Chapter 4

Power

Power is ever-present within health care settings. It is evident in the way people walk, in the way they communicate, in who gets recognised as having a presence and who gets ignored. It is evident in the tone people use when they speak, whether loudly or softly, and whether or not their words receive answers. I found on entering the hospital ward as an observer that many of the rules of ordinary behaviour were, to a large extent, suspended. For instance, people working in close proximity to each other would simply not recognise each other's presence. In other work situations there would be at least a head nod or a few words exchanged but in the hospital ward, contact between individuals and groups was highly structured and often highly ritualised. Over a five month period, I never saw, for instance, any contact between a cleaner and a doctor. They simply did not recognise each other. This was also sometimes the case between doctors and nurses, especially if the nurse was very junior. In these situations the doctors (usually in a group) would seem to sail in like a ship of state, walk up to the patient's bed and proceed to talk to or examine the patient as though the nurse was simply not there. They would then walk out of the ward, after scribbling a few (often illegible) notes in the patient's report, leaving the nurse to decipher what they had written (often a request for the nurse to follow up) after they had gone. Nurses would sometimes do a similar thing in a different way. They would sometimes

congregate together around the ward desk and laugh and talk together as though an Intern (Resident Medical Officer/Junior House Officer) sitting and writing notes was not there at all. To an observer used to a more informal work environment, this could all appear quite strange.

It certainly stimulated me to ask, what was actually being worked out here? What were these patterns of behaviour achieving or preventing? I came to think that, in a silent sort of way, it was about claiming ownership of the ward. The doctors acted as though it was their ward and the nurses were there to provide the necessary but secondary services. The nurses on the other hand attempted to constitute the ward as belonging to themselves and the patients, with the doctors being regarded as a necessary but disruptive and distracting presence. I was frequently advised by different nurses to 'come in on the weekend; it's a different place altogether, no doctors to get in the way' or 'no doctors to trip over and interrupt the work'. While both nurses and doctors constituted the reality of 'ownership' in different ways, according to their standpoints, there were definite occasions and definite issues when it became very clear that power was operating in ways that advantaged doctors and their approach to illness and therapeutics.

MEDICAL POWER IMPOSED ON NURSES

This was brought home in a vivid way during the course of an evening shift. After a busy day, the nursing priorities revolve around giving evening medications, taking observations and, in general, settling patients, rubbing their backs, making them comfortable and readying them for sleep. Unless it is urgent, they prefer medical procedures to be undertaken during the day when the ward is full of activity. This particular evening was rolling along in a quietly busy way when a newly admitted patient walked up to the desk at 7.00 p.m. and informed the nurses that the RMO had told him he may be back later to perform a chest aspiration (a fairly major procedure). The nurses checked the notes, found nothing documented and so told the patient they doubted that it would be done that night as they had been told nothing about it. At 8.40 p.m. the patient, now agitated and anxious, approached the nurses again

and stated that he wanted to know one way or another about the procedure. He needed to ring his wife at home to let her know what was happening. The charge nurse for the evening (a nurse with about five years experience) checked the time and told him: 'No, he won't do it now because we haven't got the equipment up here'. The more junior nurse (a recent graduate) went further and added: 'He will not be doing it because we won't be doing it with him. We have no equipment and it's too late.' The patient then asked to use the phone to let his wife know, which he did. At this point, I found myself being rather impressed with the assertive and definite way in which these nurses set the boundaries for medical activities.

At 8.50 p.m. (ten minutes later), the RMO (the same one discussed in the previous chapter as being rude and non-communicative) arrived on the ward and asked calmly: 'Sister, have you a chest pack?' Both nurses looked at him in a startled way but simply replied, 'No'. He then said: 'Well I want to do a chest aspiration, so get one up.' To this very direct command the more senior nurse replied: 'I don't know if we can get one at this hour of night, I'll have to check.' But if this RMO detected any subtle resistance in this comment, he certainly did not acknowledge it. He replied: 'Yes, do that please. You can always get one from casualty.' At no point did he offer them any explanation or apology for his total lack of courtesy and the absence of even a rudimentary level of communication concerning his plans. At the same time, at no point did the nurses confront him with his rudeness or the fact that he was seriously inconveniencing them, not to mention the patient. The more junior nurse then began ringing round to other wards after which she went off to borrow the necessary equipment. The other nurse also had to stop what she was doing to set up the trolley for the procedure.

This story has a further twist. After returning with the borrowed equipment, the nurses were preparing the trolley and setting up for the procedure. At this point the Registrar (Senior House Officer) arrived on the ward. I heard the Registrar diplomatically mention that chest aspirations are usually done first thing in the morning so any complications occur during the day rather than in the night. They discussed this for a few minutes and then 'together' decided that the procedure could be postponed until the morning. The RMO then looked around

for a nurse and called out: 'Nurse, we won't be doing that aspiration now.' Again, no apology, no explanation. This was too much for the recent graduate. She asked incredulously 'What?' He repeated the message. She then simply walked over to him, placed her hands around his neck and proceeded to pretend to choke him. There was a sort of half-embarrassed humour about this, but the Registrar made an effort at conciliation by offering an explanation as to why the procedure had been postponed.

This unusual incident raises some interesting issues. It was, firstly, a rather naked demonstration of power. As such it was not typical of the more usual interactions between nurses and doctors on this ward. But the exercise of power in this instance was not just blatant. It also had an impersonal, almost mechanical quality to it that was only finally broken by a physical, directly confrontationist (if playful) act. The work of Jessica Benjamin is useful to help understand an incident such as this (1990). Benjamin discusses rationalisation, which as Weber conceived it, defines the process in which abstract, calculable and depersonalised types of interaction replace those founded on personal relations and traditional beliefs and authority. She makes the important point that the 'missing piece' in the analysis of Western rationality and individualism is the structure of gender domination (1990:188). Benjamin describes the way that male individuality dovetails with what has been defined as 'rationality' in Western culture. This is largely achieved through seemingly genderless and objective processes. As Benjamin puts it:

> The public institutions and the relations of production display an apparent genderlessness, so impersonal do they seem. Yet it is precisely this objective character, with its indifference to personal need, that is recognized as the hallmark of masculine power. It is precisely the pervasive depersonalisation, the banishment of nurturance to the private sphere, that reveal the logic of male dominance, of female denigration and exclusion. (1990:187)

As a result, we are dominated by impersonal forms of social relations and a 'rationality' which attempts to objectify and control everything. In this way, 'the man can remain in rational control, maintaining his separateness, denying his dependence

and enjoying a sense of omnipotence' (Pringle 1988:53). This enjoyment, however, comes at a price for the person being controlled, who is in this process denied recognition. It may be that it was this aspect of the transaction which so infuriated the nurse. Pringle makes the point that, 'Violence, whether actual, ritualised or fantasised, is an attempt to break out of the numbing barriers of self, to experience intensity and to come up against the boundaries of the other' (1988:53). Perhaps we can view the nurse's actions in this light. In an earlier interview with this nurse, she had gone out of her way to tell me that she 'did not play the doctor/nurse game'.[1] Yet it seems that endless permutations of this game are inevitable in a situation which is not based on mutual respect and recognition.

A second issue concerns the fact that the individual players in this situation were significant. This particular RMO was known to be abrupt and rude. He had in fact been reported by other nurses for unacceptable behaviour. Indeed, many of the nurses referred to him specifically during interviews to illustrate unpleasant and unsatisfactory nurse/doctor contact. In retrospect, it was apparent that the Registrar had attempted to ameliorate and defuse the situation, as though he too understood that the RMO lacked 'interpersonal skills'. The nurses, too, lacked the experience and the confidence of some of the other nurses on the ward. But while the starkness of the interaction was unusual, it did nevertheless demonstrate the power that was there to be called on behind the more polite culture that was usual for this hospital. It also demonstrated the implicit devaluing of nursing work that underpinned this interaction and may well underpin other more polite transactions. In this case, there was no recognition or acknowledgment that these nurses were being called away from anything of any importance at all. In this situation the medical agenda was *the* agenda and the nurses were there to serve it.

Power was also imposed on nurses in a way that could be described as chronic rather than acute. This concerned the constant, 'sleeping' issue of the doctors' indecipherable handwriting. This is sometimes presented as a sympathetic joke about doctors in terms of everyday folklore. 'Everybody knows that doctors have the worst handwriting'. And yet at the same time, it seemed to me to have a very serious dimension, a dimension which very much expressed a relationship of power

and dominance. I came to this observation after about the sixth or seventh time that I watched two or more nurses struggling to work out what orders a doctor had written in a patient's notes which the nurses were expected to follow up. I asked the nurses about my observations when I interviewed them individually. They all confirmed that this was a nuisance and sometimes a real problem but it was also something to which they had become accustomed. When I asked (Lisa) if she had trouble sometimes reading the doctors' writing, she replied:

> (Lisa) Oh yeh, oh yeh.
> (Interviewer) What do you do about it?
> (Lisa) Use a bit of nous I guess . . . if you know what the patient's in for, you sort of know logically what tests they might be going to have or what medications they might be going to have or if it's a change of dosage you just grab the medication chart and there are various little ways you can use to sort of figure it out . . . Yeh, usually it's just because you know what the disease is, the disease process, and you can sort of figure it out.

This is a wasteful and inefficient use of nursing skills and one for which there clearly seems to be no justification. Another nurse also described the issue as 'a big problem'. She went on to say:

> (Bev) It's their scrawl that is the problem and all of us have problems reading it and we're often giving a report (to the other nurses at change of shift) and it is hard to tell what they (the doctors) want and what they've said. So you usually have to put two or three heads together and then we can work out word by word, you know.

It appeared that this subtle exercise of power worked all the way up and down the medical hierarchy. I asked:

> (Interviewer) Is it a problem for other doctors to read the scrawl?
> (Bev) I think they, a lot of the Residents, have problems too. Dr C (names a VMO), he's the worst. I'll show you his when we go back, he's the worst one I've ever seen. It's just so, you know, like a line.
> (I) Have you ever heard the Residents complaining that they can't understand the writing?
> (Bev) Yes, they've asked us sometimes.

(I) Have you thought how the situation might be made better?
(Bev) If they printed.
(I) Printing?
(Bev) But I mean how could you get them to print?
(I) Do people ever say anything to them?
(Bev) I don't think they do, no. I don't think they're game enough.

In this exchange the nature of a seemingly technical problem was revealed very clearly as one which had power relations at its heart. This nurse knew immediately how the problem could be simply and promptly remedied, but the question, '*how could you get them to print?*' revealed her understanding of the issues of power and status which underpinned the problem. It seemed to be a clear example of the operation of 'micropower' while at the same time it carried both a heavy symbolism and strong structural connections to explicit, hierarchical, power structures. The symbolism of illegible writing says so many things. It says: I'm too busy and too important to bother about writing more slowly or carefully. It says: Your time is less important (you are less important) and therefore you can keep trying until you work it out. It says: You should be able to work this out and if you can't then you are inadequate (this introduces an element of shame and so therefore reinforces the relationship of dominance and subservience). It also very successfully undercuts the ability of nurses to construct any sort of professional mystique around their access to esoteric medical knowledge. It was not uncommon for the nurses, in desperation, to ask the patient what the doctor had said to them. In the same interview (above), Bev explained to me when I asked:

(I) Do you ever have to go to the patients and check with them?
(Bev) Well actually there was something that come up today, . . . that lady that went for the angiogram . . . no one could understand what she was to have, there was just one word, no hints . . . someone said, perhaps if we ask the patient, she might know . . . In the end we did find out, it was in a previous report written by a nurse, on a previous page in one of the nurse's reports she said 'going for an angiogram', so we knew then that's what it was but we were just about, I was just about to go down and ask the patient.

This appeared to be a 'sleeping' issue, one which caused

annoyance and inconvenience and perhaps one which had (but for the extra work of the nurses) the potential to be dangerous to the patient. It has probably existed since doctors' 'orders' have been written and was probably worse when doctors wrote in Latin (although it occurs to me that perhaps the handwriting has got worse to compensate for the lack of mystique associated with the demise of Latin!). Theoretically, it probably most closely corresponds with Lukes's 'three-dimensional view of power' which, he argues:

> allows for consideration of the many ways in which *potential issues* are kept out of politics, whether through the operation of social forces and institutional practices or through individuals' decisions. This, moreover, can occur in the absence of actual, observable conflict, which may have been successfully averted—though there remains here an implicit reference to potential conflict. This potential, however, may never in fact be actualised. What one may have here is a *latent conflict*, which consists in a contradiction between the interests of those exercising power and the *real interests* of those they exclude. (Lukes 1974:24)

Practically, it is an implicit exercise of power which goes against the grain of modern management theory with its emphasis on efficiency and teamwork. It also appears to be a practice which has survived the reforms of 'the new managerialism' in health care settings (Nettleton 1995:219).

MEDICAL POWER IMPOSED ON PATIENTS

In the sociological literature there have been a variety of ways that the doctor/patient relationship has been conceptualised. Parsons (1951) saw the relationship as reciprocal, if unequal. For him the inequality of the relationship was not a problem given the prescribed rights and duties of the physician which are underpinned by social norms and values (1951:435). This view has faced considerable challenge over the last two decades from several quarters, including from the influential work by Freidson, who has argued that reciprocity ought not be assumed; indeed, he maintains that the doctor/patient relationship is more accurately characterised as one based on implicit

conflict (1975:286). At the heart of this conflict is the necessity (from the doctor's point of view) for the patient to 'give over' authority and control of his or her body to the doctor. Both the doctor and the patient may recognise that the patient has 'rights' in the transaction but the 'good patient' will ultimately trust the doctor's expert knowledge to advise and act on what is in the patient's best interests. Fagerhaugh and Strauss (1977) have observed that different organisational settings profoundly influence the nature of patient/doctor interactions. The formality of the VMO's (Visiting Medical Officer/Consultant) visit in a teaching hospital appeared to be a situation which required more submissiveness than reciprocity on the part of the patient. This may very well be quite different from other organisational settings such as the Specialist's consulting rooms where the patients appear in their own clothes, with their own identity much more intact and where they are in a much better position to negotiate and bargain. I saw several instances of medical power unambiguously imposed on patients.

In the first instance, a senior and junior RMO (Senior House Officers) arrived at the patient's bedside at 9.00 p.m., after she had been 'settled' for the night and announced: 'We will just examine your back passage to see if you have been bleeding from there'. I could not catch the exact words of the patient but it was apparent that she was shocked and that she raised some objection to this. The doctor then replied 'Yes, I'm sorry but this is very important. Just turn onto your side please'. While I was prepared for an expression of medical authority, it struck me as quite unacceptable that the doctor had not asked permission for this most intimate and invasive procedure. The doctor had announced his intention in a loud, clear voice which would surely embarrass the patient in front of other patients and staff. (Was this a strategy to ensure co-operation?) When the patient objected, the objection was treated not as a real objection which required negotiation, but a small protest which required another instruction even more firmly put and which was clearly to be obeyed.

In the second instance, the VMO went with a nurse to visit an elderly woman who had been suffering from angina (chest pain) and who was hopeful that she would be allowed to go home. When we arrived, she was sitting on her bed and looking expectantly at the doctor. He pulled the curtains around her

bed and said: 'Let's have a look at you'. She was wearing a 'nightie' which conveniently had a button open at the front and without further ado he slipped his hand down the front of her 'nightie' and over her breast. I shall never forget the look on her face. To say she looked shocked would be an understatement. Her face flushed and he instructed, 'Relax, your heart is pounding away'. Little wonder. I assumed that he placed his hand directly over her heart in order to feel the rate and strength of the heart but it obviously had not occurred to him to explain to her what he was about to do and why. It seemed not to occur to him that the very act of examination was influencing what he was finding in his examination, and so seriously interfering with medical 'best practice'.

Both of these incidents raised the issue of the normal expectations of citizens living in civil society. If either of these incidents had occurred outside the hospital, the perpetrators would have been liable for state-sanctioned legal action. In his book on modernity and self-identity, Giddens discusses the way that in the transition to the modern state local communities were largely autonomous in terms of traditions and modes of life (1991:151). He argues that: 'In the modern social forms, state and civil society develop together as linked processes of transformation. The condition for the process, paradoxically, is the capacity of the state to influence many aspects of day to day behaviour' (1991:151).

It is almost as though a 'modern' teaching hospital is a pre-modern remnant of a remote community, which remains aloof and to some extent unincorporated into the purview of the state, 'since the state also helps define private rights and prerogatives in a positive fashion' (1991:151). At a very basic level, the obligation to show good manners to a fellow citizen was missing here.

Power also operated in subtle ways and without any obvious conflict. In the incident I am about to relate, power worked to define a situation in a way that, once again, advantaged doctors. In this case it concerned a patient's perception of her own illness and recovery. The following conversation took place between a VMO and his patient on a medical round in the presence of other medical staff, the NUM (Nurse Unit Manager/Senior Sister) and myself. This patient had been suffering from severe head and neck pain and had undergone

investigations which had produced a diagnosis. The VMO explained that she (the patient) would need to have a biopsy taken just to make certain that they were correct.

> (VMO) Well, the good news is that this condition is treatable. So there is no reason why we shouldn't be able to give you considerable relief.
> (Patient) Well it won't be for want of trying!
> (VMO) (laughs) We haven't started yet.
> (Patient) I've never been so well treated in my life. I just feel so much better.
> (VMO) You have six or seven doctors to see yet.
> (Patient) Oh, I see.

It was apparent that, in this conversation, the patient's perception was that her treatment had already begun and that she did indeed feel better. For the last week she had been on bed-rest, a good diet, symptomatic pain relief and had been receiving plenty of 'TLC' from the nurses. The VMO, on the other hand, did not consider that treatment would begin until a definite diagnosis (including biopsy) had taken place, a formal treatment regimen of medication had begun and the required number of doctors had been seen. Then the patient was free to start feeling better. There are at least three points of interest here. The first concerns the fact that we are witness to two different paradigms of illness and recovery, one the subjective experience of the patient (and presumably the nurses) and the other the objective assessment by the most powerful of the expert professionals. Nicholas Fox quotes a study by Tuckett et al. which documented an effort to introduce British doctors to the possibility that patients' own beliefs and values could contribute to their care (1993:96). The research team found that doctors saw lay beliefs in a narrow and ultimately instrumental way. These beliefs were construed as: 'a useful way of "getting the whole picture", so as to discover the real problem; to avoid appearing superior and as an aid in communication; to provide clues so that doctors could give appropriate reassurance; or as a waste of time, and only worth listening to on grounds of courtesy' (Tuckett et al., quoted in Fox 1993:96). The study concluded that the 'medico-centrism' of doctors' behaviour was a consequence of the urge to make

a diagnosis and the urge to stay in charge. This incident appeared to be consistent with these observations.

The second point concerns the fact that a real and conscious effort had to be made by the VMO to redefine the situation in the eyes of the patient. In other words, the power to define the situation as a medical success had to be worked for and an appropriate and individual effort had to be made. While the second point can be seen to be about agency, the third concerns the structural location of the VMO in relation to the patient and the nurses.

A medical round is a highly structured and ritualised activity (Atkinson 1981). It is led by the VMO (who carries no paper) and is made up of the registrar, the NUM who carries the nursing notes, the Intern or RMO who carries the medical notes and various request forms, other health professionals—occupational therapist, physiotherapist, social worker—and frequently some medical students. As a ritual it is both the exemplar and the symbol of medical power in the hospital. It also openly represents the hidden face of hierarchy to the patient. It is a formal occasion and one in which the right to speak is constrained by the formality and hierarchy. The patient is permitted to speak but not to say too much. In line with Foucault, it can be said that the patient is there to reveal, not to claim subjectivity. The other staff are there primarily to answer any questions the VMO may put to them. The third point then, is that while the VMO had to make an effort to reclaim ascendancy, he had the structural location from which to do it. Finally, through the action of reclaiming it, he reinforced the structure.

Another incident highlighted a slightly different aspect of the power of the doctor *vis à vis* the patient to be 'in charge' of the patient's body and illness. In this case there was a young (19-year-old) cardiac patient in the ward who was suffering from a severe congenital disorder which had resulted in a lifetime of illness and disability. Like many others with a long-term health problem, this young woman had an extensive and expert knowledge of her condition and its treatment (MacIntyre & Oldman 1985). On this particular day she had made quite a fuss when handed her medication. She thought she recognised one of the tablets as a drug which had caused her a previous bad reaction. She asked the nurse the name of the drug and confirmed that, yes, it was the drug which had

caused a problem on a previous occasion and, yes, her specialist had prescribed it for her. She then point blank refused to take the drug and asked to see her doctor when he came in. The next day her Specialist (VMO) arrived to visit her along with his Registrar. After the charge nurse explained what had happened the day before, the doctors walked over to her bed and pulled the curtains for privacy. This patient was confident, knowledgeable and quite assertive regarding her treatment and the nurses listened with great interest to see how the doctor would react to a situation where his authority had been challenged on apparently quite firm grounds.

After greeting her, the doctor adopted a tone which was both authoritative and patronising. He patiently explained (as though to a child) that he had not intended for her to be on the drug long-term but because she had that previous bad reaction, he wanted her to have it again so that they could see in more detail just what was going wrong with it. He successfully presented this in such a way as to make her appear at fault in doubting his judgement. She became very quiet and appeared to accept what he had to say. In the end she apologised for the inconvenience she had caused! The nurses commented that really, he ought to have discussed all of this with the patient and themselves beforehand and the patient would not have been put through this unnecessary upset. He however appeared to have no such doubts about his actions and he and the registrar sailed out of the ward, power intact and probably *enhanced* by what had occurred.

POWER TO RESTRICT

There were at least two issues which emerged during the period of this study which concerned the power of the medical profession to restrict the work of nurses. One concerned the restriction on nurses to 'put up' blood. The other related to the restriction on nurses to site and re-site intravenous cannulas. The blood issue was one which several nurses at one of the hospitals complained about. It was explained to me that even when a patient had an intravenous line *in situ*, a nurse was not permitted to replace the intravenous fluid with the blood, when it became available. The nurse had to 'page' the

Resident to come to the ward and perform this simple task. Many nurses saw this as an imputation that they could not be trusted to correctly read a label:

> (Julie) . . . and the reason they give you is that a nurse might grab the wrong bag out of the fridge, but, then in another instant you'll hear that a nurse can go and get blood but still has to check it before it goes up. I don't know, I suppose different hospitals are different but in . . . (another city), the pathologist, when you wanted blood, the pathologist in office hours checked the blood with you, in the ward you got another nurse and checked it again and put it up and out of hours, the nursing supervisor got the blood, so I mean it's just a checking game. I mean the most important thing about the blood issue is that it's cross-matched correctly and labelled correctly. So you see what I'm saying? It's so silly.

Another nurse talked about the way that this restriction worked against patient comfort as well as causing frustration to the nursing staff:

> (Bev) Just a classic example, you know, the patient has anaemia and they are waiting on blood and you want to get the blood up and running. We can't do that.
> (I) Right.
> (Bev) And the Resident knows dammed well that the patient's got to have observations with the blood and he knows he's gotta come and do it and you sit there, half the morning's gone so then the blood's running all night keeping the patient awake and creating the extra work for people.

A similar set of circumstances pertained to the issue of inserting intravenous cannulas and re-siting cannulas that had slipped from the vein and become embedded in the surrounding tissues. One nurse in particular, who had worked in pathology and had skills in venipuncture, found this restriction frustrating and annoying:

> (Denise) I just get really frustrated at the way they collect (blood). No one ever, ever collects off a supported arm. That was one of the basic rules in pathology.

She went on:

> The other thing we learnt, was always to be sure of what you feel before inserting the needle. You never push the needle in

> until you have felt exactly where you are going. I've never seen that done here yet. They just come in and . . . oh, no . . . sorry, I'll go over here and try and the more they miss the crankier they get, the more frustrated, the less time they spend on looking where they're going. Our limit was two tries. I don't care now, I just get up and say, 'I'm sorry, but it's someone else's turn now'—I've just seen too many bruises and I won't let them keep going.

This particular nurse took the issue further. It was a procedure in this hospital to hold a monthly, hospital-wide nursing meeting. At this meeting, information was disseminated 'from the top down' but it was also an opportunity for nursing staff to raise and discuss issues among themselves and with the nursing hierarchy. At the next meeting, this nurse put forward the idea that there be certain nurses from each ward who are nominated to perform venipuncture when they decided it was necessary, for instance, when a Resident was unavailable or to resite a 'tissued' intravenous. There were two reactions from nursing administration.[2] The first concerned the need to set up a training program for these designated nurses. The second illustrated the caution exhibited by sections of nursing administration over issues of territoriality. One senior administrator put forward the view that if nurses took over this job, it would take away training opportunities for Interns and Junior Residents. How else would they practise their skills? The majority of the nurses considered this argument but were ultimately unmoved by it. The nurse who initiated the discussion later recalled the meeting in this way.

> (Denise) You know, and at the meeting, I just said: 'I don't mean to be rude, but will someone tell me what sort of training the Residents had for taking blood or for doing cannulas?' and they weren't able to come up with anything apart from that little bit they get at the beginning of their training, nothing . . . that and so they virtually said that if we take that job off the Residents they won't get any good at it, but I really think they should have a training program because you should see the bruises. I mean the big bruises you see around the wards and I'm sure not just here, you would have been sacked in pathology.

There was quite a lot of support for her proposal from other nurses so this nurse then prepared a more formal

proposal to the nursing medical/surgical committee for consideration. This committee (made up of senior nursing practitioners) agreed in principle with the proposal, refined it and then made a request to another committee to set up an in-service training course for the nurses who would participate in the scheme. It was then given approval by the hospital management committee. One senior NUM remarked to me in passing: 'I wonder what will happen when we try to take something off them that they don't want to give up. That's when it will really get interesting'.

This note of scepticism notwithstanding, the issue and its outcome have much to say about the operation of power between doctors and nurses. Firstly, they demonstrate very clearly that nurses can be acutely aware of the effects of power especially in relation to restrictions on their ability to care for patients. It can also be seen that this awareness is expressed in discourses and discursive practices relating to a particular issue. Secondly, they demonstrate that, given the right structures, nurses will not just hang around the pan room and complain about these restrictions. If they see that there is a way to do it, they will identify and articulate an issue from their standpoint, and take action for change. This raises a third point which concerns the ambiguous and sometimes contradictory role of nursing administration. It can be seen from this incident that nursing administration acted to both retard and advance nursing action over this issue. In the first instance, there was an attempt to deflect action by emphasising the need for junior doctors to get practice at venipuncture. At one level, it could be argued that nursing administration was policing the sexual division of labour. But at the same time, it was nursing administration which initiated the setting up of the structures (hospital-wide expert nursing committees) which permitted the issue and the nursing proposal to gain institutional support. In relation to this issue, I gained the impression that senior nurse administrators were prepared to support nursing demands if they were thoroughly prepared, were based on sound nursing principles and supported by a significant proportion of nurses.

This impression was later confirmed at an interview when I spoke to the Director of Nursing. I asked her if she saw support of staff as a central part of her role. She replied:

> Yes, exactly. First of all encourage them to have the courage to come forward with what it is that they really believe, based on sound professional interpretation of the situation, but then promoting what it is they believe at the level it needs to be promoted in order to have, you know, the total outcome.

She went on:

> I attempt to take every opportunity to get people to go away and think, to gather together and talk together and resolve together and then to come back and then for me to promote whatever the group thinks . . . I might need to offer guidance as to pitfalls they're going to face if they don't perhaps consider something, but I mean, that's got to be my role, to offer that advice, that recommendation, 'have you looked at this and that and the other?'

And finally:

> So I believe I share full responsibility for making sure that the structure is available for them and the processes are available for them to facilitate what has to happen.

She made it clear, however, that the pressure for change had to come from the nurses themselves. This was a telling illustration of the interrelationship between agency and structure in the making and the possibility of the unmaking of the nurse/doctor division of labour. On the one hand, it was nursing agency in the form of individual and collective dissatisfaction with existing practices which led to a more formal proposal for a change which resulted in an extension of nursing jurisdiction. At the same time, these actions would not have been effective or even possible without the setting up and the gaining of legitimacy for structures which facilitated agency. This agency in turn strengthens the structures and enhances their legitimacy in the eyes of the nursing staff. In this way, it is possible to see the 'duality of structure' discussed in chapter 2. These discourses and practices are also far removed from 'the doctor–nurse game' (Stein 1967). They are also more complex and more sophisticated than the typology of discourses proposed by Turner as 'compliance' and 'complaint' (1986, 1987).

POWER AND MOVEMENT

These stories also demonstrate the relational nature of power and the fact that dominance has to be continually worked at and reinforced. The fact that it also had to be learnt was revealed to me in an unexpected way. It was my habit during the research for this book to spend some time during the day sitting at the nurses' station reading and writing up my notes. I had learnt that this was guaranteed to make me 'invisible'. People, especially medical staff, would conduct conversations as though I was not there. One particular day, a new patient was admitted and a VMO and a Registrar arrived to examine and admit him. After the examination they returned to the station to discuss the case. It was apparent that the VMO was using the situation to test the Registrar's knowledge and technique and rehearse him for his Fellowship exams. (These exams are the final hurdle to becoming a Specialist.) The Registrar ran through his observations and differential diagnosis, and then the VMO tested him further with more detailed questions and comments on his knowledge and technique. I became interested in the amount of time being spent on the details of the *method* of examination. It became apparent that the technique of the Registrar was being discussed not in terms of its effectiveness, *but on how it looked*. The VMO commented:

> I always sit my cardiac patients up for an examination. That way you don't have to move from their front around to their back. It just looks more professional if you don't move around too much. It just works out that way . . . the less movement you make, the slicker it looks.

The Registrar was being prepared for admittance to the elite club of the Specialists/Consultants and it was clear from this conversation that techniques which enhanced the prestige and power of the doctor were an important part of this preparation. This is especially interesting in light of the emphasis traditionally placed on movement and speed in nursing. One nurse recalled her first job as a nurse in a small country hospital where the matron was her aunt:

> (Gail) And my mother (also a nurse) said to me before I went, she said for God's sake around Thelma if you've got

> nothing to do I don't care what you do but walk fast because if she catches you walking slow you'll be for it . . .

In a hospital ward, the nurses are rarely still. The doctors, however, moved in and out of the ward but very rarely around (unless they were conducting a formal 'round'). It was surprising, but not greatly so, to find that movement, its range and pace, both expressed and constituted power in the hospital ward. It seemed that the right to be still and have others move around you was expressive of power and gender relations.

POWER REVERSED

While power can be, and frequently is, challenged in subtle and sometimes more obvious ways, it is rare to find it completely reversed. However, this was the case in an incident described to me by one of the interviewees, (a senior, very experienced nurse who was involved with 'in-service' education). I asked about the new, university-educated graduate nurses and whether she could distinguish any significant difference in their attitudes with patients or other staff. She replied:

> (Gail) Well actually they have less fear. I'll give you an example, this was a classic. You know Dr T (names a VMO), you know what he's like. Well he's a 'gynie' [gynaecologist] and if you lived in England you would call him Mr, he is that type of 'where's my nurse' sort of doctor. Well he was a patient in the ward here and was being nursed by one of the college people and it was beautiful because she knew nothing about him except that he was a doctor and on her first morning she walked straight up to him and said, 'All right Allen, up you get, off to the shower'. And it was gorgeous. And there was this rather straight, old-style registered nurse nearby and she told me, 'my teeth almost hit the floor and I didn't know where to look but all I knew was that I bloody loved it'. And he was treated just like any other patient. He was asked, mind if I call you Allen, not given the chance to answer of course, and I think in that regard even when they know a little bit about it, they're sort of not so intimidated.

This was interesting as well as amusing. In the long term this incident did not represent any lasting challenge to the

existing power structure. It did, however, demonstrate the interdependency of agency and structure to power relations. When a particular agent (Dr T) was separated from the hospital power structure, the relationship of power was completely changed, even reversed. This was a rare treat for the older nurse who could not have conceived of treating the doctor in this casual, offhand way. It also demonstrated the mixture of attitudes with which the older style nurses regard the new, university-educated nurses. On the one hand, many are critical of the new graduates' 'time management skills'. On the other, they admire their courage and their sense of professional confidence. I had a strong sense that the older nurses held out great hopes for the changes that now seemed possible in a future when these more assertive and formally educated nurses would be in charge. In this regard, Australia is somewhat ahead of Great Britain where the Project 2000 reforms are being implemented more slowly.

Discourses of power were instructive and sometimes surprising in that they revealed some of the many dimensions of the way power operated in the sexual division of labour. They also revealed that nurses themselves were aware of both the restrictions and opportunities connected with these dimensions. This supports the proposition that all social actors, no matter how oppressed, have some degree of insight into the social processes which oppress them. In addition, they demonstrated the relational nature of power and the fact that while medical power was dominant, it had to be continuously worked at and reinforced. Related to this is the observation that power could be challenged over certain issues in ways that enhanced the power of the subordinate group and which had the potential to destabilise the power of the dominant group. Discourses of power also pointed to the possibility that power may well be operating in other situations where no *overt* discourses of either power or conflict were evident. I shall explore some indications of this in the following chapter and return to it again in the concluding chapter of the book.