The Social Construction of Community Nursing

Anne Kelly
Anthea Symonds

THE SOCIAL CONSTRUCTION OF COMMUNITY NURSING

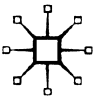
Also by Anne Kelly and Anthea Symonds and published by Palgrave Macmillan:

The Social Construction of Community Care

The Social Construction of Community Nursing

Anne Kelly and Anthea Symonds

palgrave
macmillan



First published 2003 by
PALGRAVE MACMILLAN
Houndmills, Basingstoke, Hampshire RG21 6XS and
175 Fifth Avenue, New York, N.Y. 10010
Companies and representatives throughout the world

PALGRAVE MACMILLAN is the global academic imprint of the Palgrave Macmillan division of St. Martin's Press, LLC and of Palgrave Macmillan Ltd. Macmillan® is a registered trademark in the United States, United Kingdom and other countries. Palgrave is a registered trademark in the European Union and other countries.

ISBN 978-0-333-75006-3 ISBN 978-1-4039-3765-0 (eBook)
DOI 10.1007/978-1-4039-3765-0

This book is printed on paper suitable for recycling and made from fully managed and sustained forest sources.

A catalogue record for this book is available from the British Library.

10 9 8 7 6 5 4 3 2 1
12 11 10 09 08 07 06 05 04 03

To all community nurses,
past, present and future

Contents

List of Figures and Tables

Figures

Tables

Foreword

Health care systems across the world are confronted by the problem of ever-increasing demands for services against a background of constraints on the resources available to provide them. The problem represents a major headache for those at all levels of policy-making, decision-making and commissioning services and for those at the forefront of service provision and delivery. The need to ensure that limited resources are channelled into effective interventions has provided additional impetus to the drive towards evidence-based practice, while at the same time endeavouring to reduce levels of inequalities which exist in terms of provision and health status. The notion of evidence-based practice, with its emphasis not only on how health professionals practise, but also on what they practise, has been one of the factors which have resulted in the appraisal of the roles and responsibilities of health care professionals. In addition, the social status of health care professionals in society has shifted following high profile media cases, which have seriously undermined public confidence in the health care professions.

At the same time it is becoming increasingly apparent that health professionals must learn to increasingly work in partnership relationships with other agencies and members of local communities to promote health effectively. Community involvement in health through such partnerships has been widely advocated, but translating intention into practice is complex and represents a challenge for all the stakeholders involved in the change process. Such partnership arrangements require a transformation of the professional role from protagonist to partner, and the patient–client role from passive recipient to partner. These partnership approaches have considerable merit in health care systems that emphasise active involvement and self-care actions of individuals and families to maintain health and prevent disease, and the role of community nurses within such situations has particular significance. Partnership approaches and the role of community nurses are also important in situations involving underserved, vulnerable, ethnic minority and other socially excluded groups in society. For too long, professionals and policy-makers have relegated these groups to passive roles in health decision-making and action, with health inequalities providing vivid testimony of such neglect.

Furthermore, it is generally accepted that the relationship between expenditure on health care services and the health status of a population is not directly proportional. It is far too simplistic to argue that in order to improve the health of the nation and reduce inequalities, additional resources need to

be channelled into health care services. After all, the USA is one of the least healthy of the wealthy nations of the world, despite spending some 14 per cent of its GDP on health care while Japan, which spends about 7 per cent of its GDP on health care, is one of the healthiest. Understanding the state of health within a community and differences between communities requires thinking about the wider determinants of health, which again highlights the pivotal role of community nurses in facilitating improvements in the health of such communities and the wider aspects of social welfare.

This book charts the historical developments that have occurred in the roles of community nurses, and argues strongly that the profession needs to embrace traditional and contemporary models of nursing and social care if it is to continue to make a significant contribution to the health and wellbeing of society, in the light of current health and social policy developments.

Dr Ceri Phillips
Reader

Acknowledgements

The authors would like to thank the following people whose work has contributed to the content of this book; Angela Jones, Stephanie Jones, Janice Lewis, Gail Mooney and Greg and Sue Summer.

Their hard work has provided information about current situations in community nursing. Also we would like to acknowledge the administrative support of Joyce Owen, CHEPS, School of Health Science, The University of Wales Swansea, without whose help this book would not have materialised.

List of Acronyms

BMA	British Medical Association
BMJ	British Medical Journal
CETHV	Council for Education and Training of Health Visitors
COHSE	Confederation of Health Service Employees
CPHVA	Community Practitioners and Health Visitors Association
CPN	Community Psychiatric Nurse
DoH	Department of Health
DHSS	Department of Health and Social Security
GDP	Gross Domestic Product
GNC	General Nursing Council
GP	General Practitioner
HEA	Health Education Authority
HVA	Health Visitors Association
LCC	London County Council
NASW	National Association of Social Workers
NAYIC	National Association of Young People in Care
NHS	National Health Service
NHSME	National Health Service Management Executive
PHC	Primary Health Care
PHG	Primary Health Group
PSU	Pacifist Service Unit
RCN	Royal College of Nursing
SEU	Social Exclusion Unit
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
UN	United Nations
WHO	World Health Organisation

PART I

THE CONSTRUCTION OF COMMUNITY NURSING

Introduction

Part I of our book seeks to construct an understanding of the social meaning of community-based nursing. There are many questions regarding this particular branch of nursing: What do we mean by community nursing? Why did it emerge? Who were community nurses and who are they today? What was its original purpose and has that changed? What does it feel like to be a community nurse today? What makes community-based nursing so distinctive from hospital nursing?

The most obvious and fundamental difference is of course the *site* of practice. This is nursing practice removed from its institutional base – the hospital. It involves different social relationships not just between the nurse and the community but also within the hierarchical power structure of the health service. Community nursing can in many ways be seen as 'real' nursing in the real world. But the site and everyday practices of health visiting, district nursing, school nursing and mental nursing were founded upon contradictions and these still remain:

Contradictions of *site*:
- Public health/Private home
- Collective provision/Individual targeting

Community nurses operate within territory which is owned by the client. This in itself marks it out from hospital-based nursing and sets up problems for the negotiation of power relations. The collective element in much of public health, the universalism of health visiting, for example, contrasts with the targeting of *individuals and families* for attention.

The contradictions within *practice* can be defined as:
- Care/Education
- Support/Control

All community nursing contains within it the educative function. The delivery of care is connected to the delivery of knowledge which will enable the patient

or carer to manage their health or care in a more efficient way. Equally, support for individuals and families is connected to a degree of control over their lives wherein they enter into a 'settlement' with community nurses and in exchange for care delivery they themselves become the subject of surveillance. These contradictions of site and practice were inherent within the construction of all branches of community nursing. This section does not attempt to chronicle a history of community nursing but to place its construction against a background of the concerns, discourses and policies which created a specific role for each branch. The underlying contention is that nursing in the site of the community was constructed to fulfil a specific role which overtly was within health and social care delivery, but which also was in the vanguard of the everyday administration of social order.

Governmentality

In order to clarify this argument we must utilise the work of Foucault, and other writers who also have used his theories on power and administration, to illuminate the meaning of the power of medicine and allied discourses in the construction of health services of modern states.

The work of Foucault has been widely used within studies of medicine and nursing but Foucault did not directly apply his theories to the development of health policies. Nevertheless, it is possible to understand the increased role of state intervention in the implementation of public health policies, the development of medical power and of health education policies within his theoretical framework.

Firstly, Foucault saw power as existing within *relationships* and *sites* rather than as a macro structure based in all the institutions of a Capitalist society as Marxists had previously defined it. In his study of the emergence of psychiatric medicine and the institutionalisation and objectification of 'madness' (Foucault 1973), he saw power as 'embodied in the day to day practices of the medical profession' (Turner 1997). This view of power relations as existing in everyday practices between people and especially between health professionals and clients must be placed within his theory of the necessity for a system of social order.

Foucault saw social order as the principal problem faced by the emerging modern and industrialising states from the end of the eighteenth century. New government apparatuses of administration were needed to exercise a *discipline* over a newly mobile and potentially out-of-control population. Mechanisms for the control and administration of populations Foucault defined as 'governmentality' (Foucault 1991). One of the most important elements of this mechanism was the increasing control exercised over human bodies. This control was illustrated in the new sciences of criminology and psychiatry and manifested in the building of a new design of institutions including prisons, hospitals and schools. A clear illustration of this can be seen in the design of

the Nightingale wards with the nurses' station placed so that all the beds can be observed from one single point. Schoolrooms were designed with an elevated stage at one end from which the one teacher could observe all the desks. Prisons were designed to enable the few to exercise surveillance over the many via the rounded panopticon which allowed for constant visibility. Another, more covert, illustration of this form of control and discipline over the body was, of course, exercised by the new knowledge and power of bio-medicine. Writers such as Armstrong (1983, 1995), have argued that this control exercised by 'surveillance medicine' was a feature of Britain and other European states from the nineteenth century onwards.

The legislation on public health in Britain during the nineteenth and early twentieth century is evidence that a new form of administration was being developed. The health of the population became an increasing object of concern to governments and through public health measures a degree of order and discipline was maintained. But this concern over the health of the population was only possible because of increasing knowledge of populations which was constructed via the collection of statistics on mortality, especially infant mortality, and changing theories on causation of disease.

The medical profession, which was legitimised by the state in the middle of the nineteenth century, played a leading role in the construction of the body as a site of discipline as disease was located within the individual anatomy. But this stage followed the acceptance by government that it was responsible for providing the conditions for good health and the cessation of epidemics in the legislation on sewage disposal, clean water, housing and pollution control. Armstrong (1993) has defined the stages of public health during the nineteenth century as developing from quarantine involving a separation of spaces and policed by state regulations to the separation of bodies and ideas of personal hygiene which were policed by health professionals. But the idea that individuals were in some way responsible for their own health could only be possible when the structural conditions were in place. As Osborne has noted about this development of concepts and definitions of health:

> One moves very quickly from the idea of health as being a right of citizenship to that of health being a duty of citizenship. (Osborne 1997:181)

When we look at the progression of health policies in Britain from the nineteenth to the end of the twentieth century, we can detect this change in the relationship between the government, the citizen and health.

But to return to the Foucauldian concept of the exercise of power as being embodied in everyday practice. The role of community nursing as a mechanism for order now becomes central to this idea of the 'governmentality' of society being carried out by everyday practices in health care. Nelson has applied this argument to the case of Ireland, and argued that nurses were 'in the front line in the techniques of pastoral government in the nineteenth century' (Nelson 1997:6). This view of nursing and especially community-based

nursing as being a part of the mechanisms of government in the application of social order in the nineteenth century will be the theme which underlies the opening chapter.

But the construction of district nursing, health visiting, mental, school and industrial nursing also took place within other competing and parallel public discourses including those of eugenics, the management of poverty, national efficiency, imperialism and feminism.

Concerns, discourses and policies

The use of the term 'discourse' has proliferated in recent years and is in constant use throughout this section which places the construction, reconstruction and practices of community nursing within certain discourses and regimes. It is important therefore that a working definition of this crucial concept is clearly understood. Foucault's definition of power as diverse and embodied in practices, and not solely as a class-based economic structure, is an essential ingredient in an understanding of his use of discourse analysis and the concept of discursive regimes. A discourse is a construct of power and *knowledge*. In essence, he was concerned with the question, what is knowledge? How do we know what we believe to be 'the truth'? He believed that knowledge could be the subject of an archaeology whereby its roots could be uncovered as an ancient building could be uncovered and understood (Foucault 1974).

The theory of discourse is therefore an attempt to uncover the meaning of a body of knowledge. This is to accept that definitions of certain truths such as definitions and practices which centre on 'disease' or 'madness' have been constructed at specific historical times and junctures. So concepts such as 'disease' and 'madness' are not static, they are constantly in process of change. 'Madness' in the nineteenth century was a totally different construct, subjected to different practices and was a different 'truth' than the same category of 'madness' at the present time (Fox 1997). Nevertheless, both were products of a truth constructed in discourses that posited a knowledge which became the basis of medical and nursing practices.

A discourse makes a knowledge possible, it creates a system of rules, statements and practices which then mediates power to claim a 'truth' and make statements and eventually policies which claim to be based upon this speaking of the truth. There is, therefore, a relationship between power, knowledge and discourse. An analysis of discourse therefore studies the language through which a knowledge is carried and the sets of social relationships and practices which this connection constructs. Discourses therefore create a 'regime of the truth', this regime is linked to systems of power which constantly sustain, reproduce and extend it (Foucault 1980).

An example of this is given by Sarah Nettleton (1995) in her analysis of the development of dentistry in the nineteenth century. She pinpoints the

discourse which created the 'truth' that there was a relationship between sugar and dental caries. Some texts supported this connection, others opposed it, but the debates and disagreements were all conducted within that regime of the 'truth'. David Armstrong (1986) argues a very similiar case for the 'invention' of infant mortality by medical statisticians in the latter decades of the nineteenth century. The reality was that high rates of infant mortality had always existed, but with more sophisticated calculations and techniques of diagnosing causation, a discourse of causes and the construction of it as a 'social problem' emerges as a truth. This 'truth' was then embodied in institutions, practices of medical science and health visiting, public health and education, and social policies. Everyday practices, publication of texts and pamphlets, regulations and policies all further amplify and construct the 'truth' of infant mortality as a social problem which could be solved by surveillance, regulation and administration.

In the first two chapters, we shall be using the concepts of discourse to study the emergence of various regimes of the 'truth' which informed practices and professional organisation of community nursing from the nineteenth century to the present day.

In the third chapter, we adopt a different perspective and focus on both the construction of different communities in Britain and the significance of the concept of 'community' for current social policies. It will be argued that, as in the nineteenth century, branches of community-based nursing especially health visitors and school nurses, are being utilised in the governmentality of a society experiencing social and economic change.

Finally, an analysis of current policies and a view from the 'front-line' of community nursing are presented. What are the experiences and meanings given to their social reality by community nurses themselves? What does it mean to be in the front-line today? We look at the *effect* of the 'truth' of policies and discourses based upon the management of poverty, the medicalisation of child surveillance, the 'ease' of day surgery, and the containment of mental illness. Community nursing is a construct, it is practised within certain 'regimes of the truth' which are now, as always, in process of change. It is concluded that the further challenge to community nurses will be to demonstrate that their nursing interventions span care, cure and control. They must also be able to show how their interventions can foster the image of a civilising profession which is intent on reforming and redirecting the lives of people who have been socially excluded from society.

CHAPTER 1

Public Health and Social Order: The Construction and Consolidation of Community Nursing before the NHS

Introduction

This chapter traces the function and practice of community nursing from the nineteenth century until the foundation of the postwar welfare state and creation of the National Health Service. The branches of community nursing that are focused upon in this period are those of district nursing, health visiting, school, industrial and mental health (asylum) nursing. The development of midwifery is only peripherally referred to but has been the subject of many histories and sociological studies (Donnison 1977, Oakley 1984, Hunt and Symonds 1995).

This development will be placed within the framework of three primary concerns that, it is argued, dominated political and health discourses during this period.

- Containment of epidemics and social order
- Pauperism and the management of poverty
- Control of quantity and quality of the population

These three spheres of articulated concerns must be seen as inter-connecting and crossing over many discourses at different periods of time. They cannot be seen in isolation, together they formed an overall 'regime of the truth' which informed and constructed the practices and perceived purpose of community nursing. At the same time, community-based practices themselves reinforced the discourses and reflected a 'truth'.

This period of time, covering barely a hundred years, experienced rapid social upheaval during which the certainties of the previous eras were disrupted. The First World War of 1914–18 marked a watershed between the nineteenth and the twentieth century. After the war, new beliefs and discourses were formulated which connected to those of the previous century

but also looked to new solutions based upon science, psychology and planning. Community nursing was constructed in the period before the war, and its practices and purposes both consolidated and changed in the interwar period.

The construction of community nursing was also surrounded by other influences, especially that of the gendered division of labour and a development of feminism. It also took place within a social and economic structure that changed from one of nineteenth-century imperialist arrogance and self belief to that of interwar despair and political radicalism.

The main argument to be followed is that the construction of community nursing must be seen as a part of the governmentality mechanism. This operated throughout this period to administer social order and impose a discipline upon society. The nature of the 'problems' of social order change over time, but the essential necessity for control and administration of order does not. Social order was just as essential, if differently defined, after 1918 as it was in the previous century.

Within the three main spheres of concerns, there can be seen historical changes in the object and theories of causation of problems. But the overall function of community nursing as being in the 'front-line' in the struggle for social order remains a constant.

The fear of epidemics and social disorder

The occurrence of epidemics and the fear they engendered concerning contagion serve as an almost perfect metaphor for the fear of social disorder. Epidemics seemed to be the illustration of the vulnerability of all when confronted with the infection of the few. In order to both contain epidemics and to then prevent them recurring, a new and powerful role for the state in public health legislation was projected.

The first cholera epidemic in Britain occurred between 1831 and 1832. It was initially concentrated in the port areas of London, Liverpool, Bristol and then spread to Exeter and Birmingham. Newman (1939) estimates that this first outbreak caused about 50,000 deaths in a population of approximately 23 million. But as these were concentrated in areas of population density, the effect was devastating. The panic and ensuing riots associated with cholera outbreaks posed a problem of social order. Some of the worst riots occurred in the slum areas where the inhabitants were the most vulnerable. This led to the association of disease and social unrest, it also led to the connection between disease and an 'outsider' or excluded class. The worst rioting took place in the Irish 'ghettoes' such as the Seven Dials area of London (Wohl 1983). The policy of swift burial and cremation of the dead was the cause of the riots, people were frightened of the prospect of premature burial in unconsecrated ground and there was a suspicion that bodies were being used for anatomy lessons in medical training.

Cholera reappeared at intervals throughout the early and mid nineteenth century; in 1848, a severe outbreak in 1854, and in 1865. As we shall see, the later outbreaks of cholera mirrored the expansion of public health legislation and the involvement of local authorities in the provision of district nursing.

Another epidemic that was associated with Irish immigration and the overcrowded conditions of the slums was typhus. This was also known as 'gaol fever' and 'Irish fever'. If typhus appeared to be a disease of the slums and the socially excluded, typhoid attacked all classes even reaching to the Royal family causing the death of Prince Albert in 1861 and the near death of his son the Prince of Wales in 1871. Due to the low standard of water supplies to all institutions including Royal residences and public schools, typhoid was feared by all.

Influenza was probably one of the major killers of the poor. Child mortality was high for scarlet fever, over 95 per cent of all cases were children. Later in the century, diphtheria was a cause of high child mortality due to contaminated milk supplies. The incidence of diphtheria rose in the latter years of the century due to the increased proximity of children in the new schools. After 1880, the introduction of the school register was made in order to attempt to control infection in schools by means of notification and the isolation of affected children.

Smallpox also caused social unrest, but ironically this was primarily targeted against the prevention of the disease – vaccination. An epidemic in 1837 to 1840 prompted the passing of the first legislative moves to bring in compulsory vaccination of children in 1853. But it was always unpopular with many of the poor who viewed it with great suspicion (Smith 1979, Wohl 1983). Another epidemic in 1871 centred in London, prompted the Smallpox Act, legislation that supported compulsory vaccination with fines and imprisonment.

But probably the greatest scourge was tuberculosis, the 'white plague'. This affected all classes but was most prevalent in overcrowded urban working-class slum areas. Some occupations, such as tailoring, especially in the overcrowded conditions in the garment 'sweatshops', were especially vulnerable. By 1900, it was the second most common cause of all deaths.

The panic which surrounded periodic acute epidemics, and the fear of the long-term chronic diseases of poverty, also translated into the fear of contagion and contamination of 'madness' and degeneracy. Carpenter (1980), has placed the definitions of madness and insanity which underpinned the drive to build asylums during the latter years of the nineteenth century as a response of governmentality and the need to control. The fear of contagion and contamination spread from epidemics to definitions of madness and degeneracy. As sewers were built to clear away filth and waste, so asylums were erected to house the human 'waste'. Sewers and drains were the guiding metaphors for those who depicted the deviants of this time. 'Foul wretches' and 'moral filth' lay heaped in 'stagnant pools' about the streets. When they moved they were seen to 'ooze' in a great 'tide' (Pearson 1977:164).