Edited by Geoff Wilkinson and Margaret Miers

Power and Nursing Practice

Sociology and Nursing Practice Series

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Margaret Miers
Gender Issues and Nursing Practice

Sam Porter
Social Theory and Nursing Practice

Geoff Wilkinson and Margaret Miers (eds)
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Series Editors' Preface

It is widely accepted that because sociology can provide nurses with valuable and pertinent insights, it should be a constituent part of nursing's knowledge base. To take but a few substantive examples, sociology can help nurses to understand the causes and distribution of ill health, the experience of illness, the dynamics of health care encounters and the limitations and possibilities of professional care. Equally importantly, sociology's emphasis on critical reflection can encourage nurses to be more questioning and self-aware, thus helping them to provide flexible, non-discriminatory, client-centred care.

Unfortunately, while the aspiration of integrating sociology into nursing knowledge is easy enough to state in theory, in practice their relationship has not been as productive as some might have hoped. Notwithstanding a number of works that have successfully applied sociological tools to nursing problems, there remains a gulf between the two disciplines, which has led some to question the utility of the relationship.

On the one hand, sociologists, while taking an interest in nursing's occupational position, have not paid great attention to the actual work that nurses do. This is partially the result of the limitations of sociological surveillance. Nurses work in confidential, private and intimate settings with their clients, and sociologists' access to such settings is necessarily restricted. Moreover, nurses find it difficult to talk about their work, except to other nurses. As a result, core issues pertaining to nursing have been less than thoroughly treated in the sociological literature. There is thus a disjunction between what nurses require from sociology and what sociologists can provide.

On the other hand, nurses are on equally uncertain ground when they attempt to use sociology themselves. Nurses are often reliant on carefully simplified introductory texts, which, because of their broad remit, are often unable to provide an in-depth understanding of sociological insights. Nor is it simply a matter of knowledge; there are tensions between the outlooks of nursing

and of sociology. Because nursing work involves individual interactions, it is not surprising that when nurses turn to sociology, they turn to those elements that concentrate on microsocial interaction. While this is useful in so far as it goes, it does not provide nurses with knowledge of the restraints and enablements imposed upon individual actions by social structures.

The aim of the *Sociology and Nursing Practice* series is to bridge these gaps between the disciplines. The authors of the series are nurses or teachers of nurses and therefore have an intimate understanding of nursing work and an appreciation of the importance of individualised nursing care. Yet at the same time, they are committed to a sociological outlook that asserts the salience of wider social forces to the work of nurses. The texts apply sociological theories and concepts to practical aspects of nursing. They explore nursing care as part of the social world, showing how different approaches to understanding the relationship between the individual and society have implications for nursing practice. By concentrating on a specific aspect of sociology or nursing, each book is able to provide the reader with a deeper knowledge of those aspects of sociology most pertinent to their own area of work or study. We hope that the series will encourage nurses to analyse critically their practice and profession, and to develop their own contribution to health care.

Margaret Miers, Sam Porter and Geoff Wilkinson

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Geoff Wilkinson and Margaret Miers

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Introduction

Nursing is not a powerful profession. Nursing as an activity takes place in a context of power differentials and social inequalities. Nursing's form and relationships have evolved over time, and what we imagine nursing to be today is the consequence of varied and complex interactions in a number of spheres and at a number of levels. Its current location in a centrally administered welfare system exposes it to the vagaries of political will and economic change, which has a direct effect on the work nurses do and where and with whom they do it. This book derives from concern that student nurses are rarely introduced to ways of analysing power that derive from social theories despite a proliferation of articles on and interest in nurses' role in the empowerment of those for whom they care.

Nursing is not an activity that occurs in a vacuum. At work, nurses enter into relationships that span a wide sphere. There are power dynamics involved in relationships within nursing, often based on official hierarchies and on deeper, less immediately visible, social structures such as age, gender, ethnicity and ability. Power is involved in interactions with users of health services, be they constructed as patients, clients or service users, just as there is power at work in the construction and reconstruction of these labels, which, in turn, bring with them different care and treatment connotations. The construction of care and treatment regimes and settings is in itself evidence of power, in this instance the power that comes with knowledge, skills and attitudes: those of the professional practitioner.

Neither do nurses work in isolation from other occupational and professional groups, many of whom are also competing for, or maintaining, professional status and the rewards that come with it. Each of these groups works with its own model of health and illness; not all of the models necessarily happily co-exist, yet they are frequently simultaneously applied to the same territory – the body or mind of the patient/client. The patient herself can become the site of inter-professional rivalry and conflict, becoming simultaneously objectified and subjectified. These

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claims to the body and mind are made on a number of grounds ranging from medical to managerial. Nurses may find themselves in the role of negotiator or mediator in this contested space.

Relationships can stretch beyond the arena of health services. Many patients/clients have needs other than those directly related to 'illness'. Nurses will frequently become involved with social care agencies and their representatives. When the current structures of the mixed economy of care and quasi-markets (LeGrand and Bartlett 1993) and future possibilities for health action zones (DoH 1997a) are taken into consideration, the range of service providers expands to include, for example, voluntary and charitable bodies, community groups and workers, and housing associations. The potential for different ideologies to emerge and meet is again evident.

The foregoing may indeed be a pessimistic account, assuming as it does the existence of rivalry, struggle and conflict. The social world and the world of health care are perhaps grounded much more in consensus than has been indicated. Whichever the case may be, an understanding of sociological theories of power may be of help to nurses attempting to work within the changing structures, discourses and relationships of health care policy and practice. Such an understanding has certainly helped the contributors to this text as we worked together introducing students to social science-based approaches to understanding health and health care. Varied conceptual frameworks helped us explore the complexity of the changes we were (and are) experiencing in nurse education. Our own feelings of disempowerment as we sought to maintain support for our students despite declining resources and increased productivity enhanced our concern to explore approaches to understanding power. In our teaching, we selected theories of power and authority (notably those of Lukes 1974, and Weber 1948), chosen on the basis of what made most sense to us, theories that might help nurses to identify and work effectively within the power dynamics involved in policy changes and in professional practice (Aust *et al.* 1997).

This book is structured in four main parts. Part I concentrates on the conceptual analysis of power and professional power, drawing on sociological ideas and literature. Parts II, III and IV concentrate on exploring power issues in nursing, often illustrating the relevance of the analytical approaches introduced in

Chapters 1 and 2. The chapters in Part II look at power issues between nurses and within the nursing profession. Mowforth explores the relationship between gender, power and nursing, (Chapter 3) and the subtle effects of élitism within the profession (Chapter 4), arguing, among other things, that it can be useful to see nurses as an oppressed group. Miers (Chapter 5) looks at the positive and negative consequences of hierarchical structures and the qualities of leaders in care settings.

Part III looks at nurses in the health care team, focusing specifically on nurses as health care workers (Chapter 6), nurses' relationships with doctors (Chapter 7) and power issues in community care (Chapter 8). The importance of understanding labour market processes when trying to understand nurses' relatively subordinate position as workers is central to Miers' analysis of nurses' work. Porter also identifies changing patterns of work organisation as important in attempting to understand changing work relationships between nurses and doctors. The possibilities of nurses developing their roles and improving their status within health and social care teams are examined through an explicitly Foucauldian analysis of power in Chapter 8. Understanding professional models of care as discourses that can discipline or enable professionals, colleagues, teams and clients may help nurses to develop new roles in primary health and community care's contested space.

Nurses' relationships with clients are considered in the chapters in Part IV. These chapters concern a variety of settings and specialisms, and look at changes in health care practice that have developed through a concern to give service users more choice and more control. Chapters 10 and 14 both look at the movement of clients into the community, with some pessimism. Chapter 11 looks at changes in the practice of administering medicines as a means of giving power back to children and their carers. Chapter 13 explores issues in relation to involving clients in decision making. Both these chapters seek to identify whether and how nurses might be able to 'make a difference' through their care, focusing on Giddens' (1984) analysis of power in structuration theory, on Lukes' (1974) analysis of three faces of power and on the discursive power of knowledge and practices (see Chapter 1). Chapters 9 and 12 seek to develop readers' understanding of the inequalities faced by older persons, gay men and lesbians as service

users, and the structural origins of discriminatory practices. Thomas (Chapter 9) and Godfrey (Chapter 12) are optimistic about nurses' potential to care within a philosophy of anti-discriminatory practice. Godsell (Chapter 14) and Fraher and Limpinnian (Chapter 10) see changes in our understanding of professional authority as necessary for the empowerment of users of mental health and learning disabilities services.

One of the aims of the *Sociology and Nursing Practice* series is to encourage the interchange of ideas between nurses and sociologists. Whereas all contributors to this volume are nurses, the authors have varied responsibilities for teaching sociology to health care practitioners and other students. Some authors have drawn heavily on the sociological literature about power and about nursing, while others have focused on exploring and explaining the effect of the social context on power dynamics in health care, drawing on policy and health literature as much as on sociology. The conclusion reflects on the potential of the interchange for nurses, sociologists and health care practice.

PART I

Understanding power

1 Theories of power

Geoff Wilkinson

Introduction

Power is an essentially contested concept. There is a range and diversity of interpretations of what is meant by power. This chapter will outline the main arguments from a variety of perspectives and identify their main elements.

Theories of power

It is usual to distinguish two forms of power: authority and coercion. When the exercise of power is accepted as legitimate by those upon whom it is exercised, it is regarded as authority. However, when its exercise is not accepted as legitimate, it is seen as coercion. It is, of course, not so clear cut, since it can be argued that both are ultimately based on the use of physical force. The nature of nursing care places a responsibility on nurses to reflect on the difference as well as the close relationship between authority and coercion.

Weberian approach

Giddens (1971) describes Weber's definition of power as 'the probability that an actor will be able to realise his own objectives even against opposition from others with whom he is in a social relationship' (p. 156). In Haralambos and Holborn (1991), the translation is slightly different. Power is 'the chance of a man or a number of men to realise their own will in a communal action even against the resistance of others who are participating in the action' (pp. 117–18). Putting aside the inherent sexism, Weber is arguing that power is evident when one party gets his or her own way,

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despite opposition. Thus power is evident when one party achieves its will over another. This may occur through coercion or submission to domination, but more frequently through authority.

Weber (1948) also addressed the issue of authority and identified three ideal types: charismatic authority, in which an individual's personal qualities are such that they engender admiration and loyalty (he cites Alexander the Great, Napoleon Bonaparte and Jesus Christ as examples); traditional authority, which is based on the 'rightness' of established practices and loyalty, and is grounded in obligation (the feudal system serves as an illustration); and rational-legal authority, which is based on impersonal rules frequently supported by a legal framework (the legal and military systems are examples, as is bureaucracy). Weber accepts that there are no perfect examples of these ideal types. Chapter 11 makes use of Weber's types of authority to look at power issues in caring for children. Whereas the traditional authority of doctors may inhibit the acceptance of nurses' autonomy in professional practice, rational-legal authority, through specialist education for children's nursing, helps to promote the power of registered nurses.

Inherent in Weber's definition is the assumption that power is held only at the expense of others because there is only so much to go around. This view of power has been described as the 'constant sum' concept of power. The other significant point that Weber makes is that those who hold power use it to their own ends.

Radical approaches

Lukes (1974) suggests that Weber's analysis is too narrow and postulates, in a radical argument, that power has three dimensions, or faces. The first face is in general agreement with Weber in that power can be detected when issues are settled in favour of one group over another. Lukes goes further and, drawing on the work of Bachrach and Baratz (1962); makes a case for a second face of power, arguing that power can be detected in non-decision making. Power can be exercised to keep items off the agenda and is therefore used to keep decision making in the arena controlled by the powerful. Thus power is used to limit discussion, the range of alternative actions available is constrained, and

decisions taken therefore remain under the control of the powerful actors such as the professionals and managers involved in decision making in health care.

Lukes (1974) then offers a third dimension or face, arguing that powerful individuals and groups are able to manipulate the wishes and desires of others who can be persuaded to accept things that may even be harmful to them. From this point of view, he would be in general agreement with a feminist stance that exposes the damaging effects of patriarchy on women and children. Expectations concerning women's dress, for example, may serve the interests of men who have financial control over the fashion market. Images of nurses as sexy, available and desirable can offer nurses the attraction of attention while denying them a role in health care decision making. The Marxist analysis of the harm done to the proletariat by the forms of organisation of capitalist societies, through the development of false class consciousness, is another example that supports the proposed third face.

Workers may view increased material wealth as a symbol of higher class status, failing to recognise continuing exploitation under relationships of private property. Illich's (1977) notion of cultural iatrogenesis, whereby cultural acceptance of medicine's role leads to dependency on professional care, is a health-related example of the third face.

The theories examined so far accept two important points in Weber's definition: first, that power is held at the expense of others (the 'constant sum' concept); and second, those who hold power use it in their own interests.

Functionalist approaches

Functionalists would generally disagree with both of these propositions. Functionalism suggests that social actions and institutions are capable of being understood by identifying their function, that is, their contribution to the maintenance of the social system as a whole. Power is a resource held by individuals and groups in relation to the importance of their activities to society's collective goals. Parsons (1951) rejects the constant sum concept, seeing power as a 'generalised resource' possessed by the whole society. He proposes an alternative 'variable sum' concept,

arguing that power increases in a society the more that a society achieves its desired communal ends. Increased productivity, for example, will create greater profits, leading to a higher standard of living, so everybody is more powerful. This equation can, of course, work the other way, and the effects of reduced productivity would ultimately lead to loss of power to that society and its members. It is for this reason that Parson calls it the 'variable sum' concept. In a period of recession and consequent political responses to contain NHS costs, for example, the enhancement of the managers' role in controlling costs, the reduction in the number of qualified nurses and the rise in the number of health care assistants can be seen as part of an overall reduction in the power of the professionals most closely associated with the NHS – doctors and nurses.

Parsons applies the variable sum concept to political power in a democracy, suggesting that political power is invested in the ballot box. At an election, politicians gain or lose votes depending upon how successful, or otherwise, they have been in achieving the ends of the electorate. Parsons is criticised on the grounds of offering a naïve, uncritical and apologist description that has sociologically rationalised power holders' own justification for holding power and also for failing to recognise the exercise of power to further the interests of some at a cost to others.

Pluralist approaches

Pluralists (see Chapter 4) also offer explanations of the distribution of power in Western democratic societies. There are two schools of pluralist thought: classical and élite. The latter emerged in response to criticisms of the former.

Classical pluralism sees Western democracies as the most advanced forms of government yet devised and holds that the exercise of power by the state is legitimate because governments act in accord with the wishes of the population from whom political power is ultimately derived. In this, they are in general accord with Parsons. However, they differ in a number of ways. The 'variable sum' concept is rejected in favour of Weber's constant sum; the notion of political representation based on a social value consensus is not accepted, and, following from this,

the role of the state is perceived as one of being an honest broker between a range of competing interests. The state is not seen as able to represent consensus since pluralists deny that value consensus can exist. Government is the business of compromise and mediation between different interests.

Criticisms of classical pluralism mirror, to some extent, those applied to functionalist approaches. By not acknowledging the possibility of the second and third faces, pluralists maintain the illusion of power as a widely distributed social resource, confirming a belief in democratic systems while simultaneously concealing the real bases of power from scrutiny and thereby protecting the powerful. Concealment of the third dimension creates a 'false class consciousness', which disguises the real interests of the population from itself, perpetuating the political system in the interests of the powerful. As a consequence of these and other criticisms, classical pluralism was reappraised and re-emerged as élite pluralism. Any pluralist standpoint on the nature and development of the NHS in Britain would acknowledge that, however popular the idea of a service free at the point of use, the actual form of service adopted is always a compromise between different interests, notably those of consultants, GPs, the government, health service managers and (considerably less importantly) unions and professional organisations representing other health care workers.

Elite pluralism is similar to its precursor, classical pluralism, in that it sees Western government as democratic and therefore superior to pre-existing forms, and believes that power is widely dispersed in the population and that government is essentially the process of compromise. It parts company in a number of significant ways, particularly in its analysis of the distribution of power, which it concludes is held unequally. It accepts that well-organised groups can exert control over the agenda, allowing élites to be the main decision makers in society. (Elitism in nursing is discussed in Chapter 4.) It thus incorporates the second face of power and also acknowledges the possibility of some not being represented, albeit temporarily, and others not being politically active. While this may be regarded as progress in our understanding of power in society, there are still a number of faults with the arguments. The main fracture is that, in accepting the possibility of democracies as faulty, the underlying tenet of classical pluralism, that power is

widespread in society, is exposed to doubt. In addition to this, the uncritical acceptance of élites as essentially functional to society does not allow for the consideration of their *use* of power, particularly in relation to furthering their own ends. Finally, the existence of the third face of power and the possibility of shaping desires is not entertained.

It can be argued that, with the exception of Lukes (1974) and Weber, these structural approaches to the analysis of power have been revealed as essentially functionalist. Other structural approaches, particularly Marxist/conflict approaches, should not be ignored. On the whole, these perspectives adopt a very different stance from those preceding them and, as will be demonstrated, can be numbered among the most trenchant critics of consensus approaches.

Marxist approaches

In general, Marxist/conflict approaches see power as being concentrated in the hands of minorities and used by them to further their own interests. The different interests of different groups are among the sources of potential conflict. The assumption of power being independently invested in the state is disputed; instead, it arises specifically from control over, or access to, economic resources. Marxists argue that the exercise of this power is essentially coercive because the subject class, the proletariat, submits to a situation that is against its best interests. The power of the bourgeoisie extends from the infrastructure, the economic base, and penetrates the superstructure, which includes politics and culture. Consequently, the state reflects the distribution of power in society. In this account, it is inevitable that the decisions of the state will favour the ruling class to the detriment of the general population.

On the face of it, this is quite straightforward but, inevitably, writers from this background find themselves in conflict. To illustrate this, the contrasting positions of Miliband (1969) and Poulantzas (1978), both writing in the Marxist tradition, will be described.

Miliband proposes an instrumentalist view, that is, a view that regards the state as an instrument (or tool) of the bourgeoisie. He

argues that power is derived from wealth. The instrument of the state is used to preserve economic dominance, maintain political power and stabilise capitalist society in the interests of the economically powerful, that is, the bourgeoisie. This, in Miliband's analysis, is achieved because the state is run by a number of élites that act together to serve the interests of capital and private property. As evidence to support this contention, Miliband offers the following: élite positions are held by the bourgeoisie, which is bound together by kinship, educational background and interests; many originate from upper- or upper-middle class families; the majority attended public schools and Oxbridge; thus all of them have been socialised into the ruling class. Miliband argues that socially mobile members of élites who have gained access from the working class have adopted the values, mores and manners of the bourgeoisie. Governmental power is accepted by the proletariat because the bourgeoisie are able to manipulate their wishes and desires through processes such as advertising, which promotes the view that happiness derives from the material benefits of economic success. Adverts for medicines to relieve pain, indigestion, coughs and colds are promoting pharmaceutical interests rather than the health and welfare of the population. The third face of power perpetuates the *status quo*.

In this analysis, instrumental individual human agency shapes and moulds the superstructure to the benefit of the powerful. Poulantzas (1978) offers a different perspective, one that minimises the effects of agency and re-emphasises the importance of social structure. In Poulantzas' view, the state is vital to the stability and maintenance of capitalism and *automatically* serves ruling class interests. Elites are irrelevant to his analysis because the capitalist system in itself is sufficient to ensure that the interests of the ruling class are served. This also has the benefit of making the state and the bourgeoisie appear relatively autonomous. Neither does Poulantzas agree with Miliband about the mechanisms of legitimation, although he acknowledges the vital role of aspects of culture. In Poulantzas' scenario, legitimation is tied directly to the state via its control of the repressive and ideological state apparatus. The former is related to coercive power and includes the government, armed forces, police, courts and tribunals. The latter includes religion, political parties, unions, schools, media and the family, and is more concerned with the manipulation of beliefs and values. Political ideologies such as liber-

alism, individualism and socialism can all affect the development of health service policy and thereby affect nursing. The dominance of biomedical models of health and health care can also play a role in social control and in the control of nursing.

Miliband responds to this view of legitimation by accusing Poulantzas of 'structural super-determinism', arguing that the infrastructure is not sufficiently powerful to determine all human behaviour and that there is little evidence to support this assertion. Both Miliband and Poulantzas, however, largely agree that it is in the power of the infrastructure to mould the superstructure; only the mechanisms are disputed.

Neo-Marxist approaches

Gramsci (1971), while not disputing the importance of the infrastructure, at least as the background against which social relations are acted out, denied its significance in relation to the superstructure. He also differed from Marx in his view of the state, arguing that it is composed of a dominant class constituted through compromise and negotiation rather than in terms of institutions. He was also dubious about the power of economic determinism, to the point of rejecting it.

In Gramsci's analysis, the superstructure is composed of two elements – political and civil society. Political society holds the monopoly on the use of coercive mechanisms such as the army, police and judicial system, whereas civil society is primarily institutions such as the Church, trades unions and political parties. The state is defined in terms of the activities of dominant classes rather than in terms of institutions created for them. Central to Gramsci's description of power is the idea of hegemony, which denotes general and intellectual dominance and implies an acceptance of dominant ideas. Dominant groups gain control through gaining active acceptance and approval of their ideas by articulating shared interests between dominated and dominating groups. The ruling class is prepared to compromise, both in its own interests and in those of the subordinate class. Hegemony is essentially power gained through the generation and acceptance of ideas by the ruling groups and the acceptance of these ideas by the ruled as a compromise to maintain the stability of the social order.