relative managerial fields is taken into account where previously seniority would have been the only consideration (Abbott, 1991).

Informed by personal observations, most 'dos and don'ts' in an organisation still refer to the existence of social processes within which are reflected the cultural expectations of the organisation. To this extent, the existence of numerous restricted areas is explained both in terms of technical expertise of employees but also on a symbolic level. This restriction of access is to be expected in areas where high-rank executives and elite professionals abode, but field observation showed that there are other occurrences culturally imposed barriers that would probably

come as a surprise to most people. Here is an extract from my field diary:

- *Observer*: May I speak to the physiotherapist, please?
- *Secretary*: But… who are you?
  (She looked surprised, as though I was breaking an unwritten rule).

  This evoked earlier situations in the wards, witnessing a newer authority structure in action:

- *Observer*: Could I possibly talk with the Ward Nurse, please?
- *Auxiliary*: With the Ward Nurse? You ought to wait until she has time –
  The dryness of her tone contrasted with the air humidity.
- *Observer*: Then, may I see the Shift Nurse, please?
- *Auxiliary*: She's busy now – Her tone became dryer.
- *Observer*: She knows me.
- *Auxiliary*: Okaaay, I'll let her know you're here. What's your name? –
  She came back after a while accompanied by the nurse who kissed me welcome. The auxiliary looked at me apologetically.

This episode illustrated a phenomenon expressed by Arthur (2008) while mapping the use of organisational space. To a certain extent, less-qualified workers act as a go-between separating those who can access professional staff from those who cannot. Given the example from my field diary, it is clear that specific 'spatial hierarchies' exist where new power investiture of non-medical professions has redistributed the ownership and function of organisational spaces. This redistribution has led to the near abandonment of some spaces, such as the patient rooms, while favouring the adoption of new symbolic territories. Offices and desks have almost become a symbol of this shift where a nurse's role now looks highly organisational, moving away from the patient-centred approach represented in Allen (2007). An increased emphasis on organisation has also lead to the increasing importance of professional paperwork as a way of upholding organisational order, which now consumes a great proportion of some professionals' day, as earlier reported by Jervis (2002). Again, this is an indication of how changes in the organisational culture shape the landscape that social actors inhabit.

Through the disaggregation of this titanic journey to a modern hospital, one can fruitfully appreciate disorganisation as an essential requirement for further progression, and how social processes are translated into manoeuvres, explicit or subtle, within social movements, but above all into an 'organisational capital' (Abbott, 1991) that makes the application of expertise more effective. It seems that the organisational environment has been adapted to meet the needs and aspirations of healthcare workers, particularly professionals, rather than adapt themselves to the new organisational environment imposed by reforms. This subtle difference in their approach to the reforms has ensured that the reforms did not turn into the deadliest disaster in the history of modern medicine in the country, but rather a mechanism they could adapt to their advantage.

Conclusion

This ethnographically informed account analysed the history of a specific aspect of the health reform process as constructed culturally by professionals across the organisation of a hospital. Although the main focus was that of major reforms, the arguments developed throughout this chapter also echo those of other minor-scale changes and thus could prove useful in the understanding of gradual changes in organisational cultures.

The study of organisations usually refers to a static snapshot of the internal structuring of a particular organisation using linear logics. However, Scott (2001) pinpointed of what an organisation becomes, rather than what it is, as a way to provide better a focus for understanding change as a cultural process. For this reason, my research disaggregated the transformation of the internal organisational structuring (Abbott, 2009) of the hospital in question, the exchanges professionals have among themselves and with the organisation itself.

As shown, ecological interactions account for adaptation processes in the light of the interests and aspirations of different occupational groups mediating, in turn, in a necessary disorganisation. It is important

therefore not to view state policies purely economic and technical in intervention; such an analytical starting point would consider action and skills in a vacuum and subsequently overlook crucial coexisting elements in interactions, such as affiliations, influences, competitions and struggles. The aim is to ensure a more nuanced picture of organisational regimes.

It would be misleading to consider the involvement of professionals in the process as a result of a moral credo alone. Professionals are often seeking status and rewards which are key in reforming internal logics and should therefore also be taken into consideration. Research data show their progress is in fact negotiated in exchange for a stronger identification towards the organisation, while established groups may risk an under-identification (Stiles, 2011). This analysis illustrates how the reorganisation in the practical arena has not necessarily been patient-centred, but rather politically centred, with institutional cultures shaping roles and struggles. By rethinking the organisational change in the light of professionals' interactions and interests, the gap between the two separate traditions will become narrower and in the process offer a more coherent picture of organisations and the professionals within.

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8

Nurses in the New Landscape of Interprofessional Relations

In relation to the functioning of a profession, a series of chapters is easier to evaluate than the consequences arising from any given profession's behaviour. For this reason, this analysis of the nursing world in Chile presents a rare insight into the continuing sociopolitical transformation of profession building, with a focus on nursing, around the world. Our analysis has not sought to present with certainty a final result but rather to show that this turn is far from finished and that this transformation is an ongoing process.

The initial research question posed was simple due to fact that the methodology used would ensure complex analysis to better understand entwined dynamics of the nursing profession. For this study, the systemic theory of the professions (Abbott, 1988, 2001, 2010) enables the exploration of the ecology in and through which an occupation builds itself. This theory was used as a gateway to understanding relationships among system components and identifying exchanges within the environment where interacting constituent parts have mutual implications. Here, the aim is to show that a profession's course does not rely solely on that of other professions, nor its own exclusivity and internal forces, but rather it depends equally on the social forces

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intervening in the system thus making it clearer that profession building is not a profession-centred phenomenon. Instead, it involves the interaction of numerous parallel forces which are constantly shaping and reshaping.

Abbott's perspective informed the research questions I explored in each chapter and structured the data gathering process and the way I approached the data. His theory is revelatory in the course of the sociology of the professions, and it may account for most problems arising from interprofessional competition I was interested in. Parsons' (1950) seminal work claimed the social construction of the 'sick role' in the functionality and effectiveness of the professional–client relationship, while Freidson (1970) underlined the professions' attainment of extended training to master esoteric knowledge and language, and the dominance of some professions in the labour division, while Larson (1977) illustrated the professions' conquest of status through that knowledge, becoming 'naturalised' power-centred, organised groups. More generally, Abbott's idea of *jurisdiction* comes to expand notions such as internal dominance and exclusive power, highlighting interprofessional relations as an evolving arena of permanent boundary dispute, not in a metaphorical sense but in reference to actual work. That actual work defines a permanent jurisdictional contest implies that change is the fundamental force of the system. This is a shift from a structural-functional perspective (a basic picture of society as an orderly, stable scheme) to a social-conflict perspective (highlighting inequalities and conflict as necessary for social change) I discussed in Chapter 2.

Throughout the research, some theoretical adaptation was conducted in an effort to enhance the analysis of this particular case. This was done by combining the systemic theory with other concepts to provide better scope and awareness. Among these concepts were, social reproduction (Bourdieu & Passeron, 1970), social class (Wright, 2005), gender relations (Acker, 2006; Adkins, 1995; Davies, 1995, 2004), academic credentials (Collins, 1979, 1990), Chilean social identity (Barr-Melej, 2001; Herrera-Sobek, 2012; Keen & Haynes, 2012; Larraín, 2001) and social closure (Evetts, 2013; Larson, 1977), which converged in the systemic approach where I positioned myself.

This combined theoretical foundation was used to elaborate on the internal and the external boundaries of nursing. This enabled improved understanding of the strategies it develops with regard to the interaction with environing groups—namely the auxiliary nurse, the medical doctor and the midwife—as well as the areas in which political action takes place, and the devices, strategies and alliances used as a means of strengthening the profession. The nursing profession, as this study has shown, is shaped by an ever-changing setting, the professions that it interacts with and others that at first view may seem to bear no relevance to its existence. With a view to defend its particular interests from outsiders, it also implements its own strategies to manipulate, both technically and rhetorically, its environment. By bringing this systemic interrelatedness to the fore—highlighting landscape transformations, internal logics and interprofessional contact—it becomes evident that nurses' behaviour is heavily regulated by unwritten rules and that those rules become crystallised in 'a code' as nurses are socialised into their professional culture. A core element of the nursing profession's social closure project is one that enables monopolisation of opportunities and resources as well as exclusionary mechanisms to control its power base. This can be equated with a socially constructed apparatus which would ensure increasing symbolic rewards.

In conclusion, this chapter focuses on its contribution to the field of sociology of the professions, and calls for a sociology of nursing more specifically, by drawing upon the findings of the present case analysis. While it is true that a large-scale study on the technical transformation of nursing would provide enormous insight into its development as a profession, it is also true to say that professional development is as much a technical process as it is social (Abbott, 1988). For this reason, this study has mainly focused on its transformation as a social process. The conclusions are fourfold:

1. The system and its changes—here referred to as landscape and landscape transformation—being idiosyncratic to this particular case have opened up room for the development of nursing in several ways, challenging the nursing profession to display sophisticated adaptation abilities so as to remain within the evolutionary loop of

the healthcare system. This, in turn, questions earlier approaches to the professions in Chile and elsewhere.
2. The internal functioning of nursing as an evolving profession has successfully functioned as an adaptive whole with regard to landscape transformations through a social closure project. While nursing has been concerned with its name and reputation, here we show how it has also sought to be at the forefront in the contest for highly valued symbolic attributes, obstructing in the process what may threaten its prestige, including elements associated with nurses' social background.
3. The types of interactions with other constituent parts of the system (mutualism, ammensalism, commensalism, predation, etc.), which become useful foci in the analysis for any researcher interested in studying a profession's system. As explained below in this chapter, some interactions are more evident because of the actual contact between professionals, while others need to be explored indirectly by piecing together disparate sources to infer their effects.
4. The ability to adapt to landscape transformations is complemented by an ability to manipulate the landscape. These abilities seem grounded on a larger mechanism of professional functioning, best understood as an ideological device. While Abbott might regard this device as internal to the professions, it is useful to conceive it as a specialised medium between the adaptive unity and its environment—as with many actual living beings, once reproductive structures have been broadcasted into the environment, they serve as a communicating means between it and the originating being, carrying encoded information for propagating the species.

The conclusions of this research may also help to illuminate and improve understanding in relation to the development of other professional groups, whether they be in the same working group or comparable ones. As the functioning of a given occupational system often mirrors the traits of society more broadly, acting bodies of other systems may be mapped with reference to the patterns presented here.

The System and Its Changes: Landscape Transformations

Abbott's (1988, p. 91) 'external sources of system disturbance' may be used to demonstrate changes that are external to professions. These changes may be treated as both landscape transformation and changes in the immediate ecology of the profession's settlement. Ecologies provide insight in terms of a balancing point and are therefore researchable diversely (i.e. ethnographically), while landscape transformations tend to be cumulative over time and can thus better researched historically.

In Chapter 5, I have discussed technological and sociopolitical particulars extensively as sources of system change—the overt disputes between midwives and nurses that developed from historical frictions and escalated into jurisdictional confrontations. These disputes became increasingly intertwined with an increasing technologisation of health care which triggered an assimilation process, both for skills and for status. This technologisation process has also opened up areas for nursing to advance into various medical jurisdictions providing opportunities to enter the managerial domain. These phenomena have created opportunities of both the former, horizontal, and the latter, vertical expansion.

What needs to be emphasised here is that while nurses seek to steadily enter new ground and different areas of expertise they become more and more vulnerable on 'rearguard' or what might be considered their traditional areas of work. It is likely that these areas will be occupied by other groups, such as auxiliary nurses. This 'disturbance', coupled with a continuous process of delegation from one profession to subordinate ones (Dingwall, 2008), may well prompt major evolutionary adaptation within the internal structure of the system in the coming decades. If professional evolution continues in the same line—nurses may end up becoming either physician assistants (non-existent to date in Chile) or healthcare managers (also non-existent), or both, and auxiliary nurses becoming actual nurses.

On the other hand, a new sociopolitical ambient has risen over the past thirty years, in the midst of a State reform and, as I have noticed, in the subsequent restructuring of healthcare organisation.

The adoption of a market-oriented scheme for public services, an accountability approach to public administration and universities' widening educational offer to achieve self-funding all three come to open a unique window of opportunity for nursing and other professions. This scenario has also seen the emergence of a new political consciousness (Chapters 4–7). That being said, while landscape and ecosystem give professions opportunities, progress comes from using them judiciously.

Natural and Cultural Particulars

Regarding natural and cultural particulars, evident (mostly) natural changes, be they physiological or epidemiological, have not been explicitly addressed in this work, as it would inevitably lead to a technical analysis, and they can certainly cause changes in the nature of a profession's scope. That is where my expertise ends, however.

As discussed previously in this research, cultural factors have had repercussions for professions. Chapter 6 demonstrated how the sociopolitical order shaped by ethnic backgrounds, with European ascendancy and appearance as a mark of social rank, permeates relational patterns. Thus, verticalism has become an organising principle of social life as much as it connects professional groups with one another hierarchically. This structure formed through the masculine, normative influence of the armed forces and the Catholicism. These synergic groups may lead submissive groups to either prolong the status quo of domination or to engender a competing sense of status elevation, such as the class struggle illustrated earlier in this work.

In this study, nursing has benefited from an increasing awareness of women as subjects of work. This, along with the rise of the middle classes, the success of the healthcare 'industry', favourable demographics and an open market of academic credentials, has helped to improve nursing's standing in health care. These changing cultural threads have fuelled active questioning of established relational patterns, despite that these inequalities (Chapters 3 and 4) still exist and are far from being resolved. This increasing consciousness it is thought will lead to

increased interaction and discussion among interest groups, with abilities in negotiation becoming key in changing processes.

Landscape modifications thus help to mediate in the expansion or contraction of jurisdictions beyond any spatial or functional separation between an area of work and society at large. While the level of mediation seems minimal and loose on the surface level, these changes help to aid understanding that even seemingly stationary occupational fields are in fact dynamic and that they evolve as their environment evolves. One mechanism of understanding this phenomenon is through the co-evolution of jurisdictions, or how they help to facilitate the creation of new species of occupations and challenge pre-existing ones.

Understanding these connections helps to bring a greater appreciation and improved level of understanding to professions. Increasing awareness of their theoretical value enables fuller knowledge of their incremental contribution to professional expansion. This is at odds with mainstream ideas that focus on patterns of professionalisation as each individual profession evolving independently based on its own institutional form. This discussion, by contrast, brings awareness that professional development should not take a pattern of professionalisation for granted and thus seeks to remedy that defect in the sociological thinking in Chile.

Applications of this landscape perspective are rarely seen outside the English-speaking world, and this work based in Chile suggests theoretical compatibility for studying the functioning of systemic environments for the professions elsewhere. From this, it may be inferred that compatibility can be explained mainly through the liberalisation of the economy. This, in turn, allows an indiscriminate number of professions to self-regulate which combines the mutually fuelling pairing of self-regulation and the access to ever-expanding entryways for advanced degrees. This reality may make it difficult for nursing in other Latin American systems to adapt and incorporate their professional agendas into the political discussion as they seek to professionalise as significantly more sophisticated strategies as would be needed. Charting the futurity of the healthcare system, for example, may offer critical junctures for that.

The Internal Functioning of Nursing: Evolution

While this research's principle focus was on interacting aspects, great attention was also devoted to the internal logics of the nursing profession. The important point of focus here is the mechanisms with relevance to their ecological functioning rather than the structural traits that were encountered. This section emphasises how nursing has successfully adapted to landscape transformations, mainly through a monopolising process of closure. Its particular ideological device I referred to earlier on will be discussed separately in section "Deciphering the Social Code of Nurses: An Ideological Device".

First, the increasing process of academisation of nursing education (Chapter 3) may be regarded as platform to propel development and reputation. Nursing began as an apprenticeship model in the early twentieth century, and nursing education has grown in length and scientificity, with abstraction as the landmark of the profession's control of its knowledge base. A consequence of nursing controlling its knowledge base is the development of new skills that match the continuous evolution of the healthcare system more broadly. Advanced knowledge of medical techniques to face medial scarcity (Chapter 5), and managerial skills have put them in a good position to run the internal process of change in the wards and climb into the health hierarchy (Chapters 6 and 7).

This process of academisation should not be regarded as a purely technical one as it has also served to strengthen symbolic aspects of the profession. This strengthening of symbolic aspects helps to fuel and encourage the process of nursing's professionalisation. For example, the symbolic component of nursing's credentials being prompted through relatively new postgraduate programmes in nursing has added to both its prestige and academisation. These symbolic realities, however, have also been challenged as mere aggrandisement of the profession without necessarily adding any real technical expertise. Thus, its contribution to society is being questioned as seeming to offer something impossible, namely the satisfaction of human needs from a holistic biopsychosocial approach to health care.

Rules can exculpate, however. We now know that professionalisation may be discarded in its most elite sense of identity superiority, that of a gradual progression of an occupation's course from a simple craft to a mark of social lineage. Most of today's occupations require esoteric knowledge and skills and may thus be spoken of as professions. Then nurses' sense of status elevation may be justified by a larger phenomenon of labour complexity as society gives rise to a necessary 'professionalisation' of the qualified workforce. Similarly, aggrandising claims are a common resource used by the professions in different degrees by conceptualising an area of work and constructing solutions rhetorically, just as artists assuring to bring people into enhanced sensory experiences and gigolos fantasy into the realm of possibility. By this logic, it is considered that professionals induce a certain sense of loyalty and exclusivity among their audience. This loyalty legitimises the profession-client relationship. This in turn, however, works as a factory of social differences based on eliteness. The isolation of the (so-called real) professions and of vilification of the excluded should be critically interrogated for improved understanding of power structures and elitism.

Second, I focused purposefully on the internal organisation of nursing to investigate its relation within its environment and how it enhances and consolidates the profession's jurisdiction. Important from an ecological perspective, I noted that some levels of organisation, borrowed from biology (Stearn & Hoekstra, 2005), may apply to professions as social entities: separation, cohesion, hierarchisation, ancestry and distinguishability. In this context, the evolution of nursing evolution seems to be almost textbook:

a. *Separation*: Or speciation, is the formation of a profession as a new species, different from others, regardless how, originating in a critical juncture that gives rise to a bare area of work. Nurses, in fact, tend to construct discourses of differentness that, ultimately, refer back to the contradiction embedded in their *raison d'être*: 'We do something that the rest do not, and we do it differently'. Separation organises the profession into what it is and what it does, while also surrounding itself with moralistic mandates, creation myths or other rhetorical

constructions of 'someone above' (Dingwall, 2008) who underlines separation but guarantees cohesion.

b. *Cohesion*: Cohesion is fundamental to separation which is concerning for nurses as there is fear within the group for their internal cohesion. Conflict within a group is often stymied by creating a sense of integration to prevent internal split from occurring. This is an attempt to both self-regulate the internal order and as a way of 'protecting' members from rebelling. While conflict suppression homogenises the group as to interact with similar ones safely, especially in early stages of separation, it raises its standards of internal organisation as to align—as consistently as they possibly can—their interests in appropriating symbolic rewards with their promises of high standard performance. Due to this, cohesion makes the profession more efficient both technically and socially.
c. *Hierarchisation*: Although it is true to say that nurses are busy suppressing conflict, the same cannot be said when it comes to behavioural patterns that lead to hierarchy formation. To a certain extent, they have formed into the hierarchies, improved their position due to increased levels and recognition of training practices and enjoy a closer relation with doctors (at least one disguised in that form). Chapter 6 has shown, however, that internal logics seem to remain very much attached to old forms of hierarchies. This means that they do not seek to flatten out but rather reproduce relational patterns. These patterns are visible in the case of university-trained nurses and auxiliary nurses and how they have continued to be estranged, ever since they first interacted (Chapter 3). Another example of this is the hierarchical asymmetries among nurses depending on their social background. In both these examples, the separation is socially constructed rather than taking place on a more technical level. Here, it seems that closure is seen as a mechanism of self-validation. This pattern reflects that of the doctor–nurse dynamic from the old days, where the oppressed group strove to gain legitimacy for its knowledge and practices. From this finding, one can infer that university-trained nurses may have come to occupy the position of their former oppressors.

d. *Ancestry*: The knowledge that nurses' linear ascendency becomes a multiplication mechanism of culturally transmitted values is of considerable assistance to this study. Once nurses achieved control over their own training, doctors disappeared from nursing classrooms. For this reason, nurses organised to create tighter bonds and better familiarity. Looking at the forces behind this, we see that cohesion is a horizontal force and ancestry is a vertical force. Unexpectedly, the nursing ancestry is a very closed one, and this seems to be a part of the private furniture of most nurses: no nurse can derive from professionals other than nurses; nurses can be considered as other nurses' archetypes, mentors and spiritual mothers. Following from this, it is clear that no auxiliary nurse or midwife or doctor can be expressly trained as a nurse, and attempts to offer training to provide this pathway for other groups, by universities, have been seriously censored by the nursing community. This means that despite the common ground they may share, little room is left for horizontal mobility in career reorientation which, in turn, fuels discourses of exclusiveness.
e. *Distinguishability*: By this, I do not mean the Bourdieusian idea of distinction. Rather, the members of a community are able to recognise one another by judging their values and behaviours. Being distinguishable is important to preserve ancestry and cohesion; it is in presence of fellow specimens that reproductive codes of behaviour become active.

Apart from a recognisable uniform can nurses be recognised? Can they be truly distinguished from midwives or auxiliary nurses? Although the bolder medicalisation of a sector of practising nurses (Chapter 5), there is a generalised increase in managerial roles at the expense of clinical ones (Chapters 6 and 7). One area where nurses might mutually recognise is the organising role, and yet even in this area, there is an important overlap with midwives that nurses are determined to disinter.

By looking at the way in which nursing is socially organised, we see just how related these are to biological systems, however metaphorical this statement may be. Professional systems in some ways imitate these, highlighted by ecological theory of the professions and evolutionary ecology which portrays them as interacting relatives. This research adds to these theories, underscoring the incremental value of these theories.

Types of Interaction with Other System Components

In the previous section, I discussed intraprofessional organisation. Here, I present relevant conclusions concerning interprofessional relations.

Constant reshaping of jurisdictions causes interprofessional competition. The competitive exclusion principle shows how due to competition professions struggle to define the ownership of knowledge and the right to exercise that knowledge in the working environment. This competition brings about a limit to the number of professions in the workplace. Co-evolutionary interaction of closely related groups in fact proved to be effective, even if the two species do not evolve at the same pace or in the same direction. Even though some relations are often perceived as predation or 'ammensalism' (borrowing ecology terms) through which some dominant professions may unidirectionally harm to or feed on less-empowered ones, mainstream system's literature repeatedly describes interprofessional relations as competition.

Observations throughout this research lead to the conclusion that competition is not the only possible logic in systems interactions; this is at odds with Abbott's observations. Competition most commonly works recurrently, meaning that Profession A affects Profession B and the other way around. But on some level, there are forms of mutualism at play where Profession A benefits from the interaction as much as Profession B does. This relationship form is normally more evident during the process of delegation from one profession to another. Interest in new technologies and specialisations from doctors has left areas for nurses to occupy. This, in turn, leaves space usually occupied by nurses short-handed that are, in turn, occupied by others. As we can see changes in professional jurisdictions may lead to a beneficial chain of jurisdictional flexibility; the only danger being a perceived jurisdictional invasion that may cause animosity between groupings. That being said without this chain system of subordinate professions taking on bare areas, the process of growth might in fact become difficult to develop. Likewise, the existence, and more clearly the functioning, of umbrella

organisations for a range of health professions embeds this mutualist principle.

Another, less noticeable, structural phenomenon also seems to take place. This phenomenon is referred to as commensalism, whereby one profession may benefit from another unidirectionally without affecting it. This may be the case when it comes to those that use the progress of successful professions as an existential argument for equalisation of privileges and rights; where equalisation is sought despite the reality that there is no sharing of tight junctions with them as to become contenders. It would be intriguing to explore the nuances of this type of interaction further, most notably in the areas connecting professions such as physiotherapy to nursing and dietetics to social work.

Professions seem to develop specific repertoires of interactions for different environing professions, depending on the actual or perceived jurisdictional conflict arising from their enactment. As Abbott shows, the effect of connectivity, systematisation, residuality and dominance have a bearing on the development of professions. To a certain extent, a degree of conflict between professions within a specific field is expected. This is due to common technical pathways of differentiation (or lack thereof) that seem to have followed since the rise of scientific medicine and hospitals as medical organisations. Morphological similarities help us to map pathways between professions and their assimilation strategies. These assimilation strategies have led to the medicalisation of nurses, nursification of midwives and nursification of auxiliary nurses. This shows that within a particular ecology, one profession's behaviours can possibly be recognised in another profession's behaviours, and as such, pathways between professions are traceable through a shared social code. It is therefore possible to map such social codes as social class, ethnicity and gender levels of hierarchies. Similarly, relational patterns of one ecology can possibly be recognised in another ecology.

Analysing interprofessional relations using this approach shows just how complex these systems, parallel pathways of evolution and the various types of interaction professions develop really are.

Deciphering the Social Code of Nurses: An Ideological Device

In this section, nursing is looked at in terms of an ideological device—namely a behavioural code—structuring the intricacy of its underlying principles and dynamics. Despite the fact that this code is often considered a part of internal structuring, it has been analysed further and independently here in order to explain it better as an interphase between the profession and the environment.

The conceptualising of the nursing apparatus as a code has a number of well-founded reasons. Foremost among these is that language and behaviour are used both for conveying the contents of the profession and for obscuring them. For example, how communication is ciphered among its members and with its audience. In order to read the profession's contents, it is also necessary to be well versed in the linguistics of nursing in order to discern keys and symbols, 'presents' and 'missings'. Not only that, this expert knowledge is also needed to know how to decipher this information. Lastly, it is important to note that this apparatus is not a self-generating device, but rather a machinery purposively constructed for attaining the profession's aims.

The unrestrained emphasis on ideological convergence—rather than divergences—purports to consolidate consistency of nurses' predicaments and impose conformity on the community. This itself permits the implementation of an agenda of cultural politics. Consistency leads to an ideological discourse, which in turn makes it easier to work toward filtering out certain elements considered at variance and ensuring that mainstream elements follow a systematic discourse. One way, and probably the functional one, ensuring this convergence is reached to transform predicaments into either laws or dogmas. This helps to exclude voices that do not fit in or that question the nursing ideology: the result, a doctrinaire internal culture. In such a context, agreement may be considered as a simplifying model of thinking. Taking into account that any group lacking academic literacy on the whole finds it easier to agree than it is to disagree. This is due to the fact that disagreement leads to contra-argumentation, while in agreement this is not necessary. Thinking this way, it is clear how

community members may simply respond 'so be it' to predicaments posed as inherent, abiding truths. An example of this is the hypothesis that nursing is the only piece without which no hospital can function properly, one that is as difficult to accept, as it is to assess. Another example is that nursing unquestionably is a profession (in the old-fashioned, structural sense) that society recognises the role of nurses in the form of laws (not in a metaphorical way).

With this picture in mind, the nurses' ideological device operates through seven different components:

a. *Behavioural rules*: These consist of usually unwritten norms about what to do and what not to do. Cultural convention dictates that as members of a graduate profession nurses must join to either equal or superior professionals socially (friendship–family relations), which makes up an unspoken agreement on social behaviour.
b. *Affirmation of principles*: All professions have principles, and those principles tend to be more overt than the code as a whole. This is not to say that nurses' behaviour is conflicting with their principles, as the one thing nurses put above all else is patient safety. This rule holds even in the face of political interest. The moral code, probably steaming from Christian values, is in fact an integral component of nursing. For example, it is rare to see nurses leave the wards to engage in industrial action. This highlights principles that compliment a long-standing code of ethics, which is beyond any momentary strategy of status pursuit.
c. *Statements of ideals*: Nursing is full of great idealism. Nurses' earnest ideals can be traced through their rhetoric of vindication, voicing their aptitude to govern the system is greater than others'. Though in essence, their ideals respond to the logics of social movements.
d. *Creed forms*: The nurse's creed, what they believe they profess, helps separate their fundamental beliefs from other stances. This constitutes a given truth, which must thus be agreed on by all nurses. Leading from this, those who do not follow this mantra are therefore not nurses nor do they deserve to be called a nurse. A well-known example of this is the so-called Nightingalean vocation which

highlights a paradigmatic shift in nursing, which eventually might embed their community's greatest myths.

e. *Fellowship commitments*: Commitments reinforce both linear ancestry and cohesion. Examples of these commitments, overt or covert, are that only peer fellows can enter their community. This means that only those of a graduate profession may be called and call themselves nurses. The fact is that this title can only be reached through university-based training which trained nurses support through practical training on a master-apprentice level, with the end result that only university-based nursing students are accepted into the community. Through my observations, it also becomes evident that nurses are committed to report professional problems to the Chilean Nurses Association, rather than to other immediate professionals with whom they work.
f. *Collective interests*: Status, autonomy, higher rewards, social recognition, professional image in society and a substantial change in the patterns of power all form part of nurses' interests. Nurses engage with one another to further supposed common interests in the belief that individual interests will be best assured collectively. All professions engage in lobby activities, meaning that given the ecological nature of work, nurses' collective interests are, to some measure, opposing to those of other professions.
g. An ordered language, capable of amalgamating a professional body and conveying a new form of symbolic capital. Over time, language builds a particular idea in people's minds. Nurses have learned to use this to develop a language that matches their politics and squares their interests. Language is often used to project a reality onto an audience, a perceived reality, rather than be completely accurate to the reality that is nursing.

Equally, although ordered, their language may not be fully systematic. The heterogeneous use of the vocabulary—academic, practical and political—suggests some internal atomisation of the nursing collectively, mixing randomly esoteric concepts with their practical jargon, letting sense a political undertone that reveals a larger narrative (Chapter 6). Nonetheless, language has followed a progression, partly deliberately crafted to gain public credibility, partly reflecting evolutionary changes

in the nature of the profession (e.g. from 'we take care of the sick' to 'we do management of care').

Deciphering a code and its normative and political nature is seeing the shape of a chart guiding the transformation of the profession. I currently make no attempt to forecast nursing's futurity. Rather, I stress that its interaction with the environment, its internal organisational levels, the effectiveness of its political apparatus, the comportment of and the interaction with the neighbouring professions and the landscape transformations functioning altogether may account for nursing's success—its development does not unfold by pure chance.

More important than deciphering a profession's functioning, however, is where to move from it, and that is the biggest challenge nurses will have to face. Meanwhile, I can safely say that we might now begin to understand the sociological puzzle that is nursing.

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Part III

Research Practice and Ideas

9

A Note on Methodology

I found no plausible reason to provide the methodological details in every chapter. Since most details are explained here, interspersing repetitive information among them would thus seem meandering, as much as it would interfere with the roundness of tone and register of the narrative. The intended reader of this book is foremost concerned with its contents and less so with the making of them, unless turning the attention purposively to methodology. I should like to suggest that methodology can be read as a book within a larger book, and I have proceeded accordingly.

Aside from the explained details, there are a number of issues which need further problematisation and merit, therefore, closer attention. This section is devoted to three of those issues. And although minor might seem, they must be stated and addressed nonetheless.

This study began through analysing earlier explorations of nursing identity formation in Latin America. This earlier analysis showed the need to enable a more thematic focus on the social construction of nursing, resulting in a further exploration of what nurses do, rather than how nursing is structured. To achieve this goal, an ethnographic approach was chosen as the most appropriate way to examine the topic

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of concern. The analysis involved reflective engagement with forty nurses. An empirical approach concerned spending time with them in their day-to-day activities, taking notes, sharing some practices, interviewing, having casual encounters and returning to our offices to record results. This worked in a circular process of analysis and questioning spanning a period of one year from 2010 to 2011.

Specific attention has been paid to this study as Chilean nurses are considered to be highly trained healthcare providers. That is to say that in order to become a nurse, one must undertake five years of university education on a full-time programme. Within this five-year period, roughly 60% whole is devoted to theory. Students begin their practicum in the hospital from the 3rd semester onwards; first under a lecturer's supervision and followed by a mentorship programme with clinical nurses.

A 500-bed university hospital was selected as a setting for this study due to its reputation for being a high-quality institution. It is recognised that high-quality care is related, among other reasons, to nurses' performance. Kutney-Lee et al. (2009), Aiken et al. (2012), and Lake et al. (2012) have all shown that one of the principle components of high-quality care is nursing performance, and as a teaching hospital, this location offered a significant opportunity to study not only socialisation practises but also knowledge exchange. The combination of these threads of interest made this setting ideal for this study.

Ethics approval was sought at all levels, followed by contact with both the Head Nurse and the Hospital Director to gain further access. Each interviewee was given a description of the study and then asked to discuss his/her experiences within a nursing context. This ensured the study would meet requirements of informed consent and was fully open.

The hospital employs 1800 people, across a wide range of staff groups. Nurses are grouped within the Nursing Department, which is made up of about six hundred nurses, including qualified nurses and certified auxiliary nurses, often referred to as 'paramedics'. Our observation of nurses' activities covered a purposive sample of seven different wards, on the basis of degrees of 'closeness' to patients. With this, I aimed to balance two theoretically opposing conceptions of 'good

nursing', namely technically expert nursing, such as that provided in the emergency room and the intensive care unit, and caring-oriented nursing, such as that provided within the general hospital ward and the chemotherapy unit.

Alongside this observation process and casual conversations, a wide range of informants, ranging from nursing students to experienced nursing managers, including clinical nurses and academics, together with those who had indirectly participated, as they took part in the situations being observed, were interviewed individually. These interviews were based on a semi-structured guide of open-ended questions. The interviews explored several topics planned while reviewing the literature on professional development. Each interview lasted roughly ninety minutes on average and was recorded.

The willingness of participants to speak openly was an early indication of their belief that this study was a channel to communicate information they felt could be critical for the future of the nursing discipline. This helped me to focus my approach to both fieldwork and data analysis.

With a broad-ranging study, like this, there is also the risk that obvious everyday practices might be overlooked in my recording of field notes. To minimise this risk, I engaged a second observer, who was an anthropologist. For this, I wanted to choose someone previously unfamiliar with hospital work as I felt it would enhance the reliability of the data gathering process. The anthropologist and I compared data and discussed while the patterns surfaced.

The Grounded Theory approach (Charmaz, 2006; Corbin & Strauss, 2008) provided the most appropriate means for studying the construction of class behaviour in nursing and its implications in building professional status. It was important to consider the development of concepts and processes.

This facilitated the emergence of conceptual inter-relationships from theoretical statements embedded in the technical procedures of coding. These relationships were rethought, adjusted and refined until pieces of data cohered together in a meaningful way to answer the question of interest.

Study findings are presented through a narrative ethnography approach (Gubrium & Holstein, 2008). Goodall (2000) has spoken about the movement as 'the new ethnography' which is best communicated through personal stories and enriched description of the settings. This highlights the researcher's role in the participation of the data construction. Interplay between the researcher's subjectivity and the participants' subjectivities, it is argued, gives a more vivid picture of the social setting; these are best communicated through personal stories and enriched description of the settings.

Approaching a Naturalised, Complex World

This research took place at a time of fierce struggles among occupational groups in health care, arising from the remodelling of roles and responsibilities in the context of major State reforms beginning in the 1990s and repercuting on the professions more specifically from the 2000s onwards. One aim of the study was to gain an understanding of how these professions are connected to one another socially in the dispute for status and recognition.

Avoiding to become mesmerised by and over-reliant on the first fine-sounding theory I found, I went through various different approaches. The perspective I actively decided to use brings together issues of social construction of prerogatives and of interaction in the field, and it was its re-emerging notion of 'system of professions' that motivated me to ask questions that would overcome the limitations of structural accounts: How is a profession a socially organised group? What professional groups participate in shaping the jurisdiction of nursing and what are their dynamics? How do professions relate to one another in my particular setting? How is my setting different from or similar to those where main literature bodies come from? What explanatory potential do these theory bodies have for my case study?

In developing these types of questions, I decided to challenge mainstream approaches to the problem of nursing as a profession, analysed mainly from the standpoint of nurses—that is what nurses *think* nursing is. By that time, I had become familiar with newer criticisms of some nursing scholars towards the fixation of nurses for

professional status and the disappointing, though realistic, acknowledgement that nursing theory has had little repercussion outside the USA. Nursing theory, I felt, does not elucidate very much on nursing work. With this idea in mind, not only did I put aside the continuity between nurses' rhetoric and their explanatory models, but also found myself asking questions concerning to what nurses *do*, as their actual occupational activities began to emerge as the primary focus of my interest, and their field of work became the field of my research. This enabled an account of nursing from its own internal dynamics. These dynamics, I have argued, are the means through which flows of powers and relations come into circulation—more than they do through rhetorical constructions—for behavioural patterns disclose what the rhetoric hides.

The concern here is to discuss the methodological choices involved in this process of investigating how profession making is embedded in day-to-day practices. Before I became a sociologist, I had myself a short career in nursing management. This helped me understand, on the one hand, the intricacies of hospital work, and on the other hand, empathise with the group of nurses engaged in my field research. My aim, nevertheless, was not to scrutinise the quality of the care these nurses provided. In fact, nursing roles were not analysed as set of technical tasks, but rather as a strategy.

Research of practices implied my own involvement in the setting as a participant observer, a requirement that benefitted from my background, looking for the construction of first-hand experience resources of unspoken principles and logics behind social action, considering that the research would explore aspects people do not normally think of and uncover conceptual interrelations people may not have words for. Ethnographic observations were, indeed, used for intensive cross comparison between data constructed discursively and data embedded in the social action, especially through the relationships among nurses themselves and with other professionals.

One may argue that my familiarity with hospital work could have represented an obstacle rather than an advantage, for it might cause overlooking naturalised patterns of relations. Engaging an assistant—unfamiliar with hospital work—was surely helpful, as cross-disciplinary observations and discussions assured quality data and an enhanced interpretation of them from an internal perspective and an external

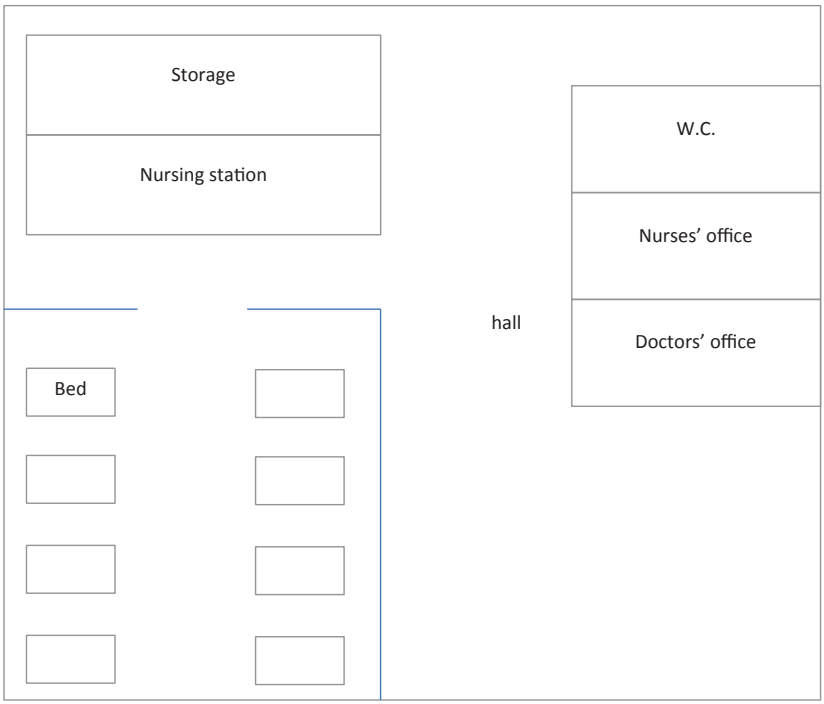

Fig. 9.1 Observational guide: general diagram of transit and relations

perspective. In order to prevent 'getting dazzled' by the complexity of the setting, we agreed on an observational guide (Fig. 9.1) with which to map firstly trajectories of the nurses in the wards and secondly relations (and lack thereof) connected to those trajectories. We first paid more attention to nursing handovers, teaching-learning situations, decision-making processes, meetings, routine activities and any activity involving inter-disciplinary contact. In a later stage, we focused the attention on gathering specific pieces of data, relevant for the specific questions addressed in precedent chapters.

Along with this observational guide, notes were kept on a diary in a two-column system, one column devoted to descriptive notes and one to reflective notes, and a line containing the chronology of activities. When possible, descriptive notes were recorded as we observed, though our participation in the field not always permitted so to do—for

example in deference to someone talking about a sensitive issue—in which case some passages might have been slightly paraphrased or reconstructed afterwards. However, the specificity of each observational fragment was not the focus of the analysis, rather the emergence of patterns embedded in organisational practices.

What should become clear is that while studying a familiar setting may raise legitimate controversies, my methodology benefited from that internal perspective shortening the acculturation time and facilitating rapport with the participants and dealt with the certainties of familiarity by doing strategic adjustment.

Sampling Heterogeneous Versions of Nursing

This research was concerned with the construction of relations and concepts. Accordingly, it seemed appropriate to design a semi-structured sample (of sub-settings and of informants) that enabled covering a range of theoretically meaningful professional roles and tasks performed in different sub-settings, but that at the same time was flexible enough as to develop and refine the emerging categories by adjusting the sample. This adjustment was not meant to increase the sample indefinitely, rather to refine ideas and relations between them as they surfaced during the constant comparison of data involved in the Grounded Theory approach.

The theoretical sample was initially aimed at balancing opposing conceptions of professionalism in nursing (e.g. caring-oriented nursing and technically expert nursing) and different degrees of seniority at work and exploring the dynamics between them in the assumption that professional groups are heterogeneous entities. This heterogeneity justified that the sample was structured considering degrees of interventionism and length of stay in the hospital (ranging from emergency room and intensive care unit to chemotherapy and dialysis to general hospital wards to management units), which assured the highest possible variation of cross-disciplinary contact between professionals and the greatest possible degree of professional role overlap. The dynamics among them in fact facilitated to observe delegation practices from one profession

to another and disputes, covert or overt, for an internalised notion of 'ownership' of tasks seem to be at the core of interprofessional work in health care. By exploring the borders of professional jurisdictions, this work eventually did not only explore the dynamics of nursing work alone, it also involved healthcare work more broadly.

The construction of data involved typical ethnographic activities: extensive in-site observations while adopting varying degrees of participation, informal talks, semi-structured interviews (see guide below), walk-and-talk moments, and hang-outs with nurses. As field research progressed, it also seemed necessary to involve other actors that were important for an understanding of the systemic relations with neighbouring professions, such as academics, medical doctors and midwives, and extend the observations into other sub-settings.

During the filed work, however, I also sampled and compiled a significant amount of institutional documents and archives connected to the topic of concern, which would provide fresh insights into conflicting interprofessional contact. Although not previously considered, documents and archives helped further interrogate observational data and the contents of the interviews in substantive areas and suggested to go back to particular respondents. Throughout this process, the sampling method was compatible with the Grounded Theory approach, as refining the sample structure evolved from certain openness to a rather selective choice of participants. Important for integrating these documents into the data and contextualise them in the period and context in which they were produced was the adoption of a social history approach. Combining this approach with the frame of Grounded Theory enabled an interpretation of professional relations as part of key socio-historical processes that would later enrich the creation of narratives.

Ethnographying Sick Nursing and Primary Care Nursing

Nursing is a broken-up world. Two differing groups with rather separate occupational profiles—that of the visiting nurse and that of sick nursing—mingle today under the umbrella term 'nursing'. Although

the primary resources of this research came from observing sick-nursing activities, the theoretical interest was concerned with the nursing profession more broadly. Initially, the sample design considered primary care as a sub-setting on one end of the continuum of interventionism/non-interventionism and of long-term stay/ambulatory care. Data gathered in this sub-setting, however, were not amply used, due to the number of important issues of theoretical interest arising from observations in the hospital wards; observations of primary care in fact constitute row data, available to be used in further examination.

During the field research, I uncovered a general agreement holding that primary care nurses enjoyed a high degree of autonomy in comparison with hospital nurses, and it would appear to be at least partly so. To a large extent, primary care institutions are organised around flatter organograms that functionally obey to the logics of 'care plans' (*programas*) developed by the Ministry of Health, bringing together different areas of expertise around priority health problems and vulnerable groups and defining the jurisdiction of each disciplinary group. This called my attention, and I understood the care plans with reference to the concept of 'commodity', discussed in Chapter 7. Commodities function as reservoirs of knowledge and expertise when there are no experts available to cover all the needs of the system or when involving experts would become prohibitively expensive, therefore unsustainable. Other examples of commodities used in primary care are guidelines, protocols and high-tech equipment.

In the view of primary care nurses, these improvements (read 'commodities') would enable to apply judgment and knowledge dispensing with medical control, and this seems to be at the core of the persuasive discourses of an alleged autonomy of nurses working there. During the analysis, however, it was difficult to discern whether this can be considered as autonomy as such, as in a given case scenario one could argue that the ownership of that knowledge is not what has been transferred to nurses, but rather the application of that knowledge to the cases defined by the centralised care plans. The supposed higher autonomy of the primary care nurse may thus be restricted to the practical arena, which—again—puts the nurse in the uncomfortable place of a 'knowledgeable doer'.

Further analysis may well shed light on how the commodities might have crystallised professional roles and in the process medicalise an area of the practice of nursing that is often claimed to be devoted to social matters. However, united culturally and academically by their university-based training, both hospital nurses and primary care nurses ultimately seem equally committed to political action, using new knowledge as the base of claims of vindication.

Empathising with Nurses: First Impressions

By taking a reflexive view of the nursing setting, I reconstructed this setting by aggregating pieces of observational data, from which I recreated what came to be my naturalistic setting of inquiry.

The layout of a typical ward contains: a nursing station, shared-patient rooms for up to six people, examination rooms, medicine storage areas, built-in wardrobes, lavatories, a hallway that frequently works like a waiting room, staff rooms and a clerical office. Most of nurses' activity takes place between the nursing station and the patient rooms. Most of auxiliary nurses' activity takes place between patient rooms and their staff room.

The importance of this setting for nurses should not be underestimated as the hospital becomes a place, not just of work, but quite often to eat and sleep as well. To a certain extent, it can be said that due to their work hours, nurses too are 'hospitalised'.

During my research, I observed thousands of patients come and go from the hospital. The constant was the nursing staff who have to deal with emotional stress and physical tiredness due not only to long hours but also witnessing the grief, pain and vulnerability of patients and their families on a daily basis.

Even the smells of a hospital are different, and the sense of activity is endless, like trollies being pushed to theatre through restricted access doors and narrow hallways. In a patient room, spotless-looking nursing students help an elderly gentleman to sit up in bed and change his linens while auxiliary nurses take patients' temperatures, heart monitors beep, and a constant blowing sound is heard from oxygen masks. In the

centre of the main corridor, a middle-aged man wearing a white smock is holding an X-ray film in front of his eyes, surrounded by a small army of youngsters dressed likewise.

A nurse and an assistant are doing a regular bedside-ward round, checking patients' records. At the nursing station, another nurse is seated, writing pages of records and filling out forms while she answers the phone. Voices, rings and beeps mingle into a constant background noise. There are several notices of all types fixed on the walls; these include phone number lists, conversion tables, treatment algorithms, fast-food-delivery flyers, wash-your-hands reminders, visiting hours and the portrait of a nurse gesturing silence.

These observations have shown that the dictionary definition of hospitals as 'a place where people stay when they are ill or injured and require care' does not give the full picture. It is clear that a hospital is much more than this. The structural details I observed suggest that multiple realities coexist for multiple individuals interacting in a complex social setting.

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10

Afterword: The Study's Inception—Occupational *Situs*

Beginning in the mid-2000s, my personal inquiry about whether nursing is a profession used as a starting point the concept of 'Occupational *Situs*' (Benoit-Smullyan, 1944). Aimed at proposing a framework for the systematic study of social stratification, the author of that model claimed that occupations can be grouped into functional pyramidal units. These pyramids define a professional hierarchy and, at the same time, outline the relative position of each occupation within that hierarchy. This structure highlights the social affiliation of a person to a group and the social function of the group using the Latin terms *status*, *situs* and *locus*. *Status* refers to the ordering of individuals within an inferiority–superiority scale on a basis of socially desirable attributes, be it an economical hierarchy, a political hierarchy or a prestige hierarchy. *Situs* represents the social affiliation of those sharing a non-hierarchical social trait, be it cultural (language, religion, etc.), biological (ethnicity, age, etc.) or geographic (neighbourhood, region, etc.); and the nature of the common trait is, in principle, egalitarian, as it reports affiliation (*situs*), not a hierarchical rank of desirability (*status*). Based on this, one can infer that professions are, social desirability aside, equal—each of them makes a particular contribution to the functioning of society.

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It might seem difficult to separate the analysis between *status* and *situs* in capitalist societies, as each social group (*situs*) is strongly associated with certain symbolic or economic desirability (*status*), generating on the one hand mechanisms to turn affiliations into markers of social rank, and mechanisms of exclusivity and exclusion, on the other. Ranks can indeed be easily identified by analysing the constructs surrounding the sexes, the social differences between intellectual occupations and applied occupations, the preferences for certain types of sports or the apparent lack of appealing of low-qualified works. Changes in *situs* even lead to infer changes in *status*, e.g. moving into another neighbourhood, changing patterns of consumption, turning into another profession. For analytical purposes, however, *situs* and *status* constitute two different categories.

The third type of social position proposed by Benoit-Smullyan, *locus*, points to the function with which each individual contributes to an organised group, e.g. head of household. The term *locus* is considered here as more specific than the term 'role', which is also used in social theory in the analysis of unorganised groups.

Status, *situs* and *locus* thus refer to three different types of social position. Whereas *status* represents higher or lower ranks, *locus* corresponds to the function within a group and *situs* to the nature of that group. Although the three of them often operate simultaneously, it is not necessarily so, as they are different social phenomena. Different statuses do not even correlate with one another; economical or political statuses, for example, do not coexist with admiration or deference, though they do coexist with covert or overt forms of imitation, in other words, aspiration.

How are these concepts relevant to the sociology of professional work? This shall be elaborated in the next section.

Occupational *Situs*

As explained, the notion of *status* indicates relations of ordination among individuals, based upon socially desirable attributes. This is to say, *status* represents a vertical dimension of the social order. This verticality is evident among occupational groups, which can be ordered in

a scale of social desirability. The notion of *situs*, however, introduces a horizontal differentiation among occupations. There are good reasons as to why a unidimensional stratification may not be an optimal model in understanding the functioning of occupations in any given society. The reason being that it offers an oversimplified view and therefore a rough, unrealistic representation (Morris & Murphy, 1953), such as those categories used in census tabulations.

Morris and Murphy (1953, 1959) employed Benoit-Smullyan's coined term *situs* to create a model representing the occupations as 'categories of work'. Sales and manufacturing, to use their same example, may be placed within the same *situs*, even if their category may have little to do with the *status* they may enjoy. By combining the two categories, status and *situs*, the model becomes a series of superior–inferior ranks (*status*) crossing groups of occupations organised by affinity (*situs*) horizontally. The resulting representation is a bidimensional model.

Arising from an era of great optimism—science and production scenarios rose in post-war sociology with a subsequent debate about what a profession is and what it is not—it is no surprise that this discussion in the USA coincides with an increasing interest, within nursing academic circles, as to whether nursing ranks as a profession (Bixler & Bixler, 1945, 1959). Such discussion brings to the fore a political agenda to reach a higher status for nurses, making up one of the most enduring struggles for prestige in the whole body of literature on the topic.

In reconstructing the Western world, there were attempts to validate a certain conception of society, devoted to in the sociology of Parsons. Here, functionalist models arise—those explaining how functional social groups are in stabilising society—with which to evaluate the functionality of occupations in covering society's needs, and the extent that a single occupation or group of occupations can cover those needs. In this light, the 'healthcare *situs*' becomes a group of interdependent occupations contributing to society's other spheres, typically the work sphere. Summarising, an occupational *situs* is a functional category, each *situs* contains occupations (functional to the *situs*) and those occupations may enjoy different degrees of *status* (within their *situs* and across *situses*).

Limitations of the Occupational *Situs* Model

While the *situs* approach solved some problems concerning the analysis of the professions, it raised others. In one influential work (Goode, 1969), the horizontal and vertical dimensions (situs and status, respectively) are combined in a pyramidal representation. The apex is assigned to what they call the 'true profession', the one that owns par excellence the necessary knowledge to make the whole occupational situs work. The remaining occupations are placed in lower strata and are named 'pseudo-professions', 'para-professions' or 'semi-professions', for they do not own the true profession's knowledge (Etzioni, 1969; Goode, 1969), and still at the base of the structure are the non-professional occupations. What this model clarifies is that, despite its apparent descriptive potential concerning the rise of new occupations at the time and the coexistence of interconnected occupational groups, its empirical applicability is limited by the fact that a whole *situs* may certainly enjoy a higher *status* than that of others—social assistance, for example, was long considered more important and more prestigious than educating a nation. In this way, the horizontality and parallelism among *situses* tend to disappear and, with them, the bidimensionality of the model (Gerstl & Cohen, 1964).

On the other hand, the practical usefulness of the *situs* approach is also limited by the behavioural aspects of the professions. Despite putting the functioning of occupational groups into perspective in the process of social differentiation (Foote & Hatt, 1953; Hatt, 1950; Morris & Murphy, 1959), it failed to acknowledge the influence exerted by the members of a given profession on the profession. Even considering the functional relation between the individual and the profession, the personal aspects of the professional performance shape intellectual and instrumental skills as well as the orientation adopted by the profession in the long run, modelling as a result its political potential. Such potential may then vary within the same *situs* and operate in some social contexts but possibly not in others (Hall & Schwirian, 1968). Additionally, non-professional or proletarian groups often exert strategies based on mass mobilisation, which tend generally to trigger more political

repercussions (practical or symbolic) than those resorted to by highly trained occupations, in ways that influence their political *status*.

One can possibly infer that the *situs* approach, beyond its empirical limitations, would be eventually rooted out from sociological research insofar as newer paradigms began to take the place of functionalism, society and work develop increasingly complex, and the post-war social model became the object of criticism on different fronts. If the usefulness of the *situs* approach was that of predicting attitudes, behaviours and lifestyles—consequently, the formation of sub-cultures based on occupational categories (Morris & Murphy, 1953, 1959, 1961), its application would later be substituted by the study of class identity.

The question of whether nursing is a profession thus remained unanswered, which led to a more extensive review of the main sociological frames for understanding the professions and thus addressing the research question in more detail. Although the concept of occupational *situs* continued to appear sparsely until the 1970s literature (Dunkerley, 1973; Pavalko, 1971), it was discarded altogether and replaced by ecological theories.

Recognising the Limits of My Work

Abbott's (1986, 1988, 2001, 2010) systemic theory of the professions has generated intriguing insights into the evolutionary aspect of occupational groups and their efforts to protect group closure (Larson, 1977). Abbott conducted his research and analysis during a time of great criticism towards professions' dominance. Despite his work's obvious benefits in improving and advancing understanding in this area, it has received criticism on some levels especially his structuralist focus. A number of critics have highlighted that along with this focus on the structuralism framework, he also failed to engage fully with Larson's theory. This failure, they claim, leads to his inability to clearly differentiate his work from the structuralist/functionalist stream (see, for example, Macdonald, 1995). Criticisms aside, it is clear that his contribution to the field still is a turning point from the mono-group professionalisation theory to a multi-group conflict approach. Systemic analysis has

shown that profession building is not a purely profession-centred phenomenon and that professions are defined by the actual work they do—in this realisation lies its strength.

For this reason, Abbott's work was chosen as the best fitting for the setting of this research. This work has shown an obsessive race for attaining university status and advanced degrees in a society severly shaped by social class, through a process of cultural assimilation between Chile and the historical context outlined in Abbott's work that showed professions at the heart of social dominance. Academisation has, as I have illustrated extensively, reinforced constructs of an undesirable social standing around other trades and crafts, and, importantly, the allocation of wages and symbolic rewards accordingly.

The exploration of the nursing profession in this research was based on a range of techniques, sources and concepts, which enabled a thorough description of the findings and thus enhanced reliability. While addressing the systemic relations between occupations, it should be noted, this work may have resorted to a structural basis slightly more than to a conflict-driven basis in its approach. For example, when analysing the evolution of the institutional devices used to wield power and the patterned affiliations of individuals to hierarchical social compartments, purposive attention to ideologies and multiple affiliations was not devoted until the last chapters. This is not to say that the dangers of functionalist accounts were ignored. The research has followed a line of argument that explains how functional relations between groups every so often benefit some while eroding others. I underlined this perspective while discussing the internal and external boundaries of the professions.

It is also possible that the methodology used may become a focus for criticism. This is due to the retaining of the reproduction of institutions under my ethnographic lens for too long. Here, the issue of representativeness arises; however, this would be a criticism levelled at any other ethnographic enterprise. It is true that structures were the base of this observational approach to the research; here, however, analysis moved the focus forward once a certain scaffolding was built. This perspective helped in guiding analysis of absent traits in one or another interacting profession and showing how those differences in

fact referred to larger dynamics. Any criticism to ethnography might begin with 'its problem of representativeness…'—this is an important concern. This research was concerned with socially constructed realities in everyday lives and their natural settings, which was done without the aim of achieving topic representativeness. This aim of this work was therefore not to overcome these obstacles but may instead stand as a reaction to the limitations of representative accounts and add to literature regarding these.

Yet while collecting stories, observational data, documents and archives, and encountering the informants in and out of the hospital, my participation in the field aimed at allowing information to speak for itself. In reality though, my own participation might have somewhat informed the construction of data, for those who joined me in my field research were willing to speak to *me*, and to give *me* access to their views on the subject, had perhaps some affinity with *my own*. My presence in the field might have out-placed a wider variety of informants should I have over-identified with a certain mindset and over-relied on my informants' willingness. To what extent, then, might I have seen my own expectations or, further, my own inner self mirrored in the dazzling reality of the field? As the analysis progressed, it was reassuring to test and discuss preliminary ideas with unknown nursing and sociology audiences. Discussions also took place with a field assistant so as to compare and discuss data and add a deeper level of analysis to observations. Although no researcher can claim scientific neutrality, especially in relation to observational research, here no such claim is made. In this study of subjects and their realities, all attempts were made to ensure that personal neutrality was maximised.

A number of issues were raised concerning access to the field. My position as a former nursing lecturer in the hospital facilitated agreement from both the Head Nurse and the Hospital Director. My background enabled me to ensure that I had sufficient specialised knowledge and skills not to transgress regulations of hospital work while undertaking observations. For this reason, I was able to gain permission and obtain the freedom of movement throughout the hospital including sharing a number of staff's day-to-day activities, from coffee breaks of clinical staff to meetings of high-rank managers. This freedom of

movement was further facilitated by Hospital Director to the wards who wrote internal memos requesting I be given access. Despite this, however, few staff seemed to grasp to the full extent the nature of ethnographic observation. It was important that my access not be seen as an imposition from above as this could have resulted in further difficulty in building rapport with the workers being observed. Having said that, the majority were keen to cooperate. Micro-negotiations, however, were necessary as the staff changed from shift to shift; in some wards, my assistant and I were requested to wear a white smock on the grounds that this helped them distinguish us from the public while handling confidential information. As our aim was to be unnoticed observers, we expressed our reticence to this, explaining that anonymity was preferable. Dressing like clinical staff, on the other hand, to distinguish ourselves from members of the public was also considered but it was felt that this would induce an undesirable sense of naturalisation. This experience helped inform my study that accepting their requirement was an important token to benefit from an inside view of hospital culture, as if hospital uniforms activated codes of more intimate, outspoken communication styles. The wallpaper role soon evolved into a partaker one thereafter.

Retrospective analysis of this methodology of gaining access, though it is difficult to think of an improved one, raises the issue of a potential instrumentalisation of the observer as a collection agent for the management board as to map loyalties, workloads and the like, undermining both trustworthiness as an insider and independence as a researcher. Yet mentioning the interest of the Head Nurse in this research was extremely helpful. She provided us with introductions to the Hospital Director and the Nurse-in-Chief of each ward and also ensured that the research was clarified to ensure that all involved were clear that in no way was the research designed for supervisory purposes. Despite this, however, a familiarity and rapport had to be built up over time to dispel any lingering concerns for individuals and allow them to become familiar with my work.

On the first day of field research, it had been over two years since I had been in a hospital setting. This gap in time allowed enough space ‘to render the familiar unfamiliar’ and to mean that social codes and the

way people react to them had to be relearned. This process, along with cross-observer discussions, enabled enriched descriptions of the setting and of the way I approached the data.

In much of my work, I have used Grounded Theory as way of approaching data and building from it. In this research, Grounded Theory was helpful in organising and compartmentalising the voluminous amount of data resulting from the diverse sources. Throughout the process, analysis shifted gradually from an open coding strategy to a selective coding strategy. This process was informed by both secondary data, provided by the hospital board or found in libraries and archives, and primary data, produced through my own research and observations. Throughout the process, it was crucial to interrogate discourses in the light of my observations, especially to overcome the risk of interpreting a priori that what people think equals what they do. Codes and categories thus suffered a constant process of adjustment until data cohered together in view of key sociological concepts.

In the final part of the research, it was important to connect the categories to the concepts and thus make sense of the coding procedure. For this reason, I do not claim that my work is 'a grounded theory' in the sense of new, revelatory theory, but rather, my research identifies with a Grounded Theory orientation—meaning that theorisation arose from the grounding in the data and within the social theory frame.

The constituent pieces of this work also tried to make their way through, somewhat understating excessively formulaic recurrences of the writing referred to as 'academic'. For me, being an ethnographer, it was important to find my own voice in my writings, and in so doing, I attempted to induce a mood that connected with the reader, and myself, more easily, instead of making up a tone that sounded like someone who has just come out of the ivory tower. I used, what I hope is, mostly accessible language, though obviously some esoteric terms had to be incorporated to fully express theories and results to the different audiences to whom the pieces were initially addressed.

There is a conceptual continuity, nonetheless, as one advances from one chapter to another. The argumentative line becomes evident by making clear that the aim was to explore the social construction of healthcare professions in their interacting environments. While the

relatively high number of pieces I wrote during my PhD research may well account for the phenomenon I was interested in, it would have been intriguing to further the analysis by using a single set of concepts in the whole series of chapters. This, however, did not seem convenient.

Engaging with Related Work

This research committed to account for how constant dispute between professions can lead to professional development. Above professional structures, organisation, functioning and remodelling, along with processes, ideologies and devices, have all been analysed to give insight and elaborate on professionalisation processes. As conflict between groups often begins in structural arrangements, it was imperative to conduct research into both spheres—that of structural-functional concerns and that of conflict-based concerns. I could not, however, catalogue my work as a conception of social functioning based on unmoving functions given by social ladders. My research, however, did not conclude with the study of structures and functions of the nursing profession; rather, this was a pathway to enable further exploration of intra- and interprofessional dynamics. The more significant and insightful aspects of the research were found rather hidden behind the structures being analysed.

By using a systemic perspective, change as the fundamental force of the professions' dynamics became central to my focus, and I investigated the problem of interest accordingly. A lively lifelong debate has closely accompanied nursing regarding its professional nature, a debate that advances as the profession and society change. Nurses writing in reference to themselves, which formed the core element of the debate, suggest both an enduring area of interest and a conflicting process of social identity construction. Sociologists often use nursing as a case to compare against its closest neighbour, the medical profession. This is to a large extent inevitable considering how the two groups change simultaneously. Though very few works can serve for comparison.

The work with which mine shares most similarities is Allen's (1996) major research. Her work, in turn, was inspired by Abbott (1988),

Hughes (1988), Strauss (1978), and Dingwall (1983). Allen's work involved field research in a hospital in the UK. Allen's aim was to look past the rhetoric and analyse nurses' actual work. To do this, she focused on sources of tension in shaping the profession such as the definition of internal nursing hierarchies through the delegation of tasks and roles perceived as a threat to nurses' identity, the devolution of tasks from doctors to nurses and the delegation of certain tasks to patients. Allen argued that the delegation of extremely routinised, boring, distasteful and unchallenging tasks is central to the reshaping of nurses' jurisdiction. She focused on the division of labour as being the focal point of jurisdictional reshaping as opposed to the conflictual dimension. She argued, moreover, that a boundary-blurring phenomenon prevented negotiation from occurring and, likewise, minimised potential interprofessional conflict.

In fact, her exploration looked intentionally for conflicts in doctor–nurse relations, which she in the end could not find. Thus, unlike Allen, in my research I sought to address interprofessional relations based on a seemingly more ecological approach. In order to do this, I looked for any type of relations that 'species' may have, without focusing solely on conflict. This proved to be a useful standpoint, enabling a closer look at different levels which relations work. From this standpoint, we analysed the expansion of jurisdictions either vertical or horizontal to see where conflicts arose, but also where they did not. So while both Allen and this research project looked through a conflict-based lens, here I showed how ecology as applied to sociology can facilitate other possible results to surface.

Roles and tasks in my field research seemed to mark a bold boundary between professional fields, to the point that legislation was used to further legitimise the nursing jurisdiction and keep expanding it into medical and managerial fields at the expense of nursing roles proper. Allen's data seemed to speak of a great defence of care as an element used not for identity building but for keeping control of boundary shaping, whereas mine suggested that nurses absorb increasingly more 'professional-looking' roles insofar as they turn away from the caring role they contradictorily use to induce trust in their audience. Both cases, however, highlight care as a rhetoric of professional building more than as an organising principle of nursing work.

Nursing, Allen (2007) illustrates, despite dominant disciplinary claims, is best described as a bundle of activities overshadowing nursing's caring roles. In her research, she concludes that nursing, despite commonly held beliefs, is not a patient-centred profession. My conclusion somehow builds on this premise showing that, despite dominant disciplinary claims, nursing is best described as a set of organisational tasks emerging from environmental changes. The conclusion shows that nursing development is neither a profession-centred phenomenon nor a caring-centred one. Intertwining the findings from these two research sites, actual nursing practice seems poorly connected to its disciplinary base, though rhetorically attached to a larger narrative of caring professionhood. This firm empirical evidence consolidates the premise that a disputed jurisdiction is often not consistently sustained with actual work (Abbott, 1988).

In his work, Abbot (1988) also focused much attention on conflict as a source of the mutual reshaping of jurisdictions. This theory has to a large extent gone unchallenged. He claimed to conceive the system of professions as an ecology. It seems though that other types of interaction were overshadowed by such a sharp focus on competition.

This research was also, to a certain extent, inspired by Dingwall's (1979, 1983, 1990, 2008) writings, especially in the area relating to conflicting relations where professionals have little or no contact in the working environment. His prolific body of literature focused on the nursing profession. His is a sociological account based on historical resources, illustrating the shaping of professions—nurses, health visitors and doctors. He highlighted the evolution of health visitors into nurses in England and the partnership between nurses and doctors, rather than the widespread idea of the ancillary position of the former. All this being said, Dingwall and I had rather different purposes, though methodological similarities connected through social history.

Latimer (2000, 2003), in another sociological ethnography in the UK, concludes that the nurse–patient relationship is crucial for identity formation. As she puts it, 'patients are nurses' key materials for the performance of identity'. While this may in principle be equally so for the setting I investigated, an argument like such would be unsuitable. Although nursing students spend a great deal of time of their

practicum with patients, professional nurses, as I have documented, have largely distanced themselves from bedside roles, a distance that continues to increase as they cement their project of healthcare management as the 'star' of their political armament. Where nurses' spaces were once conveniently placed within patient rooms, they are now more often than not found in offices. This is the likely result of the little social distance between nurses and patients, and nurses and subordinate groups. The movement of nurses into managerial tasks is analysed in Allen (1996, 2007), though she also highlights the maintenance of core roles of sick nursing. There is often a distinction of nursing practice in US-American literature which differentiates between clinical nurses and managerial nurses, without a generalised shift into management. From this, it would seem that Chilean nurses are evolving into a rather unique form of clinical management professionals, while, at the time of writing, new disputes with auxiliary nurses erupt on the grounds of jurisdictional ownership of bedside tasks understated by professional nurses. Similarly, none of the above-cited studies seemed to have uncovered clues of nurses' political enterprise or of effective social closure projects.

All things considered, my work advances the field of the sociology of the professions in Chile, meagre in fruits and disconnected from leading debates over the past three decades with the demise of its last survivor (Gyamarti, 1984), leaving many apparent dead ends. It then disappeared from the sociological agenda altogether. This is in fact a rare piece of research reviving an area largely eclipsed by the sociology of work. The field is thus endless and open for research of any form.

The case reported on here is, in the main, connected to the broader professional system in the Chilean society and its functioning. Again, without aiming at topic representativeness, it becomes clearer that both the making of a political device and a closure strategy refer to social inequalities that have pervasively existed in that country. Professions look more and more to science to face better their clients' risks and to improve themselves, and in that country science is becoming increasingly available. It seems certain that as occupations begin and continue to question professional dominance, the more debate questioning professions will arise.

Ideas for Future Research

By no means should I suggest that this research has exhausted all possible aspects of the nursing profession. There are, indeed, a number of other questions arising from this work that, due to time constraints, were not studied. While those questions can be deduced from the limitations of my work, there are some areas on which I would insist when developing further questions:

(a) Relevance: As I have elaborated, whether nursing is a profession becomes an irrelevant question, and it would be misleading to continue to use it. Researchers studying the nature of an area of work might begin with examining the notion of professionalism in that area, which is quite another thing. No constellation of traits can properly define what it is to be a profession and what it is not. Today, it seems more fruitful to consider all occupations as forms of professions, as the old-fashioned divide between professions and crafts has, I argue, led to the reproduction of the same inequalities pursued by professionalisation projects: historically disempowered groups have taken on the same exclusionary strategies implemented by longstanding groups. I have also suggested discarding the notion of 'semi-profession', which refers to the same divided, although it is commonly found in mainstream nursing textbooks. This same preoccupation has led nurses to over worry about issues of status, creating persuasive discourses that may become a source of dissatisfaction in the long run.

This type of questions, likely a reflection of aspirational ideas, has not only pervaded nursing research but also translated into political effects, as the 'eliteness' associated with the professions has led to the monopolisation of titles by university institutions.

Other researchers wanting to study other professional groups may well benefit from the framework I developed. However, the landmarks defining professional jurisdictions may change from area to area. I studied the case of health care, where the impossibility to fragment the human being produces a great overlap between professions and under certain circumstances roles and tasks of different professions are, not officially, but practically exchangeable. Healthcare professions are not

separated by clean-cut borders, and other areas such as civil engineering may find bolder limits separating contiguous groups; this information might be useful for exploring more strict forms of delegation and, importantly, more subtle strategies of negotiation.

(b) Manageability: Nurses, as I have noted, enjoy a privileged position in the hospital, accessing, collecting and keeping confidential information, and controlling flows of work. While this position is usually used to favour their cultural agenda, the information may also become a source of data for complicating the analysis, either of the professions or of the organisational functioning. Documents and archives are underused resources for understanding work in health care, just as much as the behavioural patterns I studied ethnographically. These are sources of data that healthcare workers are very familiar with, participate in their construction, and can systematise through associative research. Manageability of data is in fact an attribute every researcher values.

The particular healthcare system I studied is often discussed 'from above', ignoring the dynamics operating in actual work. While my participants might have been distrustful towards being observed, as the hospital had never served as a setting for ethnography, as fieldwork progressed there emerged greater rapport, therefore further explorations would benefit greatly from this cooperation. I have learned that healthcare professionals, when given the opportunity to appreciate the potential contribution of the social sciences to an understanding of their work and realise the advantages of field research with them and about them, become very keen on sharing their practices. Without claiming a messianic message, this window of opportunity can have a transformative potential for further research in health and for the involvement of health professionals in projects of this nature.

(c) Comparability: Like in most countries in the region, nursing in Chile has long been influenced by theory bodies developed in the US; cooperation projects implemented in the mid-twentieth century allowed nursing scholars to access South-North mobility programmes, to the extent that current versions of nursing in Latin America emulate US

nursing. However, cultural differences affecting this affinity, although evident, have been rather neglected in analyses of nursing across countries. Claims idiosyncratic to a single culture have long been assumed as universalistic, and future research, in nursing and in health care more broadly would need to overcome this assumption. It is anticipated that differing versions of nursing coexist across cultures and that the conclusions of this research or of research produced elsewhere need not to be transplanted just as they are, for the national and supranational constituent parts of the systems can modify the functioning of the healthcare systems, therefore that of the professions.

Doing comparative research seems to be the obvious step for having referential points, though comparison has a greater analytical purpose: facilitate to discover the 'presents and missings' in each of the units subjected to analysis. With this in mind, there seems to be a need for greater availability of channels of cooperation, and this is possibly the biggest challenge for newer generations of researchers.

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