An Ethnographic Study of the Organisation of District Nurses' Work

Thesis submitted in accordance with the requirements of the University of Liverpool for the Degree of Doctor of Philosophy by

Shaun Speed
February 2003

TEXT BOUND CLOSE TO THE SPINE IN THE ORIGINAL THESIS

IMAGING SERVICES NORTH
Boston Spa, Wetherby
West Yorkshire, LS23 7BQ
www.bl.uk

CONTAINS PULLOUT

Speed S (2003) An Ethnographic Study of the Organisation of District Nurses' Work.

The aims of this study were to examine how the changes in the organisation of NHS Primary Care Services have affected the work of district nurses and to assess what organisational and cultural factors influenced their work.

Thirty two district nurses were voluntarily recruited from four study sites in the North West of England. Participant observation and polyphonic interviewing techniques were the chosen methodology for the study Over 300 hours of non-participant observation and 40 non-directive interviews provided the raw data for this study. The data were analysed using a modified version of grounded theory which was combined with Foucauldian recommendations for the study of power in organisations.

The findings suggest that district nursing is in a state of flux. Data are presented on the traditional organisation of district nursing work and are juxtaposed with recent changes that had impacted on district nursing practice. The data illustrate that the change process in district nursing work had occurred at a variable rate among the participants of the study. This had implications for the delivery of equitable district nursing care. One consequence of this variability in service provision was the concerted effort employed by managers to gain tighter control of district nurses' work through both overt and covert methods of surveillance and discipline. This increased surveillance manifested in a re-organisation of district nurses' work that had increasingly involved them in rationing their services as they sought to manage the tight financial control over their work. There was also considerable evidence to suggest that district nursing services were increasingly being organised in a post-fordist manner. The trend was towards flexible working patterns, with district nurses being the most malleable member of the Primary Health Care Team The final findings chapter captures the terse and sometimes fraught relationship that district nurses had with their General Practitioner colleagues in the era post fundholding and leading up to the formation of Primary Care Groups.

The findings have implications for the future of Primary Care Services. It is suggested that district nurses are entering the newest phase of the re-organisation of primary care with significant resistance and suspicion which may very well inhibit the pursuit of flexible and effective team working in the future.

Acknowledgements

I would like to acknowledge the following people for their support in completing this thesis. Firstly, Professor Karen Luker for her continued support and excellent academic supervision. She kept me focussed during the course of this study and her faith in my abilities have given me strength and determination. Thanks also go to Dr Ann Caress for proof reading an earlier version of this thesis.

An overwhelming vote of thanks belongs to the women who volunteered to take part in this study. I was astounded by their honesty and commitment during the course of this study as they made this thesis a collaborative effort.

On a personal level, I would like to acknowledge the support of my friends Anita, Gareth, my godson Jake, Mike, Linda and Lin for leaving me alone when I needed to be alone and for being there when I need them.

I would like to acknowledge the support of my mother Mary, who taught me both how to care and to be cared for. For the last years she has needed more than ever and has made less demands on my time. Thanks.

Finally, to my partner Iain Mc Intosh – he knows the story of this thesis and the effects it has had on my (our) life more than anyone. His support for my endeavours has been beyond the call of duty.

Declaration

This thesis is the result of my own work. The material contained within the thesis has not been presented, either wholly or in part for any other degree or qualification.

Table of Contents

Abstract i

Acknowledgements ii

Declaration iii

Chapter 1: Introduction and Organisation of the Thesis

Introduction 1

Background to the Study 1

The Organisation of this Thesis 3

Chapter 2: The Historical and Policy Context of District Nurses' Work

District Nursing – An Eccentric Service 5

District Nurses and the National Health Service 8

The Battle for Training 9

An Invisible Service 11

Towards Community Care 12

The Time for Change 14

A Failing Service? 17

To Market 19

The "New" Community Care 20

The Re-Organisation of Roles in Primary Care 22

District Nursing and the Change Process 23

A New Training 25

A New "Organisation" 26

Summary 29

Chapter 3: The Research Base for District Nursing and District Nurses' Work

District Nursing Work – A Basic Service? **31**

District Nursing Education **37**

District Nurses as Educators **39**

Intra-Professional Teamwork and District Nursing **46**

Inter-Professional Relationships **52**

Summary **58**

Chapter 4: The Theoretical Underpinnings of Ethnographic Studies

From Quantity to Quality – Research Paradigms and the quest for knowledge **60**

Cartesian Naïve Realism **61**

Qualitative Paradigms **62**

Positivism and Ethnography – The Early Years **65**

Post-Positivism or Critical Realist Ethnography **66**

Critical Theory and Ethnography **68**

A Critique of Contemporary Ethnography **70**

Post-Modernism and Research Methodology **73**

Post-Modernism, Post-Fordism and the Understanding of Organisations **76**

Summary **78**

Chapter 5 – Working Methods

Introduction **79**

Personal Biography **80**

The Research Question **82**

The Research Process **83**

Getting In **84**

Choice of Study Sites **84**

Gaining Access **86**

Ethical Considerations **88**

Recruiting Participants **89**

The Characteristics of Participants **90**

Site 1 – Area 1 **91**

Site 2 – Area 2 **91**

Site 2 – Area 3 **92**

Site 2 – Area 4 **92**

Gaining Trust and Rapport **92**

Confidentiality **93**

Methods of Data Collection **96**

Participant Observation **96**

In the Field **96**

The Collection of Observational Data **98**

Field Notes **99**

Recording Observational Data **101**

Writing Up Field Notes **103**

Interviewing 104

The Decision to Interview 105

The Interview Process 106

Preparation for the Interview 107

The Interview 108

Transcribing the Tapes 111

Analysis of Observation and Interview Data 112

Open Coding 113

Constant Comparisons 115

Theoretical Notes 117

Themes 118

The Decision to Stop Data Collection 118

Re-forming the Data – Writing the Text 120

Presenting the Data 123

Conclusions – Academic Rigour 125

Chapter 6 – Findings

Introduction **131**

Habitual Nursing – Acting Down, Filling In or Saving the Day **132**

Isolated Work **138**

Dependent Patients **139**

Being Sure **142**

Idiosyncratic Care **144**

Moving On – Knowing the Patient **151**

Knowing About **159**

Knowing by Proxy **160**

New Skills **164**

Defining Skills **165**

Summary **168**

Chapter 7 – Findings

Introduction **170**

Organising District Nursing – Bringing Them In From the Cold **170**

Gaining Tight Control **174**

Being Watched – Wrong Place, Wrong Time **178**

Being Watched **181**

Challenging Autonomy **184**

Watching Your Back **188**

Indirect Supervision **192**

Summary **203**

Chapter 8 – Findings

Introduction **205**

"You Cost Too Much" **205**

The Threat of Regrading **210**

Clinical Effectiveness **212**

The Mechanics of Rationing **214**

Local Level Approaches to Rationing **214**

Flexibility **215**

Mixed Reactions **220**

Colliding Philosophies **225**

Rationing by Discretion **232**

Setting the Agenda **232**

Focussing the Patient **238**

Managing Care **239**

Providing Care **242**

On the Cusp **251**

Keeping the Patient On **254**

Breaking the Rules **257**

Bending the Rules **259**

Chapter 9 – Findings

Introduction **263**

Reluctant Inclusion **263**

Being Visible **263**

Visible but on the Edge **266**

The Contrary Experience – Salaried GPs **269**

Overt Exclusion 271

Distrust 273

Who Owns Whom? 276

Group Meetings 278

Doctor Nurse Communication 284

Compulsory Referrals 287

"Doing What They Want Us To Do" 294

Getting a Visit 297

Complaints 305

Forms of Resistance 311

Bargaining 311

Regrouping 312

Working the Contract 315

Breaking Through 315

Confrontation 321

Resistance Through Expertise 324

Summary 327

Chapter 10 – Overview of Methods and Discussion

Introduction 329

Section 1 - Strengths of the Methods 329

Limitations of the Methods 337

Section 2 – Discussion 343

Opportunities for Further Research 361

Conclusion 363

References 364

Appendices

Appendix 1 - Literature Review Summary

Appendix 2 - Information for Area Coordinators of Research

Appendix 3 - Information about the Project for Participants

Appendix 4 - Example of Field Notes

Appendix 5 - Letter to Participants About Interviewing

Appendix 6 - Extract from and Interview

Appendix 7 - Example of Open Coding

Appendix 8 - Example of Axial Coding/Theoretical Notes

List of Figures

Figure 1 District Nursing as a Peripheral Member of the Flexible Firm 348

Figure 2 District Nursing as a Core Group In the Flexible Firm 352

Chapter 1 – Introduction and Organisation of the Thesis

Introduction

Work in the NHS Primary care services, has in recent times, undergone unprecedented change. This is particularly true for district nurses (Griffiths 1996; Goodman 1998; Mc Intosh et al 2000). The introduction of the GP fundholding scheme (DoH 1990) and later the move towards Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) has meant that the configuration of primary care organisations has been the focus of Government attention throughout the last decade of the twentieth century (DoH 1990; 1992; 1994; 1996a; 1996b; 1997; 1999). With few exceptions (see for example Griffiths 1996; Goodman 1998; Mc Intosh et al 2000) little is known about the structure, organisation and experience of district nursing particularly in the light of the immense changes that have occurred in primary care (Goodman 1998). It is against this backdrop that this study is framed.

Background to undertaking this study

This study began out of an interest I had developed in the work of district nurses. At the outset of this study, I was a Clinical Nurse Specialist working in the community with people affected by drug use, HIV and AIDS. I implemented a system of clinical supervision within my own unit, which was received well by all staff. Following a successful evaluation of the supervision project, I was asked by the Trust to be a part of a practitioner based working party to look at the implementation of clinical supervision across the whole of

the nursing workforce employed by the Community Unit. This included district nurses. It was at this forum that I first encountered district nurses as a collective nursing group. I was shocked by the effect the changes in the organisation of Primary Care was having on their working life. I was even more bewildered by the scepticism with which they viewed the process of clinical supervision. I had already, at this time, made an informal application and proposal for post-graduate study to look at the implementation of clinical supervision in the community.

In view of the observations I had made and through discussion with a Professor of Community Nursing, I arrived at the realisation that it would be more frugal to look first at the culture of district nursing with the aim of understanding the effect of the changes in the organisation of primary health care on their work and working lives. Thus in the spirit of qualitative research (and in line with the belief I have in field based research which I had developed through my training in sociology) I arrived at two broad aims which guided the study:-

1. How are the changes in the organisation of Primary Care affecting the work of district nurses?
2. What organisational factors influence the work and culture of district nursing?

These aims are in keeping with those that would constitute an examination of culture which would best be realised using an ethnographic approach.

The Organisation of this Thesis

This chapter gives the reader a brief introduction to the purpose of this study. In chapter 2, I have summarised both the historical factors and the policy directives that have influenced the work of district nurses. In chapter 3, I present a review of the literature which has reported on varying aspects of district nurses' work. An appraisal of this work appears in appendix 1. It is important for the reader to understand that the material included in these two chapters was gathered and collated after ***all*** of the data presented in this study were collected and written in a draft form. Although these chapters precede and may even pre-empt some of the findings presented later in this thesis, their function is to introduce and familiarise the reader with the political and organisational milieu, which is the stage on which the findings and conclusions of this study are framed.

Chapter 4 presents a theoretical description of the influences on contemporary ethnography, as a social research method. This is to enable the reader to understand the philosophical debates that have influenced the conduct of this study. In particular, this chapter will draw together the post-modern and post-fordist theoretical work that has been used extensively throughout this thesis. Whilst chapter 4 is concerned with the epistemological underpinnings of the research process, in chapter 5 I have provided a description and critical discussion of the methods I employed during the course of the study. Above all, I have aimed to provide the reader with an audit trail of the decisions that have led to the presentation of the findings in

this thesis. It is on the quality of this information that I believe this study can be judged.

Chapter 6 through to 9 present the findings of the study. It is here that the data from this exploration of district nurses' work are presented alongside other research findings (secured through literature reviews of emerging themes and concepts) which either complement or contrast with the findings presented in this thesis. Chapter 10 discusses and evaluates both the methods employed in this study and the findings and makes recommendations for further research.

Chapter 2 – The Historical and Policy Context of District Nurses' Work

District Nursing – An Eccentric Service

The Oxford English Dictionary defines eccentric as "not placed, not having an axis placed centrally ... differing from the usual" (Oxford English Dictionary, 1992). This definition can be applied, with accuracy, to the history and corresponding organisational structure of district nursing services in relation to the wider nursing workforce of the British NHS.

District or home nurses have throughout their history struggled for recognition and acceptance as a separate discipline within nursing. It is generally recognised that district nursing proper began with an experiment initiated by William Rathbone (1810 – 1902) in Liverpool. Indeed it is acknowledged that:-

> "The story of trained district nursing began a hundred years ago in Liverpool. It was there that the conception of district nurse training evolved. To Liverpool came those who wished to learn; from Liverpool went forth those who felt the urge to teach ... they worked in harsh surroundings and under stern discipline. They were the pioneers of trained district nursing." (Stocks 1960 p215).

The Liverpool School set to recruit and train women of good character and honest disposition to work in the homes of the needy and deserving poor (Stocks 1960; Baly 1980; Rafferty 1996a).

The early preparation for district nursing recruits has been recorded as being arduous and gruelling (Stocks 1960; Baly 1980; Mc Intosh 1985). The strong military and religious influences on early nursing services required that women learned obedience and 'discipline' (Foucault 1977) alongside nursing skills (Abel-Smith 1979; Girvin 1996). The discipline involved in the training of district nurses aimed to convert domestic servants into nurses of good character (Abel-Smith 1979; Rafferty 1996b). It was noted that the aim of the training was to ensure that: -

> "moral rather than technical attributes of nurses were singled out for criticism" (Rafferty 1996b, p190)

Home nurses' obedience was secured to the largely middle/upper class women Superintendents who examined and scrutinised their work. Whilst the supervising 'ladies' often enjoyed kudos and social standing for their endeavours, practising district nurses were forced to work long hours and to live in the areas where they worked - a condition similar to that of the domestic servants of the time (Abel-Smith 1979; Stocks 1960).

It is suggested in the literature that the early professionalisation of nurses benefited, to a great extent, those middle class women who were comparatively privileged already. Despite their almost despotic rule over district nurses (Stocks 1960) it is generally accepted that the patronage of these well-to-do ladies was significant in protecting the early district nursing service from domination by medical men (Stocks 1960; Baly 1980).

During the early deployment of district nurses they were funded, organised and trained by charitable organisations (Stocks 1960; Mc Intosh 1985). For many practitioners this meant that they functioned both outside and largely independent of the medical referral system (Baly 1980; Mc Intosh 1985). One consequence of this was that district nurses' early work was visible only to those concerned enough to find out about it or by those who received it. A positive effect of this was that district nursing could and did develop in ways that were appropriate for the communities in which they worked and served (Abel-Smith 1979; Baly 1980). In today's parlance – this could be described as a "needs led" or "responsive" service (Mc Intosh 1985; Rafferty 1996a; 1996b).

Kratz (1982) argued that these early historical factors and the lack of direct allegiance to any medical authority gave rise to the ethos of care and holism that has characterised district nursing services throughout their history. Whilst Kratz's argument may have some validity, the lack of visibility of district nursing work and its eccentric position in relation to mainstream hospital care resulted in the marginality of community nursing services (Mc Intosh 1985). This fact, associated with a general attitude of medical disdain for any services provided outside the growing hospital sector, produced a situation in which community nursing services were seen as less important than the services provided in hospitals (Rafferty 1996a)

The eccentric status of district nurses has been repeatedly highlighted. Hicks (1976) suggested that since the early part of the 20th century, primary care

has been marginalised by acute care services and has been seen as "softer" element of British health care provision. Historians of nursing have chronicled the struggle that district nurses have had in defining and establishing their profession in relation to medical services (Baly 1980; Mc Intosh 1985; Rafferty 1996a). Important in this struggle has been the battle for recognition and status whilst resisting professional domination by medical services (Stocks 1960; Rafferty 1996a). This battle was fought long and hard by the pioneers of district nursing services and in particular by the Queens Nursing Institute who were integral to the development of the district nursing profession. The affiliation of district nursing with charitable organisations meant that the profession was structurally located outside the main stream of health care provision until the formation of the British NHS.

District Nurses and the National Health Service

The National Health Service Act of 1946 gave only partial support to district nursing services and their inclusion in the newly formed Health Service: -

> "It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by these of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own homes" (Cited in Hicks 1976, p300)

Mc Intosh (1985) argues that the upshot of the formation of the NHS was that district nursing services became vested into the domain of the medical officer of health. A consequence of this was that district nursing services had to

compete for funds and support alongside other health and welfare services. More importantly, it was at this time that district nursing services came to be influenced by the medical profession, losing their relatively autonomous status, perhaps as some have suggested, to the detriment of the profession (Mc Intosh 1985; Goodman 1998).

It is posited that the inclusion of district nurses into the NHS dispossessed the profession and their leaders of their collective, albeit eccentric voice (Mc Intosh 1985; White 1985; Ross 1987; Goodman 1998). The result of the formation of the NHS was disparity and fragmentation of district nursing services across and between Local Authorities (Hicks 1976; Abel-Smith 1979). Some Local Authorities took over the management of district nurses whilst others continued to contract with the well established voluntary and charitable district nursing associations (Hicks 1976; Abel-Smith 1979; Mc Intosh 1985). This effectively fragmented a previously centrally managed and essentially coherent service. Thus, the self-regulation of district nursing services, as a profession within a profession which was secured through many years of struggle, was to some degree negated by the 1949 Nurses Act (Goodman 1998).

The Battle for Training

The battle for recognition of district nursing as a distinct discipline characterised the early part of the twentieth century. Correspondingly, the struggle for control and recognition of district nurse training has characterised

much of the latter part of the last century. Prior to the 1949 Nurses' Act, the Queens Nursing Institute had a near monopoly over the training of district nurses, a monopoly that they wished to retain (White 1985). Their endeavours failed even though the struggle was undertaken with vehemence and passion (Abel-Smith 1979; Baly 1980; White 1985). White (1985) suggests that the two opposing parties were the Queens Nursing Institute and the Department of Health. On the one hand, the Institute were fighting to protect the skills and training they saw as essential to convert hospital nurses into home nurses. The Department of Health on the other hand, were concerned to produce as many home nurses as was feasible in the shortest time possible. Stocks (1960) reported that the district nursing organisations effectively lost their fight when the recommendations of the Majority Report (Ministry of Health 1955) opted for a shortened four-month course.

The organisation that had controlled and overseen the training and administration of district nurses for so many years were "punished for the obduracy" when the Ministry refused to appoint them as the central body to control the training of district nurses (White 1985; Mc Intosh 1985). The consequence of this was that district nurses lost their specialist status and were awarded a salary less than that of their hospital based counterparts (White 1985).

The result of the above changes to the training and co-ordination of district nurses has contributed to the political marginality of the profession (Mc Intosh 1985; Griffiths 1996; Goodman 1998). This marginality was also related to

their separation from the high status hospital system (Mc Intosh 1985; Rafferty 1996a; 1996b). Furthermore district nurses' and their managers have been systematically excluded from decision-making forums (Mc Intosh 1985; Goodman 1998). District nursing work was consequently marginalised by mainstream services and seen as "basic" rather than complex when compared with hospital care (White 1985; Mc Intosh 1985; 1996; Griffiths 1996). The political and structural odds have been stacked against district nurses (White 1985; Mc Intosh 1985; Goodman 1998).

An Invisible Service

The upshot and influence of the political machinations outlined above has been that district nurses' work has remained largely invisible in the wider context of the NHS (Luker and Kenrick 1992; Kenrick and Luker 1995; Griffiths 1996; Mc Intosh 1996; Goodman 1998) particularly when compared to hospital nurses and even their colleagues in the community, for example, health visitors (White 1985; Mc Intosh 1996). The complex nature and experiential knowledge accrued by the profession has been overlooked and discredited in the recent history of the NHS (Luker and Kenrick 1992; Mc Intosh 1996; Griffiths 1996). This has led some commentators to make the point that it may well be who district nurses have traditionally cared for in the course of their work that has contributed to their peripheral status. It is the poor and disenfranchised in the community who are the main stay of district nurses' work (Griffiths 1996; Goodman 1998).

A more coherent argument is that the policy drift associated with the organisation of district nurses' work has failed to encompass and recognise the complexities of the care that professionally trained district nurses provide (Mc Intosh 1985; Ross 1987). This has resulted in the political marginality or eccentricity of district nurses from the wider professional landscape of nursing (Mc Intosh 1985; 1996).

In summary, there is a wealth of opinion to suggest that district nursing has been disenfranchised, dislocated and disembodied from the main nursing body. This politically eccentric position began with the inception of district nursing services (when an eccentric position was perhaps desirable and even necessary to achieve their aims) until the 1970's when renewed interest in the community and community care began to gain political interest.

Towards Community Care

It is commonly assumed by some commentators that community care began in the late 1970's and early 80's (Griffiths 1996; Goodman 1998). In fact the ideological shift from institutional care to community care began with Enoch Powell's radical plans for a 15-year programme of hospital bed closures formulated in 1962 (Dalley 1993). Successive Labour and Conservative governments reinforced the notion of community, emphasising the primacy of family care in the home (DHSS 1981a). The Ideological shift to right wing thinking and personal responsibility is encompassed in the oft cited quote: -

> "care in the community must increasingly mean care by the community" (DHSS 1981b, p5).

The Mayston report (DHSS 1969) highlighted that community nursing services were poorly organised and essentially advocated for greater control and organisation of district nursing services to meet the new agenda of care in and by the community. In particular, a Salmon (MoH 1966) type managerial structure was implemented in the community to organise the diffuse nursing workforce. Mc Intosh (1985) argued that these recommendations were adopted with a degree of "urgency" rather than forethought or planning, as a major reorganisation of healthcare services was imminent which was to affect district nursing greatly.

The 1970's saw an ideological policy shift from secondary to primary or community care (DHSS 1976: 1977; 1981a). There were recommendations that certain groups of people such as the elderly could be better cared for by community health and social services than by hospital services (DHSS 1981b). Associated with this, was the notion that community nurses should take on more of a preventative (rather than treatment only approach) to their work thereby decreasing the load on acute hospital services. A pragmatic reading of the 1970's and early 80's legislation suggests that community care was chosen as a valid option to hospital care as it was thought to be cheaper than the established routine of health care delivery (Ross 1987; Wilson 2000). A discourse of economics was existent at this time and framed the development and organisation of the NHS.

In the case of district nursing and the development of community care policies, Ross (1987) identified three barriers to a change in practice. Firstly, the powerful professional self-interest of both the hospital and residential sectors collectively resisted a reduction in their services in favour of increased community care. Secondly the structural separation between health and social services care inhibited effective planning and liaison. Thirdly, the finances available for community and social care had been reduced. It seemed that early attempts at community care were destined to fail.

These anomalies and potential barriers to the re-organised NHS came to light during a period when the Government were intent on re-organising the NHS into a more rational and business like organisation (Maynard and Bloor 1996; Dowell and Neal 2000). Indeed, Mc Intosh (1985) reports that at a time when there was little research available as to what form of organisation should be adopted in the community, management consultants from business were brought in to advise the policy makers. Many commentators have argued that this period was the beginning of managerialism proper for primary care services (Mc Intosh 1985; Ross 1987; Baker et al 1987; Bergen 1999)

The Time for Change

It has been suggested therefore that the 1974 re-organisation of the NHS produced the greatest change in the working practices of district nurses (Baker et al 1987). It is noted that the changes that occurred in 1974 had the

effect of arranging the management of all nursing within a district or geographical area (Ross 1987). Associated with this was a structured hierarchy or authoritarian system with a chief nursing officer at the top and a clear chain of command to district nurses at the divisional level (Baker et al 1987; Ross 1987).

Some commentators have suggested that this re-organisation heralded the introduction of scientific or fordist management systems (Griffiths 1996; Wilson 2000). Fordism and fordist management are characterised by the organisation of work into structured divisions of labour. In the fordist system, unskilled work is used in place of skilled professionals and an ever increasing structured hierarchy of work is achieved (Sabel 1982; Marsh 1996).

In primary care this effectively meant that services were traditionally constructed around the functional leader of the team, the GP, who was given leave to delegate unnecessary or unskilled work to the team. In doing so, the GP gained greater control of his or her work and by default the rest of the primary health care team (Hicks 1976; Mc Intosh and Dingwall 1978; Wilson 2000). Research conducted at this time identified that doctors were in fact the centre of a hierarchical team in primary care (Gilmore et al 1976; Mc Intosh and Dingwall 1978; Reedy et al 1980a). Although others have indicated that the take up of the new ways of delegation had some opposition as traditional GP's vehemently protected their work (Hicks 1976; Reedy et al 1980a; 1980b).

It is interesting to note that much of the available research into district nursing work at this time described the work of district nurses in a fordist, task oriented manner and suggested that as a professional group they were working well below their potential (Hockey 1966; 1972; Carstairs 1966; Gilmore et al 1976; Mc Intosh 1976; Mc Intosh and Richardson 1976; Reedy et al 1980a; 1980b Dunnell and Dobbs 1982). It has been noted however, that these studies were often small scale or task focussed and overlooked the complexities of district nurses' work (Griffiths 1996). Therefore district nurses' work was mostly known and described in a reductionist format. It is hardly surprising therefore, that policy makers in the 1970's and 80's were able to suggest that community nurses were ideally situated to undertake surplus or routine work performed by their medical colleagues (Mc Intosh and Dingwall 1978; Wilson 2000). A more serious consequence for district nurses was that their work received increasing scrutiny by both medical colleagues and the wider policy making arena (Mc Intosh 1985; Ross 1987; Goodman 1998).

It is clear from research at this time that the functional roles and responsibilities of the members of the primary health care team differed (Dunnell and Dobbs 1982; Bowling 1981a; Bowling 1985). For many years, primary health care services enjoyed a relative freedom and autonomy from the wider NHS. Until the late 1980's GPs and community nurses were largely left to their own devices. This may well be the reason why some commentators have suggested that the arena of primary care was a "fertile ground" (Mc Intosh and Dingwall 1978) for interpretations of team working and

inter-professional boundaries (Reedy et al 1980a; Bowling 1985; Atkin and Lunt 1997; Goodman 1998; 2000).

It has been noted in the literature relating to the organisation of community nursing that there was great disparity between and often within organisations (Reedy et al 1980a; 1980b; Bowling 1985). This led to closer examination of primary care services in general as the quality of services on offer to the public was noted to be variable (Luker and Perkins 1988; Maynard and Bloor 1996; Dowell and Neal 2000).

A Failing Service

The 1980's saw a sustained critique of the inefficiencies of community care in general and primary care in particular (Ross 1987; Wilson 2000). The Audit Commission Report (Audit Commission 1986) typified the discourse of quality assurance and effectiveness set to confront and challenge the professional decisions made by primary care practitioners. This is essentially fordism at its most basic level which sets to challenge worker's power (Sabel 1982; Marsh 1996).

A consistent theme in nursing and medical literature since the late 1980's has been the reported decline in the professional autonomy of those involved in primary health care arena (Williams and Sibbold 1999; Tovey 2000; Benson et al 2001). For many years general practitioners could largely decide what services were on offer to the practice population (Hicks 1976). Some refer to

this period as the "golden age" of primary care (Tovey 2000) which came to an end when: -

> "the primary care agenda became replete with a number of issues that spilled over from the acute hospital sector – quality, effectiveness and cost containment" (Benson et al 2001 p216).

This form of organisation in primary care, secured through audit initiatives, set to measure services against a pre-formulated standard. The increasing scrutiny of the work process represented the holy trinity of fordist organisations that is, quality, flexibility and teamwork (Marsh 1996; Clegg 1990). The Japanisation of the management process that occurred during this period sought to expose the working practices of organisations to detailed scrutiny with the aim of increasing managerial control over the work process (Marsh 1996).

It was the Audit Commission Report of 1986 (Audit Commission 1986) that offered one analysis of community care services and highlighted the mismatch between the ideology of care and actual practice. Particularly important was the rift between health and social care services and the inefficiencies, duplication and omissions in service provision it accentuated. It was these root inefficiencies that led to charges that both health and social care organisations were failing to meet their objectives (Ross 1987; Dowell and Neal 2000; Griffiths 1996).

It is debatable whether or not community care at this time (1980's) was actually more or less efficient than any other form of organisation. It is argued that the base cause of the reported inefficiencies such as those emphasised

by the Audit Commission, were not a fault of organisation or management but rather a result of a severe and protracted lack of funding for the early years of community care (Le Grand et al 1998).

The publication of the Griffiths Report (DoH 1988) drew further attention to major failings in collaboration between health and social services. The report also highlighted the lack of clear lines of demarcation and responsibility in the provision of care (Dalley 1993; Wilson 2000) and suggested that responsibility and resources for the provision of community care be given to Local Authorities. Many nurse commentators have suggested that this was a further blow for district nurses who by default, were left in a secondary position to social workers (Dalley 1993; Griffiths 1996; Goodman 1998).

To Market

The recommendations made by the Griffiths Report (DoH 1988) were incorporated into the 1989 reforms to healthcare. A central tenet of these reforms was a firmly held belief that the professional power exerted by community practitioners, particularly GPs, was unacceptable in an increasingly bureaucratised NHS (Klein 1997; Le Grand et al 1998; Benson et al 2001). It is interesting to note that the 1988 review of the NHS was conducted rapidly and secretly (Maynard and Bloor 1996; Klein 1997). The legislation that resulted from the limited survey of the British NHS formed the basis for rapid and unprecedented change to primary care (Maynard and Bloor 1996; Tovey 2000).

The NHS and Community Care Act (DoH 1990) introduced managerialism into the arena of primary care. The then Conservative Government remained convinced that professionally led services resulted in inefficiencies, which improved management and organisation would correct. The key elements of the white paper "Working for Patients" (Department of Health 1989) were the development of an internal market, the delegation of power to local management structures, the formation of the purchaser provider split, the commodification of patient treatment alongside the introduction of general practice fundholding (Klein 1997; Benson et al 2001).

The New Community Care

The upshot of the legislative changes (DoH 1990) was a new organisation of care in the community which was divided between health and social care tasks (Griffiths 1996; Goodman 1998). This was secured without debate or consultation with the profession. A consequence of this was that work that had previously "belonged" to district nurses was reclassified as social care (Griffiths 1996). It is argued that the deconstruction of health and social care work in the community effectively dislocated many aspects of district nurses' caring work (Hiscock and Pearson 1996; Griffiths 1998). It was found in research undertaken in the years following the implementation of community care that district nurses lamented the loss of aspects of their caring work, particularly the bathing of their long term patients (Griffiths 1996; 1998; Goodman 1998).

The legislation from 1989 effectively removed some of the autonomy of GPs whilst at the same time giving responsibility for the health care budget to fundholding practices. This movement in effect placed GPs at the front line of rationing services as Central Government kept tight control over the amount of finance made available to provide both primary and secondary care. This form of organisation is reflective of a move to post-fordist organisation. Watson (1997) describes post-fordism thus: -

> "A pattern of industrial organisation and employment policy in which skilled and trusted labour is used continuously to develop and customise products for small markets." (Watson 1997, p343)

It is argued that this form of organisation places its emphasis on flexible production systems that are achieved through team working and niche marketing rather than mass marketing (Watson 1997). It is clear that the introduction of the post-fordist organisation came with the devolution of power and responsibility associated with local purchasing and fundholding. In essence, GPs were made to account for their practices and make decisions about the financial consequences of their prescribed care.

This form of organisation is typical of post-fordist management in which the overriding principle is the simultaneous loose-tight control (Peters and Waterman 1982). In practice this means that there is central control over the allocation of finances (tight control) and resources by the Health Authority associated with loose control (unit based autonomy) over the way in which the allocated funds are spent. Loose control was apparent in the incentives

offered to fundholding practices by the Government that allowed fundholders to use their budget to pay either themselves or other health professionals to provide a specified list of secondary care services in house (NHSME 1992). This had direct effects on the structure, function and responsibilities in the primary health care team in terms of the division of labour which resulted from the new regime (Hiscock and Pearson 1996; Williams and Sibbold 1999; Benson et al 2001).

The Re-Organisation of Roles in Primary Care

In post-fordist organisations, workers need to be able to switch between a range of tasks and job roles as consumer demand changes (Watson 1997). This inevitably requires the re-skilling of certain members of the labour force (Piore and Sabel 1984). The desired result is the *flexible firm* in which highly skilled individuals are given relative autonomy, security and high rewards for their ability to meet the needs of their consumers (Pollert 1991). In the case of general practice, this was achieved by allowing general practitioners to re-invest the financial savings they achieved into the property and structure of the practice building whilst simultaneously employing peripheral workers (for example district nurses) under new contractual arrangements. The flexible firm is summarised by Watson (1997): -

> "A type of employing organisation which divided its workforce into core elements which are given security and high rewards in return for a willingness to adapt, innovate and take on new skills and peripheral elements who are given more specific tasks and less commitment of continuing employment and skill enhancement" P348

Maynard and Bloor (1996) argue that GP fundholding, which was an "add on" to the re-organisation of primary care services, essentially gave control of the nursing workforce to GPs. In essence GPs were relatively free to make demands on the nursing workforce in line with central Governmental guidelines and budgetary controls (Wilson 2000).

Clegg (1990) argues that within post-fordist organisations peripheral workers are employed and dispensed with, as the market requires. They enjoy less status and more routine and mundane tasks (Marsh 1996). Their skill level is flexed up and down as the demands of the firm change (Watson 1997). It has been suggested this is a guiding characteristic of community nursing in the 1990's (Bergen 1999).

District Nursing and the Change Process

The changing nature of district nurses' work has been captured in the literature. For example in one longitudinal, four year survey of community nurses in the post-fundholding era, it was found that the morale of district nurses declined from the first to the fourth year (Wade 1993; Traynor and Wade 1994). Notably, satisfaction with working conditions and relationships under the new regime of contracts were significant influences on district nurses' morale and job security (Traynor and Wade 1994).

Detailed qualitative research approaches have also captured the changing nature of district nurses' work in the fundholding era. In an ethnographic study of district nurses work (n=37) published in 1996, it was found that the dynamic effect of the contract system was that district nurses' relationships with GPs changed dramatically and for the worse in terms of job satisfaction, particularly when the fundholding GPs had readily embraced the new ethos (Griffiths 1996). These findings were supported some two years later in a case study analysis of district nurses work (n=36) conducted in twelve Community Health Care Trusts (Goodman 1998). This study suggested that district nurses were locked into a process of contracting with GPs and were engaged in justifying their work in terms financial value within a purchasing and policy context. Others have suggested that district nurses' have reported a change in their work and perceived satisfaction arising from the new contract with GPs (Luker and Kenrick 1992; Jarvis 2001). District nurses have reported a deskilling process in their work that has left them fearful of their job security (Hiscock and Pearson 1996; Rapport and Maggs 1997; Galvin et al 1999).

It has also been noted that the GPs and practice based staff within primary care operated as a central core with district nurses on the periphery (Luker and Kenrick 1992; Hiscock and Pearson 1996; Galvin et al 1999; Williams and Sibbold 1999). It is inferred in the literature that district nurses have become simultaneously a part of the new primary care organisation whilst still occupying an eccentric position. This point will be explored further in the next chapter.

A New Training

It is interesting to note that the radical overhaul of district nurse training that occurred in the 80's and 90's has responded to market demands. The new curricula for district nurse training has essentially been set to produce a nurse educated to degree level with the ability to adapt and develop to the demands of primary care (UKCC 1991; Hallett et al 1996; Wilson 2000). The specialist practitioner course it is suggested to be less about skills than about lifelong learning and management issues. Whilst some would argue that this is apposite to nursing in the 1990's and beyond (Hallett et al 1996; Hallett 1997; Goodman 1998) others would suggest that this move pulls nurses away from their fundamental roots and provides a malleable workforce (Mc Intosh 1996; Bergen 1999). The most important point is that this change has occurred without any real form of consultation with grass roots practitioners (Hallettt 1997).

The new training curriculum serves to prepare nurses for multidisciplinary work and aims to produce a practitioner who can manage the changing services she offers (UKCC 1991). However, as Goodman (1998) reports there is little evidence to suggest that this new training has had any impact on either inter or intra-professional work. In fact there is evidence to suggest that community nurses are continuing to work as isolated groups in the community (Griffths and Luker 1994; Griffiths 1996; Quinney and Pearson 1996; Goodman 1998; Goodman 2000). On closer reading of this literature it is apparent that district nurses are organised in different ways both across and

within geographical areas and Trusts. It seems that in order to survive in the flexible firm, district nursing services in the 1990's has had to change to meet the demands of the market place. This change has resulted in a diffuse service which has different forms and structures (Mc Intosh et al 2000).

A New Organisation

The challenge to independent practice and economic determinism implemented under the Conservative Government of the 80's and 90's formed much of the debate that led "New Labour" to promise to repair and eradicate the market from the health service and to improve working conditions in the NHS. The "New NHS: Modern and Dependable" (DoH 1997) set out to tackle the issues of clinical probity and accountability among the professions within the health service. The main thrust of this legislation was a further intrusion of clinical and corporate governance into the work of health care professionals (Dowell and Neal 2000; Benson et al 2001). This has led some commentators to suggest that the current discourse is that managers alone will no longer be held solely accountable for a Trust's performance. On the contrary, all staff will now be thought of as responsible for the overall delivery and organisation of health care (DoH 1997; Haywood 2000). "A First Class Service: Quality in the New NHS" (DoH 1998) furthered the primacy of issues of quality and equity in service provision outlined in the 1997 white paper. Three reasons for the inefficiency and poor performance in the NHS: -

> " ... there were no clear standards of care which all parts of the NHS were expected to achieve ... there have never been any coherent assessments of which treatments work best for which patients ... *(and)* the NHS as a public service has not been sufficiently accountable about the quality of the services it offers to the public." (DoH 1998, p6).

The criticism of poor quality services has been interpreted as perhaps the severest assault on professional autonomy (Haywood 2000). The policing of medical services through the joint discourses of quality and inequity has led to the formation and rapid introduction of the National Institute of Clinical Excellence (NICE) and the National Service Framework (NSF), Governmental bodies and dictates which have the power to assess and control the work of GPs in primary care. This essentially fordist style of organisation relies on established professionals meeting pre-set targets and ideals (tight cultural and tight financial control associated with audit). Thus the creation of large Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) have provided a larger working team which will be better able to meet the demands of local markets (Clegg 1990; Dent 1995). It is also suggested that the creation of multi-disciplinary teams in primary care is essential to provide the critical mass of personnel to deliver the evidence based care agenda (Dent 1995; Haywood 2000).

Harrison and Ahmed (2000) suggest that this has manifested in the form of Health Improvement Programmes (HIMPS) and the statutory requirements for PCGs and PCTs to address local health needs through economic, social and environmental policies alongside the provision of general health services (NHSE 1998). Some argue that this represents a decentralising of Governmental control over primary health care services which is consistent with a post-fordist organisational style (Burrows and Loader 1994; Harrison 1999). Particularly relevant here is the idea that there needs to be diverse approaches to tackling local health care problems. The general argument is

that local organisations should be able to meet local needs in what ever way seems fit, within budgetary limits. This idea seems to be compatible with the post-fordist logic of niche market, loose control and local responses (Burrows and Loader 1994). However, these local decisions about service provision will be monitored and audited by the Commission for Health Improvement (tight control) who will measure performance against the guidelines issued by NICE (NHSE 1998; Harrison and Ahmed 2000; Dowell and Neal 2000).

This has led some commentators to suggest that the simultaneous introduction of the fordist idea of the "one best way" as exhibited by the Clinical Governance agenda for both nursing and medical staff, represents a curious mix of fordist and post-fordist philosophies (Annadale 1998; Harrison and Wood 1999; Harrison and Ahmed 2000; Bergen 1999). Harrison and Ahmed (2000) argue that under clinical governance the medical and nursing labour process is better described as mass production than the flexible production implicit in the New Labour policy directive. It is the duality of the contrasting philosophies of central control (fordist organisation) and flexibility (post-fordism) which is highlighted in the literature. Thus as Dowell and Neal (2000) suggest: -

> "the purchasing of health as a commodity and an insistence on efficiency remain" (p16).

It is this apparently contradictory co-existence of organisational approaches that invites researchers to examine the machinations of the NHS and the Primary Care arena further.

Summary

This chapter has stressed that district nurses as members of the primary care workforce have faced a battle for recognition and status from their early origins up until the present day. Repeated policies have failed to fully acknowledge the training, skills and the contribution made by this element of the primary care workforce. Thus district nurses' work has largely remained invisible in the context of primary health care. Their eccentric or marginalised position has been recorded and explained by only a small number of commentators when compared to the body of historical knowledge relevant to nursing in general.

The advent of community care increased interest in the primary health care workforce, including district nurses and like all professional members of the team their work has received increasing scrutiny. There were claims that primary care services were failing to meet their objectives, although this was never proven in any real sense. There is a consensus of evidence which states that the real problem facing primary care was severe and protracted under-funding. However, the charge of inefficiency gave successive Governments the ammunition they needed to introduce a fordist style of management and claim the service of quality and efficiency as the impetus for reform.

The ideology of community care has obfuscated the real objective of cost control in community services. Successive Governments have largely succeeded in shifting the emphasis from secondary to primary care and have introduced the notion of flexible working patterns to procure the community care agenda. This form of organisation is somewhat akin to a post-fordist management style, one consequence of which has been a new training specification for district nurses which has emphasised multi-disciplinary work, management and flexibility among trainee district nurses.

The latest re-organisation of work in primary care has simultaneous emphasised central control over decision making while encouraging local autonomy and action to tackle health needs. Whilst quality and economics still figure highly on the primary health care agenda, simultaneous loose and tight control exist. This is a curious mix of fordist and post-fordist management styles. Whilst there is evidence for the existence of these organisational styles on a global level, there is little evidence as to the effect these strategies of organisation have on the work of the primary health care team as whole and the work of district nurses in particular. This odd mix of organisational and managerial styles invites the curious researcher to look closely at the cultural effects they have on primary care workers.

Chapter 3 - The Research Base for District Nursing and District Nurses' Work

District Nursing Work – A Basic Service

It is widely acknowledged that district nursing as a sub profession within nursing is generally under researched (Mc Intosh 1985; Mackenzie 1990; Griffiths 1996). This is particularly notable when the literature for district nursing is compared to the knowledge base on the work of hospital based nurses and even other community nurses such as health visitors (Griffiths 1996; Goodman 1998). Despite this, there is a pervading sense from the available literature which suggests that district nurses' work is basic, non-technical, generally unskilled and characteristically below their level of expertise (Hockey 1966; 1972; 1974; Carstairs 1966; Mc Intosh and Richardson 1976; Kratz 1978; Reedy et al 1980a; 1980b; Audit Commission 1992; 1999).

The 1960's and 70's saw a growth in research into district nurses' work, which coincided with the political interest in primary care (see chapter 2). For example, Hockey (1966; 1972; 1974) undertook a series of observation studies into the work of district nurses. Using a structured observation schedule, Hockey attempted to describe the work of district nurses. It was found that district nursing care was highly variable and was not directly related, in any tangible way, to either their skills or expertise. It was suggested that district nurses were working well below the level of their

competence and training and it was noted that there was considerable scope for the expansion of the role of district nurses into more skilled work.

Hockey later studied the roles of nurses in the wider district nursing team (Hockey 1972). She suggested that there was considerable use and abuse of junior nursing grades within the district nursing team, particularly enrolled nurses. There seemed (according to Hockey) to be no consensus as to the boundaries between the qualified district nurse and her juniors in as much as their work was often observed to be interchangeable. Thus there was considerable scope for variations in the practice of community nursing and correspondingly the quality of care they offered (Hockey 1972).

Others came to similar conclusions. Mc Intosh and Richardson (1976) used a structured observation schedule to observe the work of Scottish Home Nurses. Their findings suggested that district nurses were engaged in basic tasks and spent considerable amounts of their working day on the less technical aspects of their work for which they were over qualified. Reedy and his colleagues came to similar results and in addition found that in comparison district nurses performed basic tasks more often (even though they were better qualified and more experienced) than their practice based colleagues (Reedy et al 1980a; 1980b).

Further research added to the notion that district nursing was an inefficient use of a nursing resource. For example, Miller and Hacket (1980) surveyed 690 GP Principals in England and canvassed their views on "attached nurses"

(return rate 77%). Two thirds of the sample suggested that district nurses, as a resource, was used less efficiently than it could be. In another survey of GP practices (n=20) in England and Wales (Bowling 1981a; 1981b) it was also found that 60% of GPs were dissatisfied with the role of district nurses. It was suggested that the same 60% of GPs wished to capitalise on the skills and experience of district nurses and expand their role (Bowling 1981a; 1981b).

There is also a body of literature that suggests that district nursing time was inefficiently managed by practitioners. Findings from a number research projects found that between one third and a half of district nurses' working day was spent on non-nursing duties (Hicks 1976; Hockey 1966; 1972; 1974; Mc Intosh and Richardson 1976; Bowling 1981a; Dunnell and Dobbs 1982; Luker and Perkins 1988; Audit Commission 1986; 1992). Even authors who adopted a qualitative methodology tended to over emphasise the tasks performed by district nursing in favour of a deeper understanding of their work (Kratz 1982; Coombs 1984). There were also suggestions that district nurses used some unknown or highly subjective method of assessment to allocate their services (Luker and Perkins 1988; Luker and Kenrick 1992). The general conclusions from the research was that district nursing services were highly variable and there seemed to be a lack of coherent structure to their work.

The research cited above is littered with methodological flaws. A number of studies began the research process with an a priori assumption of what constitutes basic and technical care (Carstairs 1966; Hockey 1966; 1972;

1974; Mc Intosh and Richardson 1976; Reedy et al 1980a; 1980b; Bowling 1981a; Dunnell and Dobbs 1982; Audit Commission 1986; 1992; 1999). The majority of these studies offered little attempt to justify their decision in the labelling of these tasks either basic or technical. All too frequently researchers failed to substantiate the formulation of observation schedules or survey methodologies in terms of validity and reliability, other than by stating that their inventories or questionnaires were based on observations or taken from the literature (for example, Hockey 1972; 1974; Reedy et al 1980a; 1980b; Dunnell and Dobbs 1982; Audit Commission 1992).

In general, researchers have assumed that unskilled work equates with "general care" or the "personal hygiene" needs of the patients which generally denotes anything other than technical tasks which are medically defined (Griffiths 1996; Mc Intosh 1996). These terms were hardly ever delineated or debated in any real sense. The psycho-social aspects associated with caring are at best represented as superficial entities and therefore were overly simplistic representations of district nurses' work (for example Reedy et al 1980a; 1980b; Audit Commission 1992). More contemporary research has given weight to the psychosocial elements of nursing work which are now known to be associated with increased stress in district nurses' work (Wade 1993; Traynor and Wade 1994; Griffiths 1996). Also, the very term basic or general care, rather than being equated with less skilled work in nursing, has more recently been equated with highly skilled and professional care which some have labelled new nursing (Salvage 1995) or even skilled professional artistry (Mc Intosh 1996).

Whilst there is a plethora of literature which has presented district nursing in a pessimistic light, there was some evidence in the 1970's and 80's which contradicted the notion that district nurses' work in the home could ever adequately be described as basic, simplistic or unskilled (Mc Intosh 1976; Kratz 1982). It seems that a part of the problem was that even district nurses themselves have had difficulty in articulating what skills they employed in their work (Mc Intosh 1976; 1985; 1996; Griffiths 1996). This may also be a fault of the methodologies employed by the researchers at this time. More latterly a counter discourse has offered an alternative interpretation of district nursing work and has challenged the reductionist methods with fuller descriptive accounts of the expertise involved in caring in the home. Some have highlighted the highly complex and intricate rules that govern the provision of care in the home (Mc Intosh 1985; 1996; Kratz 1982; Mackenzie 1990; 1992; Griffiths 1996; Goodman 1998).

A general critique which could be applied to the research outlined above is that is has adopted an essentially fordist approach to describing the care given by district nurses. It is noted that this approach reflects the dominant ideology of the 1970's and 80's which was set on finding and rooting out inefficiencies in services (Griffiths 1996; Bergen 1999). Thus the subjects were measured against pre-set ideals that had little grounding in actual practice (Audit Commission 1992; 1999; Luker and Kenrick 1992). In general the survey methods utilised have failed to capture the reasons why practitioners act the way they do. In many cases they simply record and describe their actions (Hockey 1966; 1972; 1974; Bowling 1981a; Dunnell and

Dobbs 1982; Audit Commission 1986; 1992; 1999). Thus the literature discussed above have captured only part of the picture and have failed to account for the variance in the decision making processes, which later ethnographic studies have identified and located within the culture of district nursing (Griffiths and Luker 1994; Griffiths 1996; Goodman 1998). Others have proposed that variations in the work of district nurses are related to disparities in the continuing education of district nurses (Luker and Kenrick 1992; Mc Intosh 1996). Yet others have found that differences in the delivery of care given by community nurses may be the result of the skill mix and contracting arrangements that have influenced the district nursing team (Griffiths 1996; 1998; Hiscock and Pearson 1998; Goodman 1998; Mc Intosh et al 2000).

Much of the available research places the blame for inconsistencies in care provision firmly at the feet of the district nursing profession. Little attempt is made to locate the discrepancies within the structural and organisational environment in which district nurses work. There is also an assumption that variations in service delivery are by definition inefficient. This supposition is not necessarily true and indeed runs contrary to current considerations for primary care to ensure that local services meet specific local needs. In the case of the new NHS, the variability and admonishment inherent in much of the research may now be considered necessary and desirable (Bowling 1981a; Dunnell and Dobbs 1982; Audit Commission 1986; 1992; 1999). In order to achieve this aim the professional education of district nurses has, like many other areas of their work, received attention.

District Nursing Education

There is a dearth of information, which examines the education of district nurses and their professional adjustment from hospital to home nursing. Traditionally, general nurse training has placed its emphasis on hospital nursing (Mackenzie 1990; Hyde 1995) and until the advent of Project 2000 (UKCC 1986) it was observed that; -

> "the needs of acute hospitals drive the health service as a whole, to the detriment of primary care" (Hancock 1991, p4).

A consequence of this was that there has been a pervading belief that the skills learned in hospital were simply transferable to the home (Hyde 1995; Haughey 1995). This position has been vehemently opposed by commentators familiar with work in the community who have offered a more complex understanding of the demands of care in the home (Mackenzie 1990; Orr and Hallett 1991; Mc Intosh 1985; 1996).

It is apparent in the literature that apart from historical research (Abel-Smith 1979; Baly 1980) little empirical evidence is available to illuminate the process of transformation from qualified hospital to qualified district nursing. The educational preparation of district nurses and their practice during and following their learning has eluded empirical evaluation. This may well be a further illustration of the eccentric nature or political marginality of the district nursing profession from the wider milieu of nurse education (Mc Intosh 1985; White 1985; Goodman 1998). It could also be argued that there has been a

pervading assumption that district nurses' work in the community was merely an extension of the hospital and therefore did not need separate consideration.

The relative invisibility of the educational preparation of district nurses may well help to explain why district nursing has been the target of successive attempts to devalue their expertise (Haughey 1995; Mc Intosh 1996). The stark reality is that there is little evidence to suggest that district nurse training adequately prepares its practitioners for practice. On the contrary, there is some "evidence" in the form of Governmental reviews to suggest that district nurse education has been far from satisfactory in terms of suitability and effectiveness in providing community practitioners (DHSS 1977; 1986b; UKCC 1994; DoH 1996a; 1996b).

The lack of an empirical counter argument has meant that successive Governments have had considerable political leverage with which to claim that the professional preparation of district nurses (over and above the organisational context in which they practice) is a root cause of inefficiency and stagnation. This charge has been repeatedly stressed in the periods both prior to and following the Community Care Reforms (DHSS 1977; 1986b; UKCC 1994; DoH 1996a; 1996b; 1997).

District nursing as a collective group have had little evidence with which to combat the claims made against them. It is not surprising then, that seemingly the only way forward and one that was readily embraced by the

profession, was the acceptance of higher education and diploma/degree level preparation for district nursing practice (UKCC 1994; Hyde 1995; Griffiths 1996). Some have argued that this move has allowed district nurses to compete with other specialist nurses in terms of equal professional recognition and status (Griffiths 1996; Goodman 1998). The general assumption is that degree level specialist education equates with specialist practice. This has yet to be proven both in the hospital situation and the community (Luker 1995).

It is apparent from the available literature that the design, delivery and effectiveness of district nurse education have little academic or empirical support.

District Nurses as Educators

Whilst the education and preparation of qualified district nurses has received limited attention there has been some interest in the district nurse as an educator in the community setting. This is particularly evident since the introduction of Project 2000 which placed an increased emphasis on community health care (UKCC 1986). In general it has been suggested that district nurses are ill prepared for their role as educators (Orr and Hallett 1991: Mackenzie 1990; 1992; Hallett et al 1996; Hallett 1997). In spite of this, there has been an increasing demand placed on district nurse practitioners (usually G and H grades) to facilitate the learning of a greater than ever number of student nurses in the community. This has occurred without additional educational preparation (Mackenzie 1992; Hallett 1997).

The issue of the community as a training environment has attracted some academic interest (Orr and Hallett 1991). It has been argued that this has been a useful and positive step in recognising the positive contribution that district nurses and the primary health care team make in managing the health care needs of the public (Griffiths 1996; Goodman 1998). Other, more pessimistic commentators, have reasoned that the change in focus to the community as a training environment has occurred more from a need to secure a less expensive, alternative community practitioner (Project 2000 graduates as staff nurses) than the current high cost qualified district nurse practitioners (Jones 1993; Sines 1995; Hallett 1997). Hence, by expanding the time spent in the community by Project 2000 nurses there would be a steady flow of care practitioners that would facilitate the move towards skill mix in community nursing teams (Jones 1993; Sines 1995; Hyde 1995). This suggests a move towards post-fordist flexibility in the workplace (Bergen 1999). Three major studies are worthy of detailed examination here not only for their contribution to the knowledge base on the education process but also for the insights they provide into the complexities of district nursing work.

In order to assess the actual and potential problems of the expansion of student nurse training in the community, Orr and Hallett (1991) undertook a large scale, prospective investigation of community placements. This study (funded by the ENB) was conducted in two stages across the 13 demonstration sites for Project 2000 in England. After undertaking and exhaustive literature review, the authors used a mix of qualitative interviews

(n=39) and postal survey to canvass the opinions of practitioners, managers and students based in the community (n=2500, return rate 73%). Their findings suggested that there were a number of complexities relating to the community as placement and they also drew attention to many aspects of the work of district nurses. Orr and Hallettt indicated that the presence of students in the community had a detrimental effect on the work of community practitioners and in particular their relationships with the patients. Their second concern centred on the expectation by educational institutions that the community could fulfil the learning outcomes for the new diploma course. Practitioners reported feeling inadequately prepared for this structured learning endeavour. A further concern was that practitioners feared for the safety of student nurses who were expected to visit alone during the placement. Associated with this were anxieties of a professional nature, specifically issues of responsibility for the student's practice.

The study highlighted differences between the hospital and community settings. Within the community there was the possibility and probability that patients could refuse to co-operate or accept the presence of students, which drew attention to the unique nature of the nurse-patient relationship in the home. It was suggested that skills such as negotiation and collaboration with patients were consistently emphasised as driving the care process. The ever increasing presence of students was often seen as a threat to this practice. Whilst Orr and Hallett stressed the importance of the newness of project 2000 in their findings they nevertheless concluded that the above themes were

persistent and enduring and accounted for some of the variability of the student experience (Orr and Hallett 1991).

In accord with Orr and Hallett (1991), White et al (1993) also found variability in the learning experience of student nurses. In phase 1 of their study, White and her colleagues undertook semi-structured interviews with 53 student nurses, 37 practitioners and 25 teachers of students undertaking a project 2000 course. The second stage involved a case study including 3 hospital and 3 community based placements. Their qualitative analysis identified 4 main themes.

Firstly it was suggested that there was an inconsistent use of terms by students, practitioners and educators to describe the role of the practice educator. Supervisor, mentor and educator were used interchangeably. This led to confusion among practitioners and students about their role in the process. The second theme identified was that of poor morale among practitioners. It was found that when district nurses' morale was low the student experience was poorly rated. Over burdened staff were associated with poor levels of satisfaction and there were reports of overloaded staff suggesting that they had too many student placements. The third theme identified that students and practitioners both felt that there were major problems in linking the theory taught in college to the practice both in the hospital setting and in the community. Fourthly, there were also problems with practitioners' knowledge of what was expected of diploma level practice. Practitioners failed to understand the implication of educational change and its

relevance to the student experience. In summary, White et al's (1993) work indicates that the practitioner can have both positive and negative effects on the student experience and also that there was a rift between ideal (theoretical) and actual practice.

This early research suggests that the pressures and demands of the practice area on practitioners had a detrimental effect on the learning experience for students. One problem with these findings is that although the research included three community case studies, there was little attempt in the research to discriminate between the two placement arenas even though the areas were known to differ (Orr and Hallett 1991). That being said, the findings of this study go some way to emphasise the structural and personal difficulties encountered by community practitioners in providing a positive educational experience.

Other commentators have used qualitative methods to investigate the learning experience of student nurses in the community. One ethnographic study involved participant observation and in depth interviews (n=80) with students and their practice supervisors in two educational institutions (Mackenzie 1990; 1992). Mackenzie's qualitative analysis identified four main themes. It was found that students in the community progress through a learning career (Mackenzie 1992). The learning career involved fitting in to the community placement (a new environment), fitting in with patients, testing out previous hospital learning for suitability in the home/community and adapting to the mismatch between caring theories and the reality of practice. Mackenzie

(1990; 1992) suggested that there were considerable difficulties for the practice nurse teacher in controlling the practice setting and therefore the learning environment. Consequently the learning opportunities for students were found to be highly variable (Mackenzie 1992).

Others have supported these findings in suggesting that student nurses progress through a discernable sequence of learning or learning career. Hallett et al (1996) and later Hallett (1997) used a phenomenological approach to interview nursing students (n12) and their placement supervisors (n=14). The results were analysed initially using Gadamer's circle of understanding (Hallett et al 1996) and in a follow up study were related to Schon's theory of coaching (Hallett 1997). Hallett and her colleagues' work concurs with that of Mackenzie (1990;1992) in a number of respects. The theory-practice dissonance, testing out of students' own ideas and fitting in to the community as a new environment for care were identified as consistent themes. Hallett et al (1996) also found that students lacked practical experience and skills and valued the experience of learning by doing within the community. It was also suggested that district nurse assessors reported demonstrating and enabling students by building confidence in practical procedures. The study participants reported that they encouraged the development of thoughtful practice through reflection. In contrast to Mackenzie's study, the students in Hallett's studies reported a high degree of satisfaction with learning (Hallett et al 1996; Hallettt 1997).

The literature from this area of district nursing work suggests that the learning environment offered to students can vary (Mackenzie 1990) and that structural and organisational factors affect the learning process and outcomes for student nurses (Mackenzie 1992; Orr and Hallett 1991; White et al 1993). However, it is also noted that when the conditions are favourable and district nurses are clear of the aims and objectives of the learning experience, then the learning process in the community can be mutually rewarding and positive for both district nurses and their students (Mackenzie 1992; Hallett et al 1996; Hallett 1997). It is also clear from the literature that the student experience in the community involves a considerable amount of careful co-ordination by the district nurse (Mackenzie 1992) over and above that required the hospital setting (Hallett 1997).

It is also clear that district nurses have over and over again reported feeling inadequately prepared for their role as educators (Orr and Hallett 1991; Mackenzie 1992; White 1993; Hallett et al 1996; Hallett 1997). Research consistently suggests that the modification of skills and experience gained in the hospital setting to the community is not a linear process but is one that requires considerable stealth and adaptation (Hallett et al 1996). The change process for students is complicated and sometimes unpredictable. The literature also suggests that these considerations are part and parcel of the practice of district nursing which makes the process of nursing in the home complex and demanding.

Intra-professional Team Work in District Nursing

It has long been the suggestion that district nurses do not work well with other community nurses (Gilmore et al 1976; Hicks 1976). Research has repeatedly suggested that district nurses and their nursing colleagues based in the community are often in an oppositional, rather than a collegiate relationship (Gilmore et al 1976; Reedy et al 1976; Reedy et al 1980a; 1980b; Coombs 1984; Griffiths and Luker 1994; Goodman 1998; Hiscock and Pearson 1996; Goodman 2000).

In one study, which surveyed the nursing teams in 39 randomly, selected health centres in England and Scotland it was found that there were wide variations in the interpretation of teamwork (Gilmore et al 1976). This occurred despite claims that community nurses' attachment to general practice had invariably led to team working. It was found that there was considerable misunderstanding of intra-professional roles and boundaries, substantial territorialism and sometimes animosity between the sub-professions of nursing. These findings were loosely supported sometime later in a combined appraisal of two separate studies of health visitors and district nurses where it was suggested that the field of primary care was an arena in which there were many interpretations of teamwork and the team approach (Mc Intosh and Dingwall 1978)

In a series of reports which examined the nursing establishment in primary care, a number of integral differences were noted between attached nurses (district nurses and some health visitors) and employed or practice nurses (Reedy 1976; 1980a; 1980b). The authors used a series of postal surveys to investigate the configuration, the social and biographical details and the activities of district nurses and practice nurses. In the first of their studies (Reedy et al 1976) a total of 9214 practices in England were asked for an enumeration of the nurses either attached or employed by the practice (return rate 85.3%). It was found that in practices with attached nurses there had been a dramatic or exponential rise in the numbers of employed nurses.

In a follow up study reported some years later, Reedy et al (1980a) randomly surveyed 3 clusters of health authority staff which included practice nurses (n=72) and district nurses (n=81) and examined their biographical, educational, career and personal details (response rate "high"). Interesting differences were noted between the two sub professions. It was found that practice nurses were generally younger, more likely to be married and to be from social class 1 and 2 than their district nursing colleagues. Practice nurses had more formal school based qualifications and were more likely than district nurses to have been trained in a medical school department of nursing than a school of nursing. The authors found that there were considerable variations in team working arrangements across the study sites. It was suggested that the working relationships between the groups of nurses was sometimes terse. District nurses viewed practice nurses as having a closer working relationship and a greater allegiance with the GP.

The authors concluded that GP's tended to prefer to employ younger, married, medical school educated nurses to work in their practices. This was a consistent finding even though the district nurse sample had more post basic training, community experience and continuous years of service than the practice nurses.

The third study in the series involved structured interviews with district nurses (n=81) and practice nurses (n=72) (Reedy et al 1980b). It was found that district nurses were more likely to have chosen to work in the community because they valued the caring aspect of their role whilst the practice nurses made their choice of working environment because of convenience and hours of work. District nurses felt as though they functioned outside of the team and described their work as relatively autonomous to the practice whilst practice nurses reported that they worked for, rather than with the GP.

Although the research undertaken by Reedy and his colleague is relatively old, the findings give some useful insights into the characteristics and respective motivations of the community nursing team in general practice. They indicate that historical factors and differing reasons for choosing to work in the community operated from the early days of nurse attachment/employment in primary care. This work identified that personal perspectives on care may account for the competing professional affiliations and disparate working among nursing groups in primary care.

Coombs (1984) examined the opinions of district nurses about their working role using a grounded theory methodology. Her findings suggested that district nurses worked very much in isolation from both their own (district nursing colleagues) and other nursing disciplines in the community. She suggested that this was related to their role as care givers rather than co-ordinators and indicated that their relative isolation was often a source of intense frustration for district nurses. This position has support from other researchers who have highlighted the tangential nature of district nursing within the community in relation to other groups of nurses (Bowling 1981b; Griffiths and Luker 1994;Griffiths 1996; Goodman 1998; 2000).

Griffiths' (1996; 1998) undertook an ethnographic study of 37 G and H grade district nurses employing observation and in depth interviews. Her study was conducted during the run up and early implementation of GP fundholding. Her findings indicated that there was some reluctance among her sample to either share work with other nurses or collaborate with colleagues. She described a process of etiquette and a lack of challenge and support among her sample. It was suggested that district nurses work in isolation to each other and seldom question their colleagues' decisions even when sometimes they disagreed with the care approach.

Whilst the above research identified variations in the relationships district nurses had with their practice based colleagues, it would appear that the liaison between district nurses and community based specialist nurses was even more problematic. One study, employed various interview techniques to

examine the perceptions of district nurses (n=40) their managers (n=10) and community based specialist nurses (n=12) to team intra-professional work (Haste and Macdonald 1992). They found that district nurses felt that they would prefer to carry out the specialist role themselves. Some participants reported being resentful of specialist nurses, particularly when the specialist was involved in the provision of direct hands on care to district nursing patients. The relationship between the two groups and the communication between them was strained. This study highlighted the territorial nature of district nurses and their resistance to the perceived intrusion of specialist nurses into their domain of care.

Others have supported these findings (Griffiths and Luker 1994; Griffiths 1996; 1998; Goodman 1998; 2000). It is not surprising to note that these findings have become more visible since the introduction of community care legislation and the contracting process (Goodman 1998). This may well be the result of the contracting system and the perceived threat to district nursing roles in the community that has accentuated this position. District nurses have protected their work and have repeatedly been found to fear the intrusion of other nursing specialities into their realm as they may erode aspects of the district nursing role (Griffiths 1998; Goodman 1998; 2000; Hiscock and Pearson 1996). This is particularly true in the contracting culture that followed fundholding (Goodman 1998; 2000).

Goodman (1998; 2000) used a case study analysis of district nursing work drawing upon qualitative methods. Importantly, her study provides a unique

contribution to the literature as it was conducted during a period of great change in the primary care settings she studied. Her findings, like those of Griffiths (1994; 1996; 1998) suggested that the relationships between district nurses and other nurses in the community were sometimes less than collegial.

In a series of subsequent studies, (Goodman 1998; 2001; Goodman et al 1998) the trend towards self-management within the district nursing workforce was reported. Self-management meant that district nurses were concerned with protecting their own work against the possibility of losing their contract to either other nurses within the primary health care team or indeed nurses from another trust (Goodman 2001). The general theme underpinning much of Goodman's work is that district nurses were in a position of having to defend and protect the core of their work. It appeared that fundholding and the contracting process had, in effect, placed district nurses in situation where they feared for their own jobs and the likelihood that their role could potentially be usurped.

Others, have suggested that intra-disciplinary work in the primary health care team is fraught with difficulties and have related their problems to the advent, implementation and maturation of the fundholding scheme in general practice (Hiscock and Pearson 1996; Galvin et al 1999; Williams and Sibbold 1999; Mc Intosh et al 2000). The general consensus is that there is no standard or unified intra-disciplinary nursing team within primary care and that the configuration of intra-professional team structures is variable (Mc Intosh et al 2000; Hallett and Pateman 2000). The primary health care nursing team has

been found to be constantly changing and as such the professional relationships within and between nursing teams are correspondingly ailing (Hiscock and Pearson 1996; Griffiths 1996; Goodman 1998; Williams and Sibbold 1999).

Inter-Professional Relationships

There have been attempts to organise primary care since the early part of the last century, well before the creation of the NHS. As long ago as 1920, the Dawson Report (Lord Dawson 1920) suggested a plan for the organisation of primary care services in which nurses, doctors, midwives and dentists would be placed together to provide a co-ordinated package of services. Since then there have been repeated attempts to organise primary care along the lines suggested in the Dawson Report which to a great degree have failed to achieve the aim of integration (Cohen Report 1954; Gillie Report 1963; Todd Report 1968; Harvard Davies Report 1971). The consistent themes from these reports were that the potential of primary care services to improve the health of local communities was grossly under exploited and that, in the main, there were wide variations in both the provision and the quality of care offered in primary care. This, policy directives would suggest, is a consequence of a diffuse and poorly organised team.

Early research into primary care established that there were wide variations in the practice of team working between GPs and community nurses (Gilmore et al 1976; Reedy et al 1976; Mc Intosh and Dingwall 1978). In particular,

Gilmore et al (1976) found that it was accepted that the primary health care team came into existence as a result of the attachment of nurses to general practice. However, their robust longitudinal study found that there were no systematic means of working towards common goals or aims and that co-ordination and delegation of work across the team showed great variations. These characteristics are generally those that are thought to be associated with effective inter-disciplinary work (Gilmore et al 1976; Cole 1998). Noteworthy in this study was that both GPs and district nurses reported being satisfied with this loose arrangement of teamwork and district nurses in particular valued the autonomous working arrangement. They concluded that teamwork was in an embryonic state in primary care.

Mc Intosh (1976) suggested that the power relationship between district nurses and GPs was unbalanced and that GPs exerted considerable influence over district nurses. In a later study (which compared the condition of district nursing with that of health visiting) it was suggested that GPs had a powerful upper hand in primary care organisation (Mc Intosh and Dingwall 1978). GPs were keen for district nurses to adapt to a more medically oriented way of working whilst still retaining much of their nursing role. They suggested that GPs saw the primary health care team as a team of auxiliary workers who they could organise and direct. Mc Intosh and Dingwall also drew attention to the precarious situation of district nurses and health visitors within the primary health care team, suggesting that there was a tendency to simultaneously erode and expand their role in clinical care through a process of sloughing off mundane or routine medical care to district nurses. These early reports

suggest that the association of district nurses with their GP colleagues was often tense and far from an egalitarian movement towards teamwork in primary care.

The 1980's saw a period of experimentation with primary health care and this is reflected in the variable findings in the configuration of the primary health care team and their respective roles. For example, Reedy et al (1980a; 1980b) found that district nurses were eccentric to the central core of workers in the primary health care team, particularly in relation to practice nurses who saw themselves as working for the doctor and part of the inner team in primary care. Physically locating district nurses within primary care had done little to promote the development of team working (Hicks 1976; Reedy et al 1980a; 1980b; Bowling 1985).

The literature provides some explanation for this. Bowling (1981a; 1981b) suggested that younger and more progressive doctors were more likely to work collegially with district nurses. However, there was (as noted earlier) considerable resistance to the delegation of work to district nurses (Bowling 1981b). Older GPs (up to a quarter of Bowling's sample) felt that delegation and team working was inappropriate and that it would threaten the independence of the GP. In spite of this apparent resistance to the delegation of work to district nurses, there has been an increasing trend towards the sloughing off of medical work to district nurses (Mc Intosh and Dingwall 1978). The consequence of this is that there has been a blurring of work that has

traditionally been within the domain of medical work (Bowling 1981a; 1981b; Dunnell and Dobbs 1982; Bowling 1985).

Many commentators have captured the changing professional boundaries between doctors and nurses in primary care (Ross and Mackenzie 1996; McIntosh 1996; Jenkins-Clarke et al 1998; Williams and Sibbold 1999; Mc Intosh et al 2000). It has been noted however, that the pace of change and the effect that this has had on the work and routine of district nursing has been variable (Griffiths and Luker 1994; Ross and Bower 1995; Griffiths 1996; Goodman 1998; Goodman 2000). Mc Intosh and her colleagues (2000) argue that the pursuit of flexibility and flexible team working in primary care has occurred:-

> "incrementally and unevenly across the UK, without policy guidelines, without an apparent basis upon which to judge the appropriateness of any specific mix of grades and largely without evidence based debate about the possible consequences for patient care" (Mc Intosh et al 2000, p784).

Tensions within the team have been identified. Some observers have suggested that there is considerable frustration among members of the primary health care due to the lack of clarity in roles (Bryar 1994; Wiles and Robinson 1994; Galvin et al 1999; Mc Intosh 2000). It has been noted that GP's are frustrated about the limitations and restrictions placed on the role of the nurse in primary care (Bowling 1985; Bryar 1994) particularly by Trust managers who some GPs viewed as an unnecessary inhibitor of the potential developments in teamwork (Goodman 1998).

The general consensus in the literature is that effective inter-professional teamwork is the exception rather than the rule in primary care (Wiles and Robinson 1994; Williams and Sibbold 1999; Jenkins-Clarke et al 1998; Goodman 2000). This is particularly startling when one considers that the rhetoric of teamwork in primary care has been espoused in governmental reports for some eighty years. Some suggest that this is the result of differing interpretations of both skill mix arrangements and the inconsistent utilisation of professional skills within the primary health care team (Jenkins-Clarke et al 1998; Jarvis 2001). As has been noted (Mc Intosh et al 2000) few firm directives have been given about how primary care should be organised. Thus flexibility and difference in team structures seems to be the order of the day (Williams and Sibbold 1999; Jenkins-Clarke 1998; Goodman 1998).

Flexibility and variability in teams is particularly evident, as more recent studies have shown, in the post-fundholding primary health arena where individual groups of GPs have been able to negotiate differing levels of service agreements with community nursing providers (Griffiths 1996; 1998; Goodman 1998; Goodman 2000). Consequently the configuration of the nursing team and the wider primary health care team has changed considerably but not consistently (Griffiths 1996; Williams and Sibbold 1999; Mc Intosh et al 2000; Hallettt and Pateman 2000; Goodman 2001).

Given that there is a dearth of evidence to support either the existence or effectiveness of the primary health care team, it is little wonder that some

commentators hold a somewhat cynical view of the blurring of professional boundaries and flexible working (Gibbs et al 1991; Mc Intosh 1996; Mc Intosh et al 2000). Based on systematic research, some commentators have argued that the pursuit of flexibility has been less to do with positive patient outcomes (Gibbs et al 1991; Goodman 2000) and more to do with moving care from expensive to cheaper providers, that is, from doctors to nurses and from nurses to other less qualified or even informal carers (Gibbs et al 1991; Williams and Sibbold 1999; Williams et al 1997; Goodman 2000). Thus the team concept and the consequent relationships are, it is suggested, more to do with economics and cost containment than any real desire for inter-professional working (Williams and Sibbold 1999; Griffiths 1996; Goodman 1998; Jarvis 2001)

It is more likely therefore, that the pursuit of flexibility and teamwork in primary care is likely to be the result of a number of factors. Firstly, as outlined above qualified district nurses are an expensive commodity whose skills, it is suggested, are used inefficiently (Lightfoot et al 1992; Audit Commission 1992; 1999). Secondly, it has been found that there is duplication of work across and within primary health care teams and considerable defensiveness to shared goals exist (Griffiths and Luker 1994; Cartledge and Harrison 1995; Jenkins-Clarke 1998; Goodman 2000). Thirdly, the district nursing workforce is ageing and there is noted to be a declining pool of qualified nursing labour. This effectively suggests that the future of the community nursing services and potential developments in the primary health care team will be challenged in the near future as a result of a declining collection of labour (Seacombe and

Patch 1995). Thus, the discourse of inefficiency and professional territorialism among primary health care staff and teams (DoH 1997; 1999; Jenkins-Clarke 1998; Goodman 2000) which has been used to counteract the inertia in the formation of flexible teams, is a persuasive dialogue from which to justify a move towards flexible working practices and experimentation in primary care. This may serve, at least in part, to assure some sort of sustainable workforce in the primary care setting of the future. It can be reasonably concluded that the pursuit of flexibility has more to do with securing the future of primary care services than a quest to establish a functional team.

Summary

This section has highlighted that there is some evidence to suggest that the organisation of primary care is more akin to a group of people working in one geographical area, with the same patients, than a team in any real sense. Whilst there are some insights to the district nursing profession and their perspective on the team in primary care (Griffiths 1996; Hiscock and Pearson 1996; Goodman 1998) the majority of research takes the primary health care team as a whole and often collapses the nursing contingent into one voice (Jenkins-Clarke 1998; Williams and Sibbold 1999; Jarvis 2001). This chapter has reported on research, which has consistently found that the situation for district nurses in primary care is considerably different to that of their nursing colleagues in the primary health care team. Consequently, there is a need to gather more information about district nurses as an occupational group working in the primary care arena. This is particularly important in the light of

the new arrangements for primary care and the supposed closer working relationships that will ensue as a consequence of the latest re-organisation of primary care.

Chapter 4 - The Theoretical Underpinnings of Ethnographic Studies

From Quantity to Quality – Research Paradigms and the quest for knowledge

> "A way of seeing is always a way of not seeing"
> (Wolcott 1999, p1)

Research is a matter of faith. This faith begins with the construction that the researcher holds as to the nature of reality or *ontology,* from which arises an understanding of the relationship between the inquirer and what can be known about the world or *epistemology*. These two elements of a paradigm determine the methods adopted by the inquirer and how they set about searching for new information or knowledge about the social world, or *methodology* (Guba and Lincoln 1994; Hammersley and Atkinson 1996; Marcus 1998; Wolcott 1999). Within the world of research, there is considerable and sometimes acrimonious debate between competing research paradigms. Therefore, it is customary in major research projects to make clear to the reader the theoretical underpinnings of the chosen methodology and to examine these in relation to other research paradigms. The following chapter aims to outline the theoretical underpinnings of the inquiry conducted for the study reported here.

Cartesian – Naïve Realism

Perhaps the most commonly adopted research methodology in the field of social inquiry is the positivist approach grounded in the work of Rene Descartes 1591-1650. Descartes was both a mathematician and a philosopher (Collinson 1992; Hamilton 1994). His basic epistemology centred around applying the principles of the world of mathematics to the study of human society. Descartes postulated that the social world could be ultimately represented and described as clearly as a mathematical equation could depict the geometry of a figure (Guba and Lincoln 1994). Indeed, he suggested that society could be understood with the: -

> "certainty and self evidence of mathematics" (Descartes 1968, p31)

The epistemology arising from such a belief proposes that it is possible for the human inquirer to objectively study the world and produce claims to truth about society which have intrinsic validity and reliability (Collinson 1992: Hamilton 1994; Guba and Lincoln 1994).

This discourse has for many years supplied social researchers with the epistemological justification for the formulation of knowledge about society. In particular positivism has influenced classical and contemporary sociologists in the understanding of society as a collection of social facts waiting to be discovered and verified through a discourse of rigour, objectivity and assumed neutrality in the investigative process (Ritzer 1996). Even in its more diluted

form, the post -positivist perspective of critical realism continues to suggest that the social world can be studied from a relatively objective stance, producing findings that are "probably true" and generalisable to the social world (Guba and Lincoln 1994 p109). It is against this absolutism (or in the case of critical realism shades thereof) that qualitative epistemologies have developed.

Qualitative Paradigms

In contrast to positivism, qualitative research does not assume that the social world is easily described or manipulated in the way that deductive research proposes. Indeed for many qualitative inquirers, the assumption that underpins their work rests on the central tenet that society is a complex web of competing influences. Therefore the positivist truth claims about simple relationships between naturally occurring phenomena are at best part of a story and above all temporal (Denzin and Lincoln 1994; Strauss and Corbin 1990; Marcus 1998; Wolcott 1999). Therefore, the process of human inquiry requires strategies other than the experiment, if the multifaceted nature of human society is to be known. However, it has been suggested in the literature that the nature of qualitative research has been such that the Cartesian discourse of positivism has yet to be: -

> "replaced by any of the alternative programmes that have been proposed, first, because no unanimity exists as to which of these alternatives offer what appears to social scientists to be a viable methodology for social scientific research. As a result, as many have argued, the social sciences are cast adrift without a theoretical anchor." (Heckman 1986 p1.)

Immanuel Kant was amongst the first philosophers to challenge Cartesian thought and is credited as being the ultimate source of qualitative thinking (Hamilton 1994). Kant (1949) argued that human perception is the product of not only what one senses (sees, hears or observes) but is also the product of how the interpreter organises this information through mental processes. Importantly, Kant rejected the Cartesian notion that factual truths about what does and does not exist can be established by pure reason alone. Kantian thought makes the distinction between theoretical knowledge (or that which can be tested and accepted) and practical knowledge (which refers to the process of decision making and self determination) in the inquiry process (Kant 1949). Thus the Kantian model of human rationality suggested an epistemology that moved beyond the rationalist notion of objectivity and introduced the concept of subjectivity to the research process (Atkinson 1995). As Hamilton observed: -

> "Kant opened the door to epistemologies that allowed, if not celebrated, inside the head processes" (Hamilton 1994, p63).

The freedom of practical reason (Kant 1949) allowed for the possibility that universal truths and social facts were temporal. Perhaps the most important contribution to contemporary qualitative inquiry offered by Kant, were the ideas he presented about the subject-object relationship in the research process. Where Cartesian thinking dichotomised the observer and the observed in the research process, Kant suggested that the two were locked in a dialectic relationship. The inquirer's presence was as important in the research process as that of their subjects in the generation of knowledge

(Collinson 1992: Hamilton 1994; Kearney and Rainwater 1996). The notion of methodological subjectivity in human inquiry was the greatest challenge made by Kant against positivist thought. It is this notion that was developed further by Martin Heidegger (1967).

Heidegger's (1967) main thesis examined the meaning of being which he argued had been ignored by many philosophers and social scientists in Western thought. In particular, Heidegger suggested that *being* or *Dasein* is accessible only through a world that we already understand from being in it (Heidegger 1967). Therefore the proposition that we can understand the world in any objective way is inherently flawed. As *beings in the world* we can tend only to discern what makes sense to our own personas and the way that we can conceptually understand the world is inherently influenced by our own perception of it (Kearney and Rainwater 1996). These ideas have perhaps provided the greatest challenge to the established ontological and epistemological paradigms of both quantitative and qualitative research.

The debates fuelled by Descartes, Kant and Heidegger have influenced critical theorist, post-structuralists and post-modern thought. In turn, these approaches have contributed to the developments of qualitative paradigms. However, it is this plurality of approaches that causes confusion and sometimes consternation among positivist researchers as they view the entire field of qualitative research methods with scepticism (Atkinson 1995; Denzin and Lincoln 1994). It is to the variety of epistemologies that this discussion

now turns. Particularly, the discussion of how ethnography has developed from its epistemological roots in scientific inquiry.

Positivism and Ethnography – The Early Years

It is widely acknowledged that the term ethnography arose from schools of cultural anthropology whose aim was to discover the laws and social facts that governed alien societies. The purpose of this form of inquiry was firmly entrenched in the idea that the study of primitive societies could expose or produce insights into how our own social world was constructed and or developed (Vidich and Lymen 1994; Hammersley and Atkinson 1996; Marcus 1998). However, few commentators record that the origins of ethnography were linked to the Social Darwinism and Ethological methods employed by biologists when studying not only other cultures but indeed other species (Thorne 1991).

It is hardly surprising that early ethnographers justified a scientifically rigorous or realist stance to the study of the other (Vidich and Lyman 1994; Wolcott 1999). The methodology espoused through this naïve-objectivist position assumed that the facts spoke for themselves and therefore the work of the inquirer was to merely put him or herself in the field and let the data flow (Sayer 1999).

A characteristic of this approach was that the ethnographies produced as a result of long periods of immersion in the field were often etic, that is from the

perspective of the researcher rather than the emic reality of the subjects (Harre 1984). It has been suggested that early positivist ethnographic texts were produced by ethnographers who were trained to observe from a check list of universal entities (or social facts which were inherent in all societies) which included aspects such as family life, religion, economy and money exchange as well as marriage and relationships (Marcus 1998). The texts produced as a consequence of this paradigm were for many years viewed as credible and truthful as the theoretical underpinnings held true to the rigours of the dominant scientific discourse. Universal societal laws were captured and described in a language that was assumed to be value neutral (Lincoln and Guba 1985; Sayer 1999). However, these claims to truth and representation have latterly been called into question, through what has been labelled retrospectively the *crisis of representation* (Marcus 1998; Denzin and Lincoln 1994). Old style anthropology has had to face the criticisms of legitimacy in their representation of the other in academic texts. This has led to the development of a softer form of positivist inquiry, or post-positivism.

Post Positivism or Critical Realist Ethnography

Critical realist ethnographers distance themselves from the tradition of positivist inquiry by suggesting that reality is out there (ontology) and can therefore can be studied but only *imperfectly* and *probablistically* (Guba and Lincoln 1994). There is an acceptance that ethnographic texts may still be presented in an objective fashion and that the findings are probably true and generalisable providing that a level of academic rigour has been maintained

throughout the inquiry process. It is therefore suggested that reality exists independently of the inquirer: -

> "Although social phenomena cannot exist independently of actors or subjects, they usually do exist independently of the particular individual who is studying them." (Sayer 1999, p49)

It has been noted that much of the discussion of critical realist ethnography methods has retreated in writing about fieldwork techniques rather than dealing with the mission impossible of tackling the ontological and epistemological problems of contemporary ethnography (Hammersley 1993; Wolcott 1999). Indeed, the branch of critical realism labelled naturalism purports that; -

> "Naturalism proposes that through marginality in social position and perspective, it is possible to construct an account of the culture under investigation that both understands it from within and captures it as external, and independent of, the researcher! In other words as a natural phenomena" (Hammersley and Atkinson 1996 p9-10).

There has been some movement within critical realist ethnography to accept the epistemological challenges presented by Kantian and Heideggerian thought and the critique of logic. However, the prevailing critical realist stance still generally opines that micro descriptions of society can be applied and generalised to the whole. The links to positivism and empiricism can be seen in the way in which methods are employed as a means to an end rather than as means in themselves of accessing knowledge: -

> "Methods are mere instruments designed to identify and analyse the obdurate character of the empirical world, and as such their value exists only in the suitability in enabling the task to be done" (Blummer 1969, p27-8)

Therefore contemporary critical realist ethnography has not rejected the principles of realism per se but rather accepted that doubt has been thrown onto the claims to scientific authority associated with it (Hammersley and Atkinson 1996; Sayer 1999).

Critical Theory and Ethnography

The school of critical theory has been influenced by the works of Marx, Kant and Weber. The stated aim of the school has been to develop an understanding of the oppressive apparatus that exist in society which perpetuate racism, class and gender oppression (Gramsci 1971).

It is postulated that historical factors have shaped society and as a consequence of this, a series of structures exist which are taken as real or immutable (Guba and Lincoln 1994). Kincheloe and Mc Laren (1994) argue that people act as if certain social and cultural relations are true, even when they are not. Thus the proposition that power exists only because we obey its rules, is integral to the critical theorist's study of society. It is suggested by critical theorists, that the acting *"as if"* relations explain the forces that reproduce the economies of power and hegemonic relations that exist in society and these relations are the mainstay of critical theory inquiry (Gramsci 1971; Kincheloe and Mc Laren 1994).

In practice therefore, a critical theorist's ontology would suggest that the mechanisms of oppression either existed (historically) or exist today. Their epistemological stance is one in which the researcher can relate to the other in an attempt to understand their perspective on the world and discover the truth about the lives of the subjects in relation to the powers that oppress (Kincheloe and Mc Laren 1994: Guba and Lincoln 1994). Importantly, critical theorists ask pertinent questions which locate their texts in history by asking how things have come to be a certain way? Who benefits from them? And importantly how do we as researchers construct the world? (Guba and Lincoln 1994; Hammersley and Atkinson 1996; Sayer 1999). Thus researchers who adopt a Marxist, Feminist, Weberian perspective view the world from their carefully located theoretical underpinnings and set about inquiries from within the confines of their academic or political discipline.

Critical theorists raise important questions as to how the inquiry is conducted in qualitative research and provide a critical stance on important methodological issues. For example, feminist writers have offered a sustained critique on the essentially masculine paradigm of interviewing techniques and have alerted qualitative researchers to pitfalls in the quality of the data they collect in the process of interviewing women (Oakley 1981).

For the critical theorist, the important part of the inquiry process is to enter into an investigation with their assumptions on the table. In doing this, there can be no confusion as to the political or philosophical belief of the investigator

and the reader of the text is aware of the methodological pre-suppositions of the author. This has been an important development for qualitative research and perhaps the first time in modern ethnography that the Kantian and Heideggerian ideas of subjectivity have truly entered the discourse of qualitative inquiry.

A Critique of Contemporary Ethnography – The Influence of Post Modernism

The previous sections have outlined contemporary paradigms in ethnographic research. What they generally have in common is the proposition that the reality of the social world is to a greater or lesser degree a fact, which investigators can study with varying degrees of objectivity. Even at the softer end, critical theorists still pertain that social structures exist, even if they are only in the mind and actions of actors in society. It is from here that the philosophy of post-modernism developed.

Post-Modernism has developed from the work of Lyotard (1984) Derrida (1976) and Foucault (1977). In essence, their philosophical approach respects the complexity of the social world as a multifaceted entity that is ever subject to change and difference. In relation to the influence of post-modernism on research, perhaps the most accessible account is offered by the post-modern feminist Patti Lather: -

> "Postmodern – a response across disciplines to the contemporary crisis of uncertainty brought about by crash of modern hope of rationality and technology to solve human dilemmas and quest for a description of 'truth and reality'" (Lather 1991, p20)

It argued therefore that there are limits in our ability to understand the world in any objective way. Therefore our way of knowing the world is influenced strongly by the prevailing discourses of the time, which have an effect on knowledge and understanding (Foucault 1977). Here the influence of Heidegger is evident. Kincheloe and McLaren (1994) argue that an essential part of the post-modern influence on ethnographic writings is the temporal nature of knowledge and truth and consequently post-modernist investigators have suggested that investigative work should be tempered with research humility. Research humility is an approach to the inquiry process that suggests the social world is essentially unpredictable and acknowledges the capriciousness of the investigation. The post-modern approach to ethnography requires the inquirer to construct their perception of the world anew in a way that undermines what appears natural and to open up what appears obvious (Slaughter 1989). In essence, post-modern approaches adopt a philosophical slant which:-

> "Privileges no single authority, method or paradigm" (Denzin and Lincoln 1994, p15)

Thus, post-modernism aims to challenge the wholly legitimate recording of experience in research by questioning the nature of truth (Kincheloe and Mc Laren 1994; Marcus 1998). The idea of a completely authentic representation

of "the other" in research , it is suggested "finds its epitaph in post-modernism" (Parsons 1995, p23).

The Post modernism critique of ethnography critically assesses the claims that ethnographic texts have made to authority, arguing that the discourse of scientific inquiry inherent in the work of ethnographers is but one way of seeing the social world (Clifford and Marcus 1994: Kincheloe and McLaren 1994; Marcus 1998). The methodological workings of post-modernism suggest that the social world can only ever be captured in context and therefore can only be described in reference to this context (Gbrich 1999). An important deviation from other approaches to human ethnographic inquiry has been the reflections it has made on representing a part of society as reflective of the whole: -

> "just because people are together in one area, does not mean they share a common culture" (Laugharne 1995 p52)

In accepting this premise, post-modernism has suggested that ethnographic methods should include the idea of heteropia or polyphonic interview styles (many voices) and should be multi-sited so that diversity and consensus can be accounted for in the text (Hammersley and Atkinson 1996; Marcus 1998; Wolcott 1999). It is the act of presenting disparities in the research process rather than conflating incommensurables together in the search for theory (eg grounded theory, Strauss and Corbin 1990) that should be the substance of post-modern ethnographic texts (Marcus 1998).

In doing so, ethnographies influenced by post-modern thinking reject the notion of a privileged frame of reference and accept the fallibility of the text alongside the possibility of its emancipatory potential (Kincheloe and Mc Laren 1994). Importantly, research humility casts doubt on absolute claims to truth and validity of any research in the positivist sense of the meaning.

Thus, post-modern ethnography attempts to make clear the trials and tribulations of the messiness of fieldwork so that the reader of the text may assess the value of the work (Marcus 1998). Importantly, the influence of post-modernism has suggested that in the final analysis the ethnographic text remains just one version of reality, however much the findings may or may not resonate with the wider population (Lincoln and Guba 1985; Marcus 1998; Wolcott 1999). However, it is rare to find an ethnographer who adheres totally to the post-modern methods, rather : -

> "The label of post-modern anthropology is usually applied hostily to the critics of ethnography ... it is rare to find anyone who will own up to it." (Marcus 1998, p185)

Post Modernism and Research Methodology

The most common methodological approach associated with post-modernism, particularly within nursing and medicine, has come to be termed discourse analysis (Potter and Weatherall 1987; Denzin and Lincoln 1994; Geertz 1988). This is a specific ontological position which aims to dissect social interaction with the purpose of highlighting how power and knowledge are mediated

through language and interaction (Potter and Weatherall 1987; Geertz 1988; Ritzer 1996). Heckman (1986) argues that discourse analysis aims to uncover the positive unconscious of knowledge through intricate examination of the nuances and structure of speech and interactions. Many commentators and researchers have been persuaded by this form of investigation and have provided useful insights into the power dynamics between doctors and patients (Lupton 1996; May 1991) and indeed the influence of the language of nursing texts on nursing practice (Armstrong 1983).

However, as a research method, there are very few practitioners of discourse analysis within nursing. This is most probably due to the fact that the training required for discourse analysis is highly specialised (Hammersley and Atkinson 1996; Gbrich 1999). As a consequence of this, there are few suitably qualified and experienced supervisors in this area of nursing research (Watson 1995). In the case of the study presented in this thesis, the lack of adequate specialised training and the dearth of appropriate supervisors were influential in the rejection of a discourse analysis perspective and consequently the adoption of a broader post-modernist approach.

That being said, a major criticism of discourse analysis is that too much of a reliance is placed on the analysis of spoken language (Atkinson and Hammersley 1994; Marcus 1998) and the role of observation is often negated or reduced to a very minor place in the acquisition of some background knowledge of the social context (Atkinson 1995). Commentators on the outside of post-modernism (Atkinson and Hammersley 1994; Hammersley

1992) and those within (Marcus 1998) have suggested that attention to the language forms of social interaction is an important adjunct to ethnographic texts. It can not, nevertheless, be a substitute for a more holistic approach which involves informal conversations between investigator and research participants, the questioning of contributors, the use of multi-sited study centres and the process of observation (Atkinson and Hammersley 1994; Marcus 1998; Gbrich 1999). Therefore, a wider analysis of power through a process of deconstruction, which may at times include a detailed examination (rather than analysis) of linguistic interaction, is most commonly associated with post-modern approaches to research (Denzin and Lincoln 1994; Lincoln and Guba 1985; Watson 1995). In the case of post-modern ethnography a more holistic, multi-method approach associated with deconstruction is currently favoured (Clifford and Marcus 1994; Geertz 1988; Denzin and Lincoln 1994; Marcus 1998).

Deconstruction is the process by which researchers examine the social world of the researched by explicating the knowledge, power and discourses existent in social interaction (Derrida 1976; Foucault 1984; Denzin and Lincoln 1994: Watson 1995; Parsons 1995). The post-modern research act seeks to highlight: -

> "Contradiction, multiplicity of perspectives through deconstruction, which involves searching through the discourses to unravel ... power and knowledge bases, and biases of particular truths" (Gbrich 1999, p24)

Nurse researchers, particularly those influenced by post-modernism, have commented that understanding social life is best achieved through a multi-

method approach in the research process (May 1992; 1995; Parsons 1995; Watson 1995; Johnson 1997). This involves the researcher moving to a level of interpretation, which makes sense, offers interpretations and explains and explores the data (Watson 1995; Johnson 1997; Gbrich 1999). As Parsons argues: -

> "The researcher can not rely on the research interview or observation alone to generate an understanding of social life" (Parsons 1995, p25).

It is therefore suggested that the researcher has a philosophical belief or interpretive framework from which to examine, explore and contrast the data from a study. In the case of my own personal philosophy, the associated political, organisational or interpretive framework of post-fordism will be used extensively throughout this study.

Post-Modernism, Post- Fordism and the Understanding of Organisations

Post-fordism has been previously described in thesis as a flexible form of organisation that has replaced the traditional fordist model of management (Watson 1997). It is argued in the literature that the post-fordist movement has been an attempt by sociologists to apply the logic of post-modernism to the work place (Piore and Sabel 1984; Gartman 1997; Salvage 2000; Hugman 2001). Where as post-modernism is an overarching social theory, post-fordism is the comparable method of understanding contemporary organisations (Fox 1993).

Sociologists influenced by the post-modern philosophy have argued that in recent times they have seen the demise of the standardised, mass produced goods (economies of scale) including health care services (Amin 1994; Hurst and Zetlin 1994) in favour of a wider product bases (economies of scope) which focus on niche markets, are consumer led and constantly changing with consumer demand (Sewell and Wilkinson 1992; Hurst and Zeitlin 1994; Piore and Sabel 1984; Harrison and Wood 1999; Hugman 2001).

The characteristics of the post-fordist workplace are the creation of specialised niche markets (Hurst and Zeitlin 1994;) flexible and adaptable workers and working methods (Clegg 1990; Salvage 2000) and reskilled workers whose structural position within the workforce is ever changing with the demands of consumers and or service users (Clegg 1990; Sewell and Wilkinson 1992; Watson 1994; Salvage 2000; Hugman 2001). Perhaps the most essential feature of post-fordism and the relationship with post-modernism is the absence of a grand narrative (discourse) of capital accumulation and the standard product. In its place there is an ever changing workforce, flexible specialisation and an increasingly malleable workforce (Hurst and Zeitlin 1994; Watson 1998; Salvage 2000).

In research terms, the greatest contribution of post-modern/post fordist researchers in the study of the sociology of work is the unique way in which they interpret the term Organisation. Post-modern/post-fordist researchers view organisation as both a noun and a verb (Fox 1993; Watson 1997; Salvage 2000). The term organisation is used not only to identify the physical

space within which work is carried out but also to examine the way in which people are "organised" either by a managerial system or through self regulatory mechanisms (Sewell and Wilkinsons 1992; Fox 1993; Hugman 2001). It is here that the links to the post-modern notions of power, knowledge and discourse are clearly evident. The approach invites the researcher to open up their understanding of organisations by studying them as both an entity and a process. It is this position that has been influential in the production of this text.

Summary

This chapter has attempted to outline the philosophical underpinnings of contemporary ethnography from the early positivist roots to the latter day critiques of ethnographic research offered by post-modern commentators. The link between post-modernism and post-fordism has also been discussed. It is my assertion in this thesis, that the research humility and openness in the research process advocated by both critical theorists and post-modern researchers should be the main element of any research project. Therefore, the next chapter will address the issues of the inquiry process in detail in the attempt to allow the reader to judge the quality of my research findings.

Chapter 5 - Working Methods

Introduction

It is usual in qualitative research for the researcher to make the process of their decision making clear to the reader of the text (Lincoln and Guba 1985). In doing so, the researcher makes explicit the methods used during the study which enables others to make judgements about the quality of the text, the worthiness of the data and the pertinence of the final story (Wolcott 1999; Marcus 1998). Whilst qualitative research has moved away from the rigours of scientific inquiry, the trustworthiness of a naturalistic text depends on the reader being able to follow and understand the way in which the inquirer has arrived at the final conclusions or theory (Lincoln and Guba 1985). In doing this, the author affords the reader the ability to make critical decisions about the value of the research findings (Marcus 1998; Altheide and Johnson 1994).

It is therefore essential in describing working methods that the author portrays both the smooth and the bumpy conduct of his or her data collection. It has been suggested that contemporary ethnographers should explicate the surprises, the problems and the difficulties that they encountered along side the less troublesome aspect of the research process (Wolcott 1999). This in itself helps the reader evaluate the text. That being said, this section is not an attempt at proposing that the data presented in this thesis are valid or reliable in the way that positivists would attempt to defend their work but rather aims to assist the reader to review the findings with a critical eye.

Personal Biography

It is generally accepted that the subjective nature of qualitative enquiry depends as much on the researcher and his or her personal biography as the methods chosen to collect information (Fine 1994; Lincoln and Guba 1985; Marcus 1998). It is therefore important in presenting the methods employed in a study to include any personal details about the researcher which might affect the process of information gathering (Fine 1994; Punch 1994). Indeed, there have been calls for qualitative or naturalistic inquirers to make their own "intellectual autobiographies" (Oakley and Callaway 1992) explicit in order that the reader understands the reasons why academics end up studying what they do. The following is a resume of the influences on my own life that I consider important to the readers' ability to judge this text.

I trained as a general nurse in a local district general hospital and qualified as an RGN in December 1985. Following this, I worked for a short time in a variety of staff nurse posts, mainly on medical wards. After a somewhat early promotion to a charge nurse post (eighteen months post qualifying) I inherited my own medical ward, which I ran successfully for one year. I became increasingly personally dissatisfied with my position and although I loved nursing, I felt intellectually stunted. Therefore I left my nursing post to study for a full time degree in sociology and psychology which I completed in 1990. I therefore consider myself to be a nurse first and a social scientist second.

Following graduation I took up a position with a community based drug service and was quickly promoted to the post of Clinical Nurse Specialist for HIV/AIDS and Drugs. This was a community based post, which involved nursing people and their families affected by and with the HIV virus. It is here that I first encountered and worked with district nurses.

Whilst working in the community I also trained as a counsellor and psychotherapist. This obviously has important bearings on how I interact with people and who I am in the research process. I will return to this aspect later when discussing the conduct of the research process.

Politically, I am a committed socialist, and for many years I held Marxist beliefs. More latterly, I have become a follower of the post-modern movement and I am highly influenced in my thinking by the work of Michel Foucault. I am a strong union member and have been active in nursings' political struggle. The particular danger here is outlined by Fine (1994) where she states that this may be a pitfall for qualitative researchers if they attempt to speak out for "the other": -

> "Herein lie the very profound contradictions that face researchers who step out, who presume to want to make a difference, who are so bold and arrogant to assume we might. Once out ... we trespass all over the classed, raced, and otherwise stratified lines that have demarcated our social legitimacy for publicly telling their stories" (Fine 1994, p80)

Whilst I will address this methodological issue later, it is important that the reader remains aware of my own biography in comprehending the rest of the findings presented in this thesis.

The Research Question

It is commonly accepted that ethnographic research begins with a broad research question, which guides the initial stages of the inquiry Wolcott (1999). As outlined in the first chapter the aims of this investigation where to answer the following questions:-

1. How are the changes in the organisation of Primary Care affecting the work of district nurses?
2. What organisational factors influence the work and culture of district nursing?

In essence, the aim of the research was to discover more about the culture of district nurses. The particular reason for choosing this group was that my interest in their response to clinical supervision had stimulated my curiosity.

In order to meet the aims, an ethnographic approach was decided upon. In keeping with contemporary ethnographic traditions, participant observation and polyphonic interviews were chosen as methods of data collection. The reasons for drawing on a range of qualitative methods (observation, polyphonic interviewing and informal interviewing) is in keeping with contemporary ethnographic research which places an emphasis on

discovering the social world (Hammersley 1992; 1993; Murphy et al 1998) through direct engagement with and immersion in the concrete reality of social life (Hammersley 1992; Murphy et al 1998). Modern-day ethnographic researchers stress the importance of flexibility in the research approach. This can be achieved through the use of both observation and interviewing (Munhall 1993; Marcus 1998; Wolcott 1999). As Murphy et al (1998) suggest: -

> "Relying on what people say, without observing what they do ... is seen as particularly likely to distort social reality" (Murphy et al 1998, p 83)

Thus, this study has utilised the concept of an emerging design using triangulated methods (observation, informal conversations, interviews) that has encompassed plasticity both in design of the investigation and the approach on the researcher (Guba and Lincoln 1994; Murphy et al 1998; Johnson et al 2001).

The Research Process

Qualitative research generally follows a flexible but none the less organised pattern (Altheide and Johnson 1994; Wolcott 1999). The general schema for the collection and interpretation of data in the study reported here was based on reading many texts and the format below was adopted: -

- Getting in or accessing the scene
- Self presentation

- Developing trust and rapport
- Fitting in
- Mistakes, misconceptions and surprises
- Methods of data collection
- The organisation of data
- The writing and the organisation of the text

(Fontana and Frey 1994; Burgess 1993; Altheide and Johnson 1994; Hammersley and Atkinson 1996; Wolcott 1999).

Getting In

Gatekeepers are crucial to the success of a qualitative study (Argyris 1969). It is suggested that researchers may suffer by being seen as extensions of their political sponsors or supporters of the management structure within the setting despite their protestations or denials to the contrary (Punch 1994). For this reason, I chose not to study the district nurses that I had had passing acquaintance with (those within my own Trust) but rather opted to contact two Trusts outside my own area. This resulted in my being granted access to four study sites based across the two Trusts.

Choice of Study Sites

I chose the first study site as it was a large first wave Community Health Care Trust which had been at the forefront of GP fundholding. One of the main reasons for choosing this Trust was that of those Trusts I had considered, I

was offered a contact in this area and a named person that I could approach. It was near enough to be reached from home during periods of observation and there were many teams of district nurses' based within the community services. This particular Community Trust was far enough away from my own practice area for me to be unfamiliar with the organisation and therefore I could enter the field with little or no preconceptions of the personalities or organisational practices that I might encounter. For reasons of confidentiality, only a brief description of this area is provided.

This particular trust was a demographically large Community Trust, which was a largely suburban district which neighboured a large provincial city in the North West of England. It had a high number of first wave general practitioner fundholders. The most important demographic details of this particular site was that most of the inhabitants of this area belonged to the professional classes, with a fair percentage belonging to social classes I or 2. There were only small pockets of identifiable social deprivation or poverty in this area.

In contrast to site one, site two was an urban area located in a large city in the North West of England. This particular Community Trust had a chequered history of GP fundholding and there were still pockets of resistance among GPs to the advent of fundholding at the commencement of this study in late 1996. This was one of the main reasons for choosing this study site was that I could look at the differing effects GP fundholding (the most important structural change in the reconstruction of district nurses work) may have had on the organisation and culture of district nursing. Another contrasting feature

of this study site, was that there were large pockets of social deprivation which co-existed with sub-urban areas, similar to those in study site one. I felt that this site would highlight both contrast and similarities with the first study site.

Gaining Access

Access to both study sites was initially initiated via a telephone call to each of the senior nurses in the respective study sites. Both nurses had responsibility for the overall organisation of district nursing services. In both sites I made an appointment to see these nurses and outlined the nature of the project, the broad aims and objectives and the details of the commitment required from participants willing to participate in the study. At this point I stressed that participation in the study was to be voluntary and that I would not consider being allocated to either a group or a team of nurses.

In site 1, once I checked that the purpose of the study was understood, the gatekeeper facilitated my access to her senior nurse colleagues, who were responsible for the direct management of locality based nurses. Following this, I was invited to attend a meeting of these senior nurse managers, where once again I outlined the nature, aims and objectives of the study and allowed time for questions. Importantly, I discussed the resource implications of the study for managers, which I felt was to be minimal in terms of time and hours spent away from work. At this point two managers indicated that they would like to have their teams "observed". I declined their offer and requested that I be allowed to attend a meeting of all of the Trust's district nurses, in which I

could address practitioners *en masse* to explain the purpose of the study and introduce myself and my reasons for undertaking the investigation. All of the senior managers at this meeting indicated that I might meet with problems as the 1992 Audit Commission Report (1992) had been undertaken in this area and had left a bad feeling among nurses about any form of observational research. I noted this suggestion but at this point I had already made appointments to see both major trade union representatives in this area (RCN and UNISON) to explain the project and enlist their support.

Through my meetings with these two gatekeepers (union representatives) I was able to explain the purpose of the study, that I was funding the project myself. I outlined that my aim was to look deeper than the Audit Commission Report (and similar "research") at the work and organisation of district nurses work and that I was aiming to capture how district nurses felt and reacted to each other, their managers and their conditions of work. This seemed to satisfy these nurses who both gave me verbal permission to state to participants that my project had their respective Union's support. I felt that this was an integral way of distancing myself somewhat from my primary contact with managers and the Trust as an organisational body. This is an essential process in assuring that I was not seen as an extension of this organisation (Punch 1994).

In the second study area, after repeating the above process with the senior nurse and nurse managers, I gained access to participants directly through the union representatives (following the procedure outlined above) who gave

me the names of individual district nurses from within the trust. I requested that the gatekeepers contacted the nurses prior to my own cold contact and to then inform me if the nurses decided for what ever reason, not to take part in the study. None of the teams refused to take part at this stage. From then on I arranged to meet with the nurses directly. This was particularly important as the nurses from this area had been involved in a long standing dispute with the Trust managers about industrial relations and staff conditions of employment. Through this process I was able to address three teams of nurses from different areas within the study site and gain entry to all of them. I was again able to use the approval of the two professional organisations as a way of legitimising and supporting my requests for access.

Ethical Considerations

In both study areas, I raised the issue of ethical approval directly with the senior nursing staff. I was referred to the Trust research/ethics advisers and I met with the respective people to outline the purpose of the study. At both of these meetings, I gave a detailed description of the study aims and objectives, my own ethical concerns and made it clear that although I would be observing the work of district nurses in patient's homes, I would not ever be interviewing or soliciting the opinions of patients or relatives. A copy of the information I supplied to each study area appears in appendix 2. In both study areas at this time, it was felt that formal ethical approval (via the local ethics committee) would not be required as I would not be interviewing either patients or their relatives.

However, in both of these meetings, I raised the issue of potential malpractice. Neither lead person for ethics approached this subject first. I felt that as I would be observing district nursing practice in the home, there may have been a chance that I could encounter either poor or dangerous practice. I therefore felt it important to make clear my stance on this issue. I did this by assuring each of the parties concerned that I was primarily a nurse, registered with the UKCC and therefore bound by the same code of ethics and scope of practice as any of the nurses that I would be recruiting as participants. If I encountered any malpractice, I would behave in the way that would be expected of any responsible nurse encountering such ethical dilemmas. I also made clear to each of the study areas that I would be using the expertise and insight of a former community nurse, now professor of community nursing as a formal overseer and supervisor of my work.

Recruiting Participants

I attended a meeting organised for district nurses. I was given space at the end of their meeting in the absence of any managers. I was introduced as a Clinical Nurse Specialist (my job title at that time) who was undertaking research into the work of district nurses. In area 2, I used the same approach but with individual teams of district nurses rather than a collective group.

I described the nature of the study as an "ethnography," which would involve three main components; participant observation, an unstructured or semi

structured interview and perhaps a second interview or meeting to check out my findings once I had analysed the results. I took time to explain in plain language what each part of this process would involve for them and that I was only concerned with their perceptions of their work and its organisation. As an example, I made it clear that the process of participant observation would involve detailed note taking of their interventions with patients, their colleagues and any other professionals that they encountered during the course of their working day.

In site 1, 17 nurses initially volunteered to take part in the study. In area 2, each of the 3 sites I approached agreed to participate.

The Characteristics of the participants

For reasons of confidentiality, only brief characteristics of the participants are presented here. This is to ensure that the identity of the participants remains as anonymous as possible. The most pertinent characteristics relevant to this study was felt to be the breakdown of qualified to unqualified nursing staff and the average length of service they had had working as a community nurse. It is important to note, that whilst these characteristics may make the participants identity obvious to themselves and their own team, these broad characteristics will inhibit identity by other teams.

Site 1 – Area 1

The team was composed of 9 qualified district nurses, with an average of 10 years district nursing or community experience. The maximum length of time spent working as a community nurse was 22 years and the minimum was 1. Three of the qualified district nurses were within a few years of retirement and 1 nurse was due to retire during the first year of the study. Four staff nurses were also recruited from this area. They had an average of three years community experience and as a collective group, these nurses were shared between the qualified district nurses to assist in the organisation of their work. There were also two nursing auxiliaries, who like the staff nurses, worked across the team with the district nurses and staff nurses.

Site 2 – Area 2

Four qualified and trained district nurses were recruited from this study area. They had an average of 6 years experience of community nursing, the maximum qualified experience as a district nurse was 12 years and the minimum was 1 year. Two staff nurses were employed in this area, both of whom had had 3 years experience of community nursing. There was one part time auxiliary in this area who had worked with the team for 4 years.

Site 2 – Area 3

Three qualified district nurses were recruited from this area. They had an average of 8 years experience of qualified district nursing, although two of these nurses had had staff nurse experience of community nursing. One nurse had been qualified for 20 years and the newest qualified district nurse recruit had had just 1 years post qualifying experience. Two staff nurses were shared across the team, one had been based in the community for 8 years whilst the second had had just 18 months community nursing experience.

Site 2 – Area 4

One qualified district nurse with some 8 years experience who worked with three staff nurses were recruited from this area. The staff nurses had worked in the community for an average of 18 months. One auxiliary nurse who had worked with the team for 5 years was also recruited.

Gaining trust and rapport

At each study site, I left the volunteers with written information about the project (see appendix 3) and I indicated that I would give them time to consider their decision. An important part of this information was the inclusion of a statement that once they had agreed to participate in the study, if they changed their mind or thinking, then they would be free to withdraw at any time, for any reason. I also indicated that I would telephone two days after initial contact, when they had had time to consider their decision. They could inform me personally if they felt that did not want to participate. I made it clear

that as they would be consulting with their team members (staff nurses, auxiliaries etc) that they would not have to give me an explanation but just a simple yes or no answer. When I contacted these potential participants, three of the nurses in site 1 decided not to take part in the study after consulting their staff. I simply thanked them for their time. None of the teams I approached in the site 2 declined to participate. I felt that this process went some way to engender trust, both in myself and my integrity as a nurse researcher and in the aims of the project.

Confidentiality

In the majority of study sites, at least one, sometimes more district nurses asked me would the study be confidential. I assured them that I would never identify individual nurses directly, although my thesis (and subsequent publications) would involve the presentation of direct quotes from observation and interview. This would mean that people may be able to identify themselves and what they had said and may even recognise what others have said if a group meeting was reported, but I would make every attempt to anonymise the data I presented. I indicated that they would be recorded as either a district nurse/staff nurse etc from area x (that is the area would be represented by a symbol) in the North West of England. Where team meetings were reported, I informed participants that the same procedure would apply they would be reported as a team from area y. Whilst I feel that this direct form of response may have had some initial effect on my observation and interviews with participants, and indeed my trustworthiness, I

felt that this was the only ethical way to deal with this potential problem. One nurse from study area 1 offered support that my explanation was understood and was good enough for her by saying "oh good, we like anonymity!".

On two separate occasions (once in area 1 and once in one of the sites in area 2) a district nurse stated that "we were part of the value for money study and there we are frightened that we are being studied again". This aspect of selection of participants represented a potential problem in the process of data collection as I had underestimated the level of the participants' suspicion.

I reassured these nurses that I would not be using the same methodology as that particular study, which did not ask for district nurses' understanding of their work and I reiterated the nature of the study. I took this opportunity to inform participants that the study was undertaken by myself, for my own professional development and therefore I was not working for any other organisation or statutory body. I repeated the fact that if at any time they felt uncomfortable, they were free to withdraw from the study.

In view of the importance of this potential barrier to the study, in the sites where it was not addressed with me by the volunteer participants themselves, I raised it as a concern and I offered the same level of explanation. My research diary at this time recorded that I had a cautious optimism that I felt that I had gone some way to securing trust. Importantly, I felt that I had not fudged any issues.

In the writing of this thesis, therefore, respondents are coded as the status grade (eg sister, staff nurse) and the area from which they were recruited. Whilst this invariably means that the subjects can identify themselves in this text they could be any one of a number of participants. In the reporting of the data, this has meant that the possible over-representation of key informants cannot be effectively determined by the reader as unique identifiers have not been used. This has been the trade off for maintaining confidentiality within this thesis. I felt, that had I provided unique identifiers, for example numbers or letters associated with personal biographies then this would have made participants more identifiable. In the final analysis, this would have meant that members of teams who gave me information about their colleagues and managers would have been more easily identified.

This problem occurred only very late on in the writing of this thesis. At this point it would have been unacceptable and unethical to change the coding system. Therefore, the reader has to take on trust, that I have endeavoured to provide a range of views from different respondents in this thesis. Where the same nurse is repeated this is made clear, or where a particularly unique view was encountered (that is one that differed from the main body of opinion) then this is also made explicit in the text.

Methods of Data Collection

Participant Observation

It is suggested that one method of participant observation is a peripheral membership role, which allows the researcher to gather the insider's perspective. Correspondingly the researcher observes and interacts closely enough with the group without participating in those activities which are integral to the cultural life of the group under study (Adler and Adler 1987). As a nurse, but not a district nurse, this seemed to be the most appropriate observation role to adopt for the course of the study. In practice, it meant that I was situated outside the action, primarily as a researcher, although my identity as a general nurse was known to all participants involved in the study. It also meant that I was able to observe the action without influencing through comments or opinions, the action I was studying. I also took the stance that I would not respond to direct clinical questions or requests for advice, unless the patient was in danger and the information or experience that I had as a nurse would help.

In the field

During the process of participant observation, I generally reintroduced the aims and objectives of the study, the issue of confidentiality and note taking and the way in which I would record and store my field notes. I informed participants that field notes would be stored securely and safely, at my home

under lock and key in a filing cabinet. I also informed participants that the only other person that would see this anonymised raw data would be my supervisor.

During the process of observation I chose to wear the uniform I wore to my own work as a nurse, that is plain black trousers, the standard male nurse's tunic and navy blue epaulets. This uniform was, coincidentally, similar to that worn by male district nurses. This was not a deliberate attempt to fool participants, patients or other people I would encounter but was rather a reflection of who I was and what I actually did. In the study areas where uniforms were not worn, I wore smart but plain casual trousers a plain shirt and in winter times a casual dark overcoat. This was to avoid standing out which has been reported to be a block to the openness of the observation process (Adler and Adler 1987; Hammersley and Atkinson 1996; Wolcott 1999).

I always requested permission to observe participants well in advance of the time I had available. This was for two reasons, one to allow participants time to organise their work so that I would not interfere with particularly sensitive patients and secondly so that they could inform patients that I would be attending in their home. I felt that this was the best way of ethically managing the observation process by allowing both participants and patients the chance to refuse me access to their work and homes respectively.

The Collection of Observational Data

Observational data were collected from the minute we left the meeting point until the period of work was completed. During the process of participant observation I adopted what has been described as a common sense approach to qualitative inquiry (Wolcott 1999). I endeavoured to be seen as the interested and curious human being and nurse researcher that I was (Adler and Adler 1987; Wolcott 1999). It is suggested that many of the data gathered in participant observation come from informal conversations in the field (Fontana and Frey 1994). It is particularly noted that this form of informal data collection can provide the researcher with information that arises from the participants' perspectives and provides rich source of data (Marcus 1998; Wolcott 1999). This approach is entirely consistent with the post-modern approach to research described as polyphony or many voice research (Marcus 1998; Wolcott 1999; Gbrich 1999).

In essence, open dialogue allows for reciprocity and humanness in the process of inquiry and in particular this approach allowed me to forsake my own agenda in favour of following the participant's version of the story. In practice, it allowed me to ask questions from the participant's frame of reference (Rogers 1966) which where truly grounded in the action. Thus questions such as "you looked really annoyed then?" or "you sounded upset, has something gone wrong?" and "I am a bit lost can you tell what has just happened?" enabled me to tentatively access the social world of the participants. To adopt this approach was not difficult for me as my training in

counselling and psychotherapy has given me the gift of being able to recognise and to know when to respond to overt expressions of emotion. The same training has also provided me with a respect for human psychological defences and the skill of knowing when to back off and show consideration for defensiveness. In practical terms this aspect of qualitative inquiry has been labelled the "Ouch Factor", where both experienced and novice researchers can crash through psychological boundaries and evoke distressing emotions (Gbrich 1999). When raw and overt emotions were encountered, my strategy for managing this was sensitive and boundaried.

Perhaps the most important element of my approach to participant observation data collection was that being situated in the action, even if I was on the periphery, I was able to develop a sensitivity to the work of district nurses and the emotional impact it had on them by using all my senses and importantly my own humanity. This position, it is suggested, is essential to the ethical collection and documentation of rich observational data (Wolcott 1999).

Field Notes

It has been suggested that all observation should contain reference to participants interactions, routines, rituals and social organisation (Denzin 1989). However, it is more likely the constraints of the action in the field will mean that field notes will contain only some of the above elements (Adler and Adler 1987) as the situation varies in complexity and detail. As a working guide, I kept the recommendations outlined by Denzin above and combined

them with the work of Foucault (1988) who makes firm recommendations on the study of power in social interactions. Consequently, I constantly asked myself the following questions during the process of observation, *for this participant*: -

- What is going on in this situation?
- Where is it happening?
- What authority/power is being applied or used?
- What effects does this action, strategy or ritual have on the nurse/patient/or other involved party?
- What is the atmosphere like?
- What is not being said?

In doing this I was consistently alert to minutiae of the action and interactions I encountered and facilitated the recording of observational data. I undertook 300 hours of observation with 28 of the community nursing staff, this approximated to twelve hours with each of the participants. In total, I observed some 400 nurse patient interactions. I did this over a period of three years of data collection, specifically late 1996 to 1999. The final analysis of the data was undertaken during 2000 –2001.

The decisions about who to observe and when, were dictated by a number of circumstances. Firstly, key players in the action alerted me to other members of the team, and how their work differed from their own. For example in area 1, one district nurse suggested that I must work with one of her colleagues early on in the research process as she worked in a mixed socio-economic area which had both affluent and poorer areas. In area 3, it was a gatekeeper who alerted me to the fact that the nurses in area 4 were on the border of two competing Health Authority Trusts and therefore had a particular and peculiar relationship with GPs. This method of *sampling* is somewhat akin to what

symbolic interactionist researchers have labelled theoretical sampling (Strauss and Corbin 1990). In essence it meant, for me, relinquishing command over the research process and letting the most knowledgeable people about the phenomenon (the study participants) guide the research structure (Strauss and Corbin 1990).

The observation period was also dictated by the time I had available. As I undertook this study as a part time student, initially I observed participants at a rate of one per week. This was so I could accurately record, transcribe and analyse the data before re-entering the field. However I felt that my relationship with the teams was compromised and my recollections and reflections about this indicated that I felt like a visitor. When I requested a period of two months leave of absence (on two separate occasions, with two different employers) which would have corrected this state of affairs, I was refused. Consequently I resigned and took the time between employment (periods of unemployment) to work with district nurses. This in essence gave me two sets of two months continuous work with participants which I feel contributed to the depth and once again trustworthiness of the data I collected.

Recording Observational Data

During my time in the field, I had a note pad that was an obvious recording tool for the action I was observing. It is suggested that overt recording of observational data in this way inhibits or stunts the collection of data (Adler

and Adler 1987; Hammersley and Atkinson 1996; Johnson 1997). Indeed there are many accounts in the ethnographic research literature where researchers go to great lengths to conceal their note taking from participants, even when their position as an overt researcher is known to participants (Johnson 1997). I did not do this. Whilst I appreciated that the disclosure of information may be inhibited by overt note taking, I felt that overt recording in this way, kept the research process above-board to participants. It also showed them my commitment to maintaining an accurate record of what I observed and also further indicated that I was human in so much as I was not a machine capable of recording and retaining the huge amount of important data I was observing without making notes. This coupled with the fact that during the writing of these notes, I often asked questions, meant that participants knew to a significant degree what I was recording during observation.

This may be considered a failing in the research process in that information may be censored, but my own experience of this process was that participants were often keen for me to record even the most sensitive of data and to understand its significance for them. Although it may well still be argued that this form of honest, open note-taking could obstruct the truth, another defence for this decision is that whilst district nurses may have been able to edit their own reactions, they were constantly interacting with other people. This inhibits their ability to behave differently (if indeed this was ever an intention) and my reaction to the data indicate that I seldom felt it was staged. I am confident I would have noticed this.

The method of data collecting and the informal conversations associated with it meant that the participant's perspective of the action was often called for and I took great pains to check out my own assumptions. I felt that this managed the ethical considerations noted to be a problem in participant observation (Adler and Adler 1987: Wolcott 1999). Above all, unlike studies that are based on a ward, I had the opportunity of writing and asking questions when participants and I were driving from house to house. Therefore I seldom had long to wait between periods of action and this informal note taking, which gives added trustworthiness to the field data I collected.

Following each period of observation, I made it a routine to thank the participant for their time and offered an opportunity for them to ask questions about the data I had recorded. I also used this time to ask questions myself. I also asked participants if there was any part of the data collection that they felt worried or compromised about or that they would rather have me not include in my study. In doing so, I gained what some researchers have termed process consent, that is active and ongoing permission to collect the data presented in this study (Carlisle 1997; Gbrich 1999). None of the participants asked me to exclude any interaction or data.

Writing up fieldnotes

After leaving the field, I made it a practice to drive to a secluded spot where I could make additional notes or correct the short hand I recorded in the

informal notes. This process in itself often took up to 2 hours. During this time, I was also able to include my feelings, in red pen as opposed to blue or black ink, either in the margin or the text of the informal notes. In this way, I was able to accurately record such aspects as my relationship with the participant and difficulties in the interactions if they occurred. This procedure is usually done in a field work diary, separately from field notes (Carlisle 1997). However, I agree with more contemporary thinkers on qualitative research that if subjectivity in data collection is to be considered as not only an inevitability but also an asset to observational data (Gbrich 1999) then the researchers feelings should be included alongside the data, rather than separate from it. Following this, I wrote the notes in long hand in a pad and then set about transcribing the data onto computer, with names erased or changed and a code allocated to protect the anonymity of the participant. I then checked the notes for accuracy alongside the short hand, informal notes before moving on to analyse the data. Whilst this was a laborious and intensive process – each four hour piece of observation took approximately 10 hours to write up and transcribe – the benefit in the findings presented in this study is that I was and am intimately acquainted with the data. On no occasion did anyone else transcribe my data or indeed findings. An example of transcribed field notes appears in appendix 4.

Interviewing

The aim of polyphonic interviewing is to capture the voices or different perspectives of people in a variety of situations. This is achieved, as far as is

practical, through a de-centering of the researcher (Clifford and Marcus 1994; Marcus 1998: Wolcott 1999: Gbrich 1999). In simple terms it is a process of: -

"saying more by letting others say it" (Marcus 1998, p36)

I decided on this strategy (or rather this strategy decided on me) because the participants in this study were exposed to and worked in very different circumstances, even though they had the generic title of district nurse. The unstructured interview, which is characteristic of polyphonic interviewing, is suggested to be the most useful method of capturing diversity among research participants (Gbrich 1999; Choularaika 1997). Although such an unstructured approach may miss important or salient data on which participants have an opinion, it is my belief that polyphonic interviews go some way to ensure that the data collected is not forced or artificially constructed. More importantly, participants are not guided down a data trail that has some limited significance to their experience. This form of interviewing is receiving increasing attention in the literature (Fontana and Frey 1994; Choularaika 1997; Gbrich 1999) as a way of representing the multi-perspectives and multi-site ethnographic data.

The Decision to Interview

I took the decision to interview participants when I felt that I had developed a good enough relationship with the teams I worked with. The criteria I used to assess this were subjective. They included feelings of inclusiveness within

the team which were guided by my field notes and personal reflections. For example, with one team, I knew that I felt included when a row broke out between two district nursing sisters in my presence. They could easily have left the room. With another team, I knew that I was accepted when a staff nurse made a crass remark, in front of senior district nurses during a lunch team meeting. I knew how the various team members would respond to her remark and they reacted in much they way that I had expected.

The Interview Process

I approached participants directly and asked them when would be the best time to arrange an interview. Most participants, interestingly, chose the lunchtime so they would not waste valuable nursing time, even though in each of the areas I had secured both time and absence from work from their managers! I drew up a table with dates and times spread out so that I could allow at least two days between each of the interviews, but in practice it was often more than this. This was to ensure I had time to transcribe and begin to review the data before moving on to the next interview. I gave each volunteer a letter explaining the process of the interview once they had enlisted. This letter appears in appendix 5.

I asked participants to suggest a place where they would like the interview to take place and where I was to meet them. Although the majority of people decided to be interviewed at their central base or meeting place, some chose a venue in their GP practice. Two participants came to my office at the

University and I interviewed one participant in her own home as she had recently retired from full time district nursing. There is a significant body of literature which warns the researcher of the importance of allowing the participant to decide and control as much of the research process as possible (Oakley 1981; Hammersley 1993; Finch 1993; Fontana and Frey 1994). This was one way in which I gave some control to the participants in my study. More importantly for this study, given the level of suspicion of managers that I encountered during data collection, it gave some participants the chance to escape from an unsafe environment.

Preparation for the Interview

Prior to the interview, I checked my routes, ensuring that I would have enough time to arrive in good time. I also checked my recording equipment the night before and on the morning of the interview. I did a voice check prior to the interview and set the recorder on ready. I placed the tape machine in an unobtrusive situation but within easy reach of myself.

Although this process of preparation sounds formal and ritualised, it has been noted in the literature that such actions are essential to avoid unnecessary distractions, which may influence the interview process (Fontana and Frey 1994; Carlisle 1997; Parahoo 1998; Murphy et al 1998; Gbrich 1999).

The Interview

Having followed the above procedure, I invited participants to take a seat and informed them I would commence recording immediately. Although some researchers suggest and recommend a warm up period (Hammersley 1993; Finch 1993; Parahoo 1998) I had learned from previous research that valuable data could be lost if the tape was not active. Also, I knew from experience, that the interview situation could easily turn from casual conversations to serious issues very quickly and stopping or interrupting participants when they had begun to talk invariably meant that the flow of the conversation was adversely affected. In contrast to other researchers, I already knew the participants I was interviewing and had met them and most often worked with them, therefore the formalities of warming up (Gbrich 1999) were most often unnecessary.

Before I commenced any questions or dialogue, I referred participants back to the interview letter (see appendix 5) and I asked if they had any questions about the interview. In line with more sensitive qualitative researchers I did not take the informed consent for granted and I offered participants a chance to decline to be interviewed at this stage (Munhall 1988; Fontana and Frey 1994). I reinforced the issues of confidentiality, transcription and destruction of the tape. I always informed the participant that they could terminate the interview at any point and I would never question their decision. This practice ensures that participant control is kept to a maximum (Gbrich 1999) and that process consent is maintained (Carlisle 1997).

Following the principles of polyphonic interviewing, I generally began the interview proper with an extremely broad general question. Thus such questions as "I have not seen you for a couple of weeks, how have things been?" and "you looked flustered when I came in have you had a busy day?" often led participants into describing their experiences and work. These questions also conveyed my genuine concern, humanity and sometimes openness in the process.

In general, as the interview moved on, I proceeded to follow the participant by asking open ended tentative questions like "are you saying that doing that every day bores you?" or " can you tell me some more about that?". In most cases as the interviews progressed, I was able to ask direct questions based on the material being presented. Thus questions such as "you sound fed up and bored?" and "he really pisses you off when he does that then?" indicated where I became actively involved in the process. This phenomenon has been described in the literature as open communication and natural conversational interaction, which is thought to be important in human research (Oakley 1981; Fontana and Frey 1994). However, as open and honest as I was in the process, I was ever mindful of the stern critique made by Fontana and Frey (1994) that all interviewing is essentially unethical as it is a means to end and essentially involves a level of exploitation of the participants. However, I took my lead from participants as much as I could.

If the flow of the conversation dried up between myself and the participant, then I referred back to my mental notes taken from observation to regain a

flow of conversation. Thus, on certain occasions I would ask direct questions such as "when we were out together, I remember you told me that nursing people in working class areas was harder than in middle class or rich areas, can we talk about that?" On a few occasions, the flow of conversation between myself and the participant was extremely stunted. On reflection, post interview, this was due to my failure to recognise that the nurses were busy and genuinely harassed.

During the interview process, following the guidelines suggested by feminist commentators, I encouraged participants to diversify and elaborate on what they were saying to me (Finch 1993). In practice, this meant backing off but staying active in the process using minimal non-verbal encouragement (Hargie 1993) or active listening skills (Egan 1998) to ensure that participants knew that I was present and listening. I generally followed the principles of communication outlined by humanistic psychologists, that is I offered warmth, congruence and empathy (Rogers 1966). It is here that my psychotherapy training aided my work.

Finishing the Interview

As the interview reached a conclusion, which I noted by observing that material was either repeated, restated or that no new ideas were occurring in the conversation (that is that I had reached saturation point with the participants) I began to draw back. I took my cues both from myself and the participant. I asked more closed questions. Sometimes, I terminated the

interview directly, by stating the obvious fact that we were both getting tired, particularly when it was a long or difficult interview. I was sensitive to both my own and the participant's energy levels.

At the end of the interview, I reiterated the confidential nature of the process, what I would be doing with the tape and that I would be transcribing it. I also sought consent by asking participants if they felt uncomfortable or uneasy with any of the issues we had discussed. I offered to send them a copy of the transcript if they wished to see it and informed them that they could add or remove anything we had discussed. Out of the total of 40 interviews, lasting between 25 and 105 minutes, only three participants took up the offer to review the transcript. As a result of this, I deleted a section of sensitive data from one nurses' interview (which the participant felt may have identified her, her team or more importantly the patient and his or her relative). In the second instance, a nurse added to the transcript and in the final situation, the nurse made no additions but did correct my many spelling mistakes!

Transcribing the tapes

Following the completion of the interview, I endeavoured to reach home as soon as possible so that I could listen to the tapes. This was important to me as it enabled me attend to the dynamics of the interview and acknowledge any areas of difficulty, high emotion, tedium (either my own or the participants) or other salient factors which might have affected the quality of the data. I made notes about the interview which were then attached to the completed

transcript to remind me at the point of analysis about the conduct of the interview. Thus comments such as "what is happening here?" "sounds bored" and "stunted interaction" were placed in the margin were appropriate. I was also able to make reflections on non-verbal communication when necessary as the interview was fresh in my mind. Once again, comments such as "becomes tearful" and "cries" or "voice raises sounds angry" were included in the text of the interview.

I transcribed all 40 of the tapes myself, using a standard transcription machine. In the process of transcription, I added points such as "goes quiet," "thinks for a long time" once again to alert me to the dynamics of the interview. Although this process was long winded and labour intensive, the procedure meant that I became intimately familiar with my data. An extract from an interview appears in appendix 6.

Analysis of Observational and Interview Data

It is widely accepted in inductive research that the collection and analysis of qualitative data occur simultaneously (Strauss and Corbin 1990; Becker 1983). This enables the researcher to explore themes, categories and ideas as the research process progresses. It is also a way of ensuring that theoretical sensitivity is enhanced and examined and that emerging ideas remain grounded in the data (Strauss and Corbin 1990; Coyne 1997; Gbrich 1999). In the study reported here, it also enabled me to identify consensus in the data but also to remain alert to the non consensual aspects of the data.

I decided to treat all data equally, that is the same process of analysis was applied to observational data, informal conversations and the unstructured interviews I undertook with participants.

Open Coding

Open coding is the systematic, line by line examination of the data which reduces material to a series of coded units (Strauss 1987; Strauss and Corbin 1990; Corbin 1987). Following this method of analysis, I systematically examined the data and coded each section of the work with simple codes which reflected the action and statements I encountered (Strauss and Corbin 1990). For example, the code "getting in" was a code and descriptor used by district nurses to describe the process of entering the patient's home. In qualitative research, it is generally suggested that as the data collection progresses and analysis is continuous, then similarities and differences are known to arise (Glasser 1978; Strauss and Corbin 1990; Gbrich 1999). This meant examining the nature of the action and highlighting the similarities and differences between the strategies used, in this example, to enter the home of the patient. These data showed that there were a number of approaches; sometimes the process was consistently formal (knocking and waiting) sometimes it was informal (direct entry and announcing their presence). Notes were made in the margin to acknowledge these differences.

As this one example shows, from this simple but painfully laborious process, connections began to emerge and patterns arose. This has been labelled the condensing of codes (Glasser 1978; Strauss and Corbin 1990; Gbrich 1999). This is the beginning of the text and story in the analysis of data. In the example of getting in, I found that the process varied according to the workload of the nurse (it was a less formal and respectful process if she was busy), the social class of the patient (it was consistently formal and respectful) and the length of time she had been visiting (more cordial and collegiate). This form of detailed analysis occurs time and time again through out the process of the investigation and alerts the researcher to look for more examples in the next data collection phase as well a re-examination of the already collected records. Most of all, this systematic and constant scrutiny of the data increased my sensitivity and familiarity with the data.

An example of open coded text appears in appendix 7. It is important to note that the application of open coding can often result in dual codes being applied to the same piece of action or text where meaning may reflect more than one attribute of the data.

It was at this point that I used supervision most. The utilisation of an experienced researcher (who was also a district nurse) was invaluable in terms of bouncing ideas, testing out tentative formulations and venting my frustrations. This position has been noted in the literature as a way of ensuring that the data is viewed with a degree of evenness and balance

(Strauss and Corbin 1990; Gbrich 1999). To increase my sensitivity to the data I also checked out emerging ideas with groups of district nurses that I was teaching at the time. This proved to be a fruitful exercise, as rather than achieving an overriding consensus from these people, their responses to the ideas I was presenting were varied and mixed. This confirmed my impression that the data were complex and that a simple unified story was not occurring in the data. This turn of events gave me both encouragement and concern. The encouragement was that I was finding a trustworthy representation and my concern was with how I would report the disparities in a coherent presentation. The process of checking codes and assumptions with other data and indeed other professionals has been labelled the constant comparison method.

Constant Comparisons

It is suggested that in the analysis of qualitative data that a process of constant comparison among different groups encountered in the study, different sets of data, emerging concepts and observations is necessary in the development of a trustworthy analysis of the data (Glaser and Strauss 1967; Denzin and Lincoln 1994). Indeed it is proposed that the continuous comparison of one perspective against another is the way in which researchers retain an analytic stance when processing data (Strauss and Corbin 1990). In practice this meant making margin notes on the data which drew my attention to both similarities and differences in the data which enhanced my sensitivity to the findings in the study. It also meant that my

initial coding was constantly reviewed and reassessed in comparison to new data.

As a consequence of this, during the process of data collection, new situations occurred which prompted me to re-examine the data. One example of this was when I observed an extremely collegial relationship between a district nurse and a GP. This rare occurrence impelled me to re-examine the mass of data I had collected in which nurses and doctors interacted. I realised that this special event shocked me so much that I may have taken for granted the usual or ordinary relationship that I had been observing between doctors and nurses. A further piece of shocking interaction (which bordered on the doctor bullying a particular nurse) further alerted me to look at the ordinary nuances of behaviour and interaction for signs of power imbalances.

On another occasion, it was the refusal of a patient's relative to allow the district nurse to withdraw their service (bathing) that led me to re-examine the data for the ways in which district nurses both allocate and withdraw services, the consequences for them and the threats that exist in this level of interaction. These are just two examples from many that I could cite. The important point here is that one occurred early on in the data collection process (the latter example) and the other very late on in the investigation (the former). However, the process was the same in that it resulted in a thorough review of the data. Thus, as has been noted in the literature, the process of data analysis was continuous until the final stages of data connection (Miles

and Huberman 1997; Silverman 1998). Once again, this flexibility ensured that the data remained truthful and trustworthy to the participants' accounts.

Theoretical Notes

Theoretical notes are usually used to explain aspects of the data as it emerges to increase the theoretical sensitivity of the researcher. They also function to offer the beginning theory or text some substance and grounding in the action (Strauss and Corbin 1990). Memos take the form of analytical and process notes to keep the researcher alert to the possibilities in the data (Strauss 1987). Process notes have been dealt with under the transcription of data.

The theoretical notes and memo's were initially recorded in a note book after the notes were made on the transcribed data. This enabled constant comparisons to be made as outlined above. This process has been accounted for in the literature (Strauss and Corbin 1990; Silverman 1998). When these notes and memo's began to re-occur with consistency I began to record them on large sheets paper as discrete aspects of the data. In doing so, I was able to visually (and actually) draw links between the codes and make comparisons, joining the notes in the form of loose spider-gram which highlighted the connectedness and eccentricities of some aspects of the data or emerging categories. This process has been labelled axial coding (Glasser 1978; Gbrich 1999). It was from this point that themes arose from the data. An example of this appears in appendix 8.

Themes

Themes arise when the data connects and inter-relates to form a theoretical outline that integrates the main ideas (Glasser and Strauss 1990; Silverman 1998). This process once again involves re-examining all of the codes as they may very often apply to two different themes and have different meanings. The same piece of dialogue may have to have different codes and may well be only differentiated by the context of the action or what preceded or followed it. It is here that I felt that choosing to code by hand, rather than by computer, paid dividends. I was able to trace back the codes by re-examining the data, checking theoretical notes and importantly re-gaining a sense of context for the codes, categories and themes. This, I feel, may have been lost if I had fractured the data by using a computer package.

The Decision to Stop Data Collection

It is generally suggested in the literature that the researcher continues to collect material until the emerging themes and categories are saturated and no new data occurs (Strauss and Corbin 1990; Miles and Huberman 1997; Gbrich 1999). Grounded theory relies on the process of narrowing the questions asked in interviews and observation down a data trail, which it is suggested, arise from the data collected. It is here that the positivist influence on the grounded theory method is most obvious. The process of reducing the data to previously held ideas presented by participants can force data in subsequent observation and interviews rather than encourage diversity. In simple terms, qualitative researchers can be seduced by the emerging theory

(Guba and Lincoln 1994; Gbrich 1999). Thus the idea of data saturation, it is suggested, occurs when interviews undertaken towards the end of data collection test hypotheses and no new ideas emerge. However, in the study presented here, I feel sure that had I carried on researching other groups of district nurses in other areas I would have carried on exposing both more diversity and perhaps more consensus. Therefore, the decision to stop data collection was taken when I felt I had collected enough data from the participants I had recruited and they had told me all that they felt was important for them. I therefore attempted to reach data saturation with individual respondents rather than the collective group of participants.

For many readers this may be seen as a methodological inconsistency which overlooks the basic foundation of human inquiry that consistency can be achieved in ethnographic texts (Strauss and Corbin 1990: Miles and Huberman 1997). My own critique of the notion of completeness in a set of data follows that of Hammersley (1993) where he indicates that the theoretical underpinning of grounded theory, symbolic interactionism, emphasises creativity and the indeterminism of human action. In many grounded theory studies human action is often presented as a complete representation of the phenomenon which, using positivist discourse, may be representative or generalisable to the wider population, group or phenomenon under study. I make no such bold claims here. The data presented in this study, I would suggest are an accurate account of the individuals who took part in this study. I am sure that there are other viewpoints, held by district nurses but this does not repeal those perspectives presented in this thesis. This approach is

supported by post-modern ethnographers who suggest that the pursuit of absolute truth is a tradition which slips into positivism rather than celebrating the uncertainty of human life (Marcus 1998) which I have aimed to capture in this thesis.

In multi-site ethnography, the author could continue to find new sites of study and uncover new data ad infinitum. Thus the decision to terminate my inquiry came when I felt I had a manageable amount of data that could be presented within the guidelines required for a thesis.

Reforming the Data – Writing the Text

Once the data was reduced, theoretical notes were written. The grounded theory method of analysis was adapted and modified. In traditional grounded theory studies, following the development of theoretical notes, the data is usually recollected and grouped in categories and finally themes. It was at this point I felt that this process would effectively artificially compress my data into a simple story rather than a multiplicity of experiences. Therefore rather than adopt this traditional approach I used the recommendations suggested by Foucault (1988) for the analysis and study of power. This technique has been used by others (May 1992) to enhance this dimension in ethnographic research. I used the following guidelines to re-form and place the data in context: -

- The analysis of power should focus upon forms of local decision making and the techniques involved

- The analysis of power needs to identify the targets of power and its effect
- The analysis of power needs to identify how power circulates through a range of social institutions and people
- The analysis of power should be undertaken from the bottom up rather than the top down
- The analysis of power should study the link between power and knowledge and the means by which that power is circulated

In reformulating the data, I therefore used these comprehensive guidelines in the construction of my text.

The decision to break with the traditional method of grounded theory approach was based upon the fundamental post-modern beliefs which have characterised and influenced my thinking. Many researchers forget that theoretical and philosophical foundation of grounded theory is in fact symbolic interactionism. At a very basic level this approach postulates that all human experience (or Society) is located and to be found in the interactions between the self and other or the environment (Ritzer 1996; Denzin and Lincoln 1994). Whilst grounded theory offers a structured and rigorous approach to the handling and analysis of data, the interpretation and standing of theories rests on this central, micro-level sociological analysis (Marcus 1998; Wolcott 1999). Many commentators would argue that this provides an ahistorical and apolitical representation of human life (Kincheloe and Mc Laren 1994; Ritzer 1996; Johnson et al 2001). Another criticism is that grounded theory relies too heavily on other research to confirm the findings of the study rather than

sociological theory (Gbrich 1999). In contrast, post-modernism provides a macro-level analysis which, I believe, is more capable of both locating and explaining action within an historical, power-knowledge axis (Kincheloe and Mc Laren 1994; Marcus 1998; Watson 1995).

However, there have been calls from within nursing to remain methodologically true to a research (Morse 1991). Some have gone so far as to argue that no method is credible if used inappropriately (Baker et al 1987; Koch and Harrington 1998). In a somewhat acrimonious debate centring around methodological purity versus plurality, Johnson and his colleagues have demonstrated that even the purist of the pure have begun their studies with a theoretical framework in mind (Johnson et al 2001). In the same publication they call for a celebration of plurality, adapted or modified methods and argue that the rigid adherence to static methods of inquiry are: -

> "in many cases this is neither necessary nor more likely to increase the validity of the research outcome." (Johnson et al 2001 p239)

They also warn, as do others, that a deviation without justification or a clear theoretical understanding seriously affects the value of the text (Johnson 1997; Maggs-Rapport 2000; Johnson et al 2001). More prosaically, Wolcott (1998) argues it is time that qualitative researchers accept the fact that they do not have an "immaculate perception" (p34). We are theory laden and we have beliefs. It is argued therefore, that researchers should make their theoretical stance known so that readers can assess the text with insight (Kincheloe and Mc Laren 1994; Marcus 1998; Watson 1995: Koch and

Harrington 1998; Johnson et al 2001). It has been the explicit aim of this thesis to make this aspect of my work clear.

Presenting the Data

The presentation of data is an important part of the research process. It is the point at which the re-combined data are linked to existing research or theories and comparisons and contrasts are exposed (Miles and Huberman 1997; Strauss and Corbin 1990; Gbrich 1999). It is suggested that in the post-modern tradition that researchers should experiment with the presentation of a "messy text" which is representative of a disorganised social world (Marcus 1998). I agree that the process of academic writing, indeed my own writing and presentation, reduce complex data to a readable story, thereby reducing the complexities encountered in the field to a simple representation. However, my objection to the post modern form of data presentation (messy texts) is that qualitative research needs to be judged by others otherwise the findings will have little, if any import. Therefore, in the absence of established criteria for judging not only post-modern texts but qualitative texts per se, then I have adopted the most usual form of presentation which is expected and accepted in academic writing.

It has been suggested that qualitative research methods rely too heavily on linking new data with existing theories (Geerson 1991: Thorne 1991; Gbrich 1999). Where appropriate, in the presentation of this thesis I have endeavoured to explore the findings in relation to well established sociological

and nursing literature. This has been achieved through selective reviews of the literature which were pertinent to the findings presented in this thesis. Even though my own theoretical perspective is largely post-modern, I have consulted and cited modernist literature (Giddens 1991; Beck 1992) as well Marxist (Fanon 1967) Critical Theorists (Porter 1992) and both paradigm based nursing literature (Mc Intosh 1996) and non paradigm based nursing research findings. However, as previously identified, my own leanings will invariably bias the literature I cite or the explanations and comparisons I make in the findings section.

With reference to the interpretation of the data presented in this thesis, I undertook a number of steps to achieve academic rigour. It is often suggested that qualitative researchers can make their data fit existing theories (Denzin and Lincoln 1994; Marcus 1998; Johnson et al 2001). In order to prevent this from occurring in this thesis I ensured that I kept as true as is practically possible to the participant's own accounts of the events or action as they saw it. In the findings section, when I have made an interpretation, I have made it clear by referencing the ideas I present that it is an interpretation rather than participant led. Another methodological check I used during the writing of this thesis was that of keeping all of my early drafts of the various chapters I wrote. The reason for this is two fold. Firstly, I wanted to ensure that I remained faithful to the data. In early drafts of this thesis I wrote the story with little or no interpretation. Once I had established some order in the presentation of this thesis, it was then that I undertook secondary literature

reviews based on the themes identified in these early drafts. Thus, the literature was used to supplement the data and not the other way around.

The second reason for keeping all of the early versions of this thesis was to audit and monitor the level of abstraction that may of occurred as a consequence of the writing up process. It is all too easy in qualitative research when applying established work to the findings to become excited and over zealous when the data are either supported or contradict established work (Hammersley 1992; Marcus 1998; Wolcott 1999). By keeping the early drafts of this thesis, I was able to maintain a sense of balance and check that I had not deviated too far from the original data or over emphasised "interesting" data. I aimed to ensure that I was not seduced by the emerging themes to point where I overlooked conflicting data (Guba and Lincoln 1994; Gbrich 1999). Correspondingly, in the spirit of good qualitative research, I presented the ordinary alongside the extraordinary (Gbrich 1999).

Conclusions - Academic Rigour

In the field of qualitative research the debates about the methods of assessing the methodological rigour of a study are contentious. On the one hand there are those qualitative researchers from a post-positivist perspective who offer substitute concepts for the largely quantitative methodological rigours of validity and reliability as a method of assessing qualitative research (Hammersley 1992; Le Compte and Preissle 1993; Altheide and Johnson 1994). Whilst in a diluted form, these pseudo-scientific (Johnson 1997)

concepts rest largely on the contentious issue of objectivity in the investigative process (Murphy et al 1998). An example of this is offered by Hammersley (1992): -

> "There can be multiple, non contradictory and valid descriptions and explanations of the phenomena by multiple researchers in qualitative enquiries" (Hammersley 1992; p51)

This position is endorsed by grounded theorists who argue that multiple investigators can study the same phenomenon and arrive at the similar conclusions (Strauss and Corbin 1990; Parahoo 1998; Baker et al 1987).

At the other end of the spectrum, there are those who opine that both researchers and research subjects both construct their own realities in different ways at different times and this should be celebrated as part of the human condition rather than ignored in research (Smith 1984; Watson 1995; Parsons 1995). The consequence of this methodological stance is that there is no single or privileged truth and hence there will be no simple method(s) of evaluating the rigour of qualitative research (Smith 1984; Parson 1995; Gbrich 1999). Smith (1984) argues that: -

> "the assumption of multiple realities ... undermines the notion of applying foundational criteria to distinguish trustworthy results from untrustworthy ones ... different claims about reality result not from incorrect procedures but may simply be a case of one investigator's reality versus another" (Smith 1984, p383)

Between these two extremes (realist and post-modern) lies a middle ground. This is summarised by Altheide and Johnson (1994): -

> "As long as we strive to base our claims and interpretations of social life on data of any kind, we must have a logic for assessing and communicating the interactive process through which the investigator acquired the research experience and information" (Altheide and Johnson 1994, p485)

In most cases, nursing researchers revert to the criteria for assessing rigour suggested first by Lincoln and Guba (1985) and modified later by Denzin and Lincoln 1994). These criteria, credibility, transferability, dependability (or confirmability) and auditability are generally accepted as good enough criteria for assessing qualitative texts (Kincheloe and Mc Laren 1994; Murphy et al 1998; Gbrich 1999).

Credibility is defined as the extent to which the researcher's conclusions are endorsed by the subjects involved in the research (Denzin and Lincoln 1994; Murphy et al 1998) or the presentation of faithful renditions of "the others" experience (Gbrich 1999). It essentially contains participant confirmation of the assumptions and conclusions made by the author in the text.

In the case of this study, this was achieved through the collecting of data in a number of ways. Informal conversations with participants, achieved through the mixed methods of participant observation and unstructured interviews helped to ensure that I was led rather than leading in the process of the investigation. During the investigation I was able to check my findings and assumptions with respondents whilst the action was going on and later in the

form of an interview. The use of polyphonic interviews and an unstructured interview technique has also aided this process. This has, I believe, added credibility to the findings which will be presented in this thesis. The methods of data analysis and the extent to which I maintained integrity and rigour in the data processing procedure (see above) have also contributed to the credibility of the findings.

Transferability is achieved through providing a rich descriptive and detailed data set in the text (Lincoln and Guba 1985; Denzin and Lincoln 1994). It is the extent to which the data can resonate with other groups in similar circumstances. In order to achieve this, I have attempted, in the findings sections to include rich and thick data that describes the context and content of interactions which can assist in deciding the transferability of the findings. It remains to be seen, through publications, how much transferability exists in the data, but, as the findings will show, there are aspects of this study that both resonate with well established nursing research literature and that contradict it. This is some confirmation that the data is, somewhat comparable to the real life of nurses.

Transferability is also associated with membership checking (Murphy et al 1998). That is checking out the findings with other groups similar to those in the study. In the case of this study, this was done with both trainee and trained district nurses where my preliminary findings and assumptions were checked. I did this (as outlined above) in such a way as to encourage discussion and debate and found that the contradictions and consistencies

that I was finding in the data resonated for some nurses at times and for other nurses they were only partially true. I believe this to be a reflection of the varied conditions under which district nurses currently work.

Dependability or confirmability rests on the reader being able to rely on the assumptions made by the author in the text (Denzin and Lincoln 1994). It is the account that the author gives of the data collection, data analysis and data presentation process that contributes to this aspect of rigour. I have, in this chapter, taken great pains to describe the steps I have taken to achieve integrity both in the collection and analysis of the data. I have made my own pre-conceptions and potential biases clear and explicit and this permeates through the thesis. In the presentation of the findings I have given the reader rich and plentiful data that I am sure will enable them to form alternative and even conflicting interpretations of the information I have offered. Above all, I am sure that triangulation of methods – that is the use of observation, informal conversations and interviews (and their subsequent analysis) have provided as dependable a data set as I could conceivably achieve.

Where I have made links between the data and established sociological (in this case mostly but not exclusively post-modern/post-fordist theories) I have aimed to provide enough context and data to convince the reader of the relevance of the theory. I am sure however, that this will enable the reader to form alternative theoretical interpretations of the data presented in the findings. I see this as a valuable facet of this thesis.

Auditability is defined as a clear outline of the decisions taken in the study (Lincoln and Guba 1985). It has been the primary aim of this chapter to provide the reader with an audit trail of the decisions I took in the course of this investigation. I have taken time to explain the process of this inquiry and provide, where possible, the theoretical or personal justification for my decisions. I have accounted for the various stages of the investigation and made the decisions and steps I took as clear as possible. I believe that this will be a major contributing factor in the ability of a reader of this text to assess the value, trustworthiness and relevance of the findings of this thesis.

Chapter 6 - Findings

Introduction

The Cumberledge Report (DHSS 1986b) provided "evidence" that District Nursing services were being poorly managed and were failing to respond to the health needs of the community.

> "It is essential that neighbourhood nursing services, if they are to provide responsive, flexible and effective services to people in their area, should have these key management aspects strengthened (*setting aims and objectives, planning, monitoring and controlling)* ... Despite reservations and fears sometimes heard from nurses, there need be no conflict between the exercise of strong management and the application of personal professional skills. Although a nurse is a "professional in her own right," she needs a manager to support her in maintaining her professional standards and to ensure the services she provides are in line with health authority policy." (DHSS 1986b).

District Nurses were frequently reported to be "acting down" from their role and were entrenched in "traditional practice" (Hockey 1966; 1972; Mc Intosh and Richardson 1976; Kratz 1978). The Cumberledge report therefore, represented perhaps for the first time, a major policy shift that attempted to change so called traditional and ritualistic nature of District Nursing services.

This chapter charts the recent history of District Nursing. It is important to iterate here, that the following sections rely on the respondents recalling the events of the recent past, as they most often related to the period immediately prior to and after the implementation of the Community Care Act (DoH 1989).

The following sections therefore record the participants' account of how it used to be, the mechanics of working in the community, the culture of the past and the practices involved therein.

Habitual Nursing – Acting Down, filling in or saving the day?

In their recent past (and for some even now) district nurses undertook aspects of patient care which some felt were beyond the professional definition of their role. For some nurses, care often included doing everything, from skilled nursing tasks, through to domestic duties. District nurses were in situations where they often encountered unmet needs in the home. They were frequently the first service (following the General Practitioner) to have contact with people with a diverse range of needs, as one nurse recalls: -

> *"When we used to go out – we really didn't know what we were going to meet in the home. The doctor may have done a visit and asked us to go in – it would be the first time that they had seen any health services and you would go in and there would be all kinds going on, not necessarily health problems or minor health problems, you know, but what they really needed was something to eat you know, they couldn't get to the shops and there was no one to go for them and the Doctor would ask us to go in as an emergency, but wouldn't tell you there was no food, it would be for other things like checking their hygiene, but it was basically to feed them, the were isolated – even though you had a thousand other things to do, physically they were OK but you know you had to go in and get them sorted with some food – he (the doctor) expected us to and so did the patient." Observation – Sister Area 1*

Important in this quote was the mechanics of the intervention. It seemed that the expectation of the doctor was such that this form of work, whilst not directly the role of the nurse, would nevertheless be attended to. District nurses often recalled a sense of feeling manipulated and being forced into responding. This is captured in the following quote: -

> *"Yes I can remember doing that (social care), doing our calls and putting people to bed on the bed, undressing them and putting them into bed, erm, setting the alarm for them an all this sort of thing, making them a cup of tea... and not so long ago either, well after the community care reforms and contract " Interview Sister – Area 1*

What is important here, is that this nurse recalls doing the extra "social care" recently in her work. Another nurse with just 5 years experience recalls:-

> *DN:When I first came out into the community, I set the fire, I did the shopping, put the cat out and put the dog to bed."*
>
> *SS: "Did the shopping?"*
>
> *"DN: I've done the shopping, because I've been to people and they would say they've been unable to get out, because they are elderly, to go and do the shopping and they would say 'nip down the shop and get my bread and I've got nothing for my tea ... I didn't say no, I thought I should do it and the reality was that they were vulnerable" Interview – Sister Area 3.*

The sense of vulnerability is important in the action remembered here. The word vulnerable comes from the Latin verb vulnerierare, meaning to wound (Rogers 1997). Implicit in the concept of vulnerability is the notion of threat that is, that the patient was under threat and action was required to prevent

harm. It has been argued that the most potent indicator of vulnerability is the presence or absence of social support (Glitterman 1991, Rogers 1997). The language in this extract indicated an integral feature of the Nurse-Patient relationship of the recent past (and for some even now). It pictured a situation in which the nurse incorporated extra work in to her role. In her area, it was custom and practice to provide a level of care (which included domestic tasks) certainly for a limited period of time and sometimes continuously. It is interesting to note, that many of the district nursing text books at this time supported total physical care. One nursing text in particular (the study bible for many of the nurses in this study) recommended thus: -

> "It is important that district nurses, as members of a team, work out a personal philosophy for themselves concerning their various roles, for only when they have done this can they develop commitment to care. Traditionally in hospital as nurses become more senior they perform the more complex technical tasks; however, the district nurse is in the unique position of having only one patient to care for at a time, and carries out the whole range of care. Much of the work of the district nurse is what is commonly called 'basic nursing care' which in hospital all too frequently is left to junior nurses or auxiliaries; but what can give more satisfaction to the nurse, and benefit to the patient than to be able to give and receive total care from one person. This is quintessential nursing." (Baly 1986 p96-7)

It has been suggested in the literature of this time that the aged generally resisted the use of formal support services, preferring instead to rely on the support of immediate kin (Litwark 1985). However, other authors have suggested that with the demands and constraints imposed by illness, particularly chronic illness, there is an increasing preference for formal services (Marshall et al 1987). Further it is suggested that this may have

stemmed from an unwillingness to burden children, the absence of friends and family due to bereavement and physical proximity of close enough friends to undertake domestic duties (Todhunter and Pearson 1995). Other authors have suggested that formal services would only be contacted and used when a process of substitution has eliminated all other forms of help (Cantor 1979). This factor caused many of the respondents in this study to oftentimes dread new visits. One nurse recalled a sense of apprehension that this form of cold visiting evoked: -

> *"you used to dread going into some people, 'cos you knew what you would find ... you couldn't get away from helping them sometimes – they had nothing, no help, no food and you felt that they were at your mercy they pulled at you heart strings really" Observation – Sister Area 1.*

The above quote illustrates that nurses undertook "non nursing duties," "the extras" or "invisible work" (Colliere 1995; Griffiths 1996) and duties interpreted as "acting down" (DHSS 1986b; Audit Commission 1992) not because they thought they should but rather out of a sense of necessity, due most often to compulsive situational factors.

Many commentators have described the process by which nurses work and nursing as a profession has come to be inextricably linked with the role of women in society (Abel-Smith 1979; Ungerson 1990; Davies 1995). In particular, it is suggested that this has been largely due to the early history and recruitment of nurses from certain professional backgrounds which were considered to be complementary and co-terminus with "good womanhood".

Carpenter (1978) for example, has described how hospitals and the nursing professions have merely reproduced the ideology of the patriarchal family in the domain of care.

It is argued then, that in the professional health care/caring system women are systematically oppressed, manipulated and work within and to predetermined, socialised roles that reflect the gendered relations in society. The data presented here, indicate that nurses' work in the home was sometimes viewed both internally (by nurses themselves) and externally (by both patients and doctors) as being co-terminus with women's domestic work. As Davies (1995) argued the taken for grantedness of these power relations results in the relative invisibility of womens' work and consequently nurses work, and certainly the data presented here shows how, on occasion, nurses' readiness to undertake domestic work was indeed taken for granted.

Some participants described how this form of care, once offered, slipped into the routine of District Nurses work and became habitual: -

> *"Before you knew what was happening you were doing it all the time for them really – you had set a precedent and you just carried on doing it for them, it was hard to let them go and they sometimes would not let you go!" Observation – Sister Area 2*

Setting a precedent meant for some nurses that the work had to be continued and maintained. Patients expected it, others knew about it and as one nurse suggested, "patients talk". This meant that expectations among communities were such that if care was provided for one person and other patients knew or heard about it, then the nurse felt compelled to provide the same level of

service. This may explain why some research findings suggested that the provision of district nursing services was variable (Luker and Perkins 1988; Audit Commission 1992; 1999). The idea that nurses felt compelled or coerced into providing services outside of their role has received scant attention in nursing literature. Here, the data suggest that some district nurses felt compelled to provide services.

It was a truism among the participants of this study that patients from middle class backgrounds traditionally received more of the extras than those from lower social classes. One Nurse explains this: -

> *"It wasn't so bad in working class areas really, you could always get a member of the family to help out, you know a daughter or someone, someone was always around. But in the richer areas, and I have both, it was, it is harder. The families all work or live a way away so there is no one to help. Neighbours don't bother that much and anyway you don't like to bother people in those sort of areas, not like around (name of area) where I could just knock on a door and say 'you wouldn't mind just keeping an eye on Maisie would you and see if she needs any shopping from time to time" Observation - Sister Area 1.*

It was commonly suggested that access to informal care was traditionally much easier to secure in working class or poorer areas. Nurses were able to off-load some of the burden of extra care in working class areas, which by contrast was more difficult to do in other, more affluent areas. It was also commonly suggested that people from middle class areas "knew their rights" even before these rights were made explicit in the form of a patients charter (DoH 1992) and so were more likely to know that they could demand the

services of the district nurse. Thus district nurses working in higher socio-economic areas felt an added pressure when compared to those working in poorer districts. For the nurses in this study then, accessing informal social care was much easier to do in working class rather than more affluent areas. These data indicated that the coercive effect of patient power was not a new phenomenon but rather it existed in areas where patients were articulate and demanding.

Isolated Work

District nursing in the recent past was an isolating experience. Many of the participants recalled the sense of isolation associated with community nursing:-

> *"DN: You were allocated a geographical area, in fact I still worked on that principle until 1995, and you basically got on with it really. You got to do the work and you knew exactly where you were based, the boundaries of where you could go and what was needed and available in that area. The problem was that you never saw another soul, well not exactly another soul, you had your EN and the auxiliary but that was it. It was you.*
>
> *SS: and what was that like then?*
>
> *DN: It was hard really, I don't know, when you were in hospital and worked on a ward there was always the camaraderie between you and the people you worked with, I miss that, I still do, but when I took my patch it near drove me mad for a while, the loneliness, you know not seeing other people or that, other nurses, even if it was just for chat, social chat and that. But you got used to it eventually, I suppose" Observation – Sister Area 1.*

For some of the participants in this study, this form of work gave them the opportunity to develop local knowledge and information about the area. However a consequence of patch working was that contact with other nurses was rare, certainly not planned and opportunities for professional or even personal support were lacking. For some nurses, this isolation represented a situation which they often described as a *"double edged sword"* in which the segregation was allied with isolation but was counterbalanced with a degree of control and responsibility over their work and the work of the team. This district nurse described a relative cultural void in which apart from contact with GP's there was little inter-professional or intra-professional communication. A consequence of this was that many district nurses had little understanding of what was happening outside of "their own" geographical area of work, little opportunity for debate and discussion with other practising nurses and correspondingly limited exposure to new experiences and developments. This finding has been previously noted in the literature (Luker and Kenrick 1992).

Dependent Patients

One effect of providing extra care was that this work required careful co-ordination in the day to day working practices of district nurses: -

> *"I used to have to time my visits immaculately because I often had to get to the bakers in time to get bread to take to diabetics so that they could have their injection and their breakfast at the same time." District Nursing Sister –Area 3*

It meant having to ensure that visits were made on time and they had to be expertly co-ordinated in terms of timing as people were reliant on the nurse sometimes even for food and drink. Ungerson (1983) opines that women are socialised to have a set of skills that are unique to their gender in which the role of mothering or 'private work' is argued to be similar to the skills demanded in 'public' care work.

An important aspect of encouraging dependence was that it represented a precarious situation for the patient, who became reliant on the nurse for some aspects of their daily life. Whilst this was most often achievable in their ordinary day, when workloads unexpectedly increased, then this could leave nurses with an extra burden to be got through during the course of the day, even when busy *"you just did it"* (Sister Area 3). One nurse recalls the culture of dependence existent at this time: -

> *"I think back in 1990's, erm, I would say probably most of the patients we dealt with were quite elderly, and were very ready to be told what to do by nurses ... and whilst I still think a lot of elderly people would find that quite reassuring, and sometimes want us to do that to be the only one involved in their care you know that you do everything, I think we'll have to change and struggle with ourselves and stop doing that because we, we firmly believe that's not the way forward because it's a hard habit to get out of ... I think going back to 1980 when I first came into District Nursing if I was handed a patient that was a diabetic, unless they said to me, I would like to be independent, I think I would probably, you know, allow them to become dependent" Interview – Sister Area 2.*

In this excerpt, the district nurse referred to a time in which both she and her colleagues generally accepted the patient's dependence on them. It is clear

from her words that she described a habitual form of action in which the process of reliance became part of her work with patients. What is underestimated in this quote is the immense sense of responsibility felt for this type of work. Health and social care were combined in this situation and the nurse was essentially the only service involved with this patient. In the study of power, Foucault (1988) recommends that we attempt to understand power dimensions and effects by adopting a bottom up approach. Here we see a group of nurses who were isolated in the community and meeting with patients who were essentially outside of or out of contact with statutory services.

It is interesting to note, that the position of encouraging or maintaining dependence in this way was out of synchronicity with main stream nursing academic writing. From the 1970's onwards, many commentators were promoting a nursing process which emphasised self care and independence rather than dependence (Roy 1970; Meleis 1985). One post modern commentator opines that the reconstruction of the nurse patient relationship occurred through a changing discourse in nursing and to some degree medical texts during the 1970's (Armstrong 1983). It is suggested that the idea of the patient was reconstructed through a new language/discourse as a "psycho-social being" represented to be essentially independent of rather than dependent on the nursing profession. It is clear that the data presented here suggest that this discourse had failed, to some degree to impact on the work of district nurses in the recent past.

One consequence of this was that nurses in this study reported that they coped, managed and in the process fostered dependence. This coupled with the fact that the content of district nurses' work was both poorly and loosely defined, led to the situation in which there were differences in the services provided to patients. The data presented here indicated that patients attempted, through necessity and vulnerability, to engage the district nurse in activities which were often felt to be beyond her professional role. Although the situation was such that the patient has little option, the effect of the demand was none the less coercive in the way the pressure is perceived by the nurse. Although the coercion to act was benign (originating from a desperate situation rather than through deliberation) nurses undertook the work.

Being Sure

For some nurses, the pay off for dependence was security: -

> *"You just couldn't leave them without, could you? But in some strange way it meant that you would keep an eye on them, what they were eating and you knew they were secure, safe and warm." Observation – Sister Area 3.*

At the end of the day, this nurse felt that vulnerable patients under her care were adequately tended to. Being responsible in this way meant that district nurses had control over the patient and could *"Keep an eye"* to what was going on with them. It was a way of *knowing* the patient. This form of informal overseeing meant that the nurse could observe how well the patient was coping and managing at home. Little extras like picking up bread,

bringing in the washing, where family and friends were absent, might be all that was needed to keep the patient from extra social service care. The dependence on the nurse prevented dependence on other services, and for the patient the unwelcome intrusion of other professional care services.

What is noteworthy here then, was that rather than being a passive strategy totally fuelled by coercive situational factors, nurses often utilised the 'extras' as a way of securing access and surveying their patients' continuing health. This may go some way to explain why some researchers have suggested that district nurses decisions were often variable and based on some intangible or informal categorisation system (Luker and Perkins 1988) and seem to be haphazard (Audit Commission 1992; 1999). Informal overseeing as recounted here, gave the nurse the opportunity to monitor states of cleanliness, check on how the patient was eating and so therefore monitor coping.

The provision of social support in this way has been described as the buffering effect (Cohen and Wills 1985). Essentially, the nurse in this situation provided minimal, although sometimes burdensome (to her workload) social support where it was lacking and continued contact. This active strategy provided direct support through care and attention and therefore helps people cope with the effects of stress associated with illness. The direct effect hypothesis (Cohen and Wills 1985) helps by making patients feel cared for, and can facilitate some level change in health behaviours as one commentator suggests: -

> "because others care about them they feel that they should eat well, seek medical attention before a problem becomes serious" (Sarafino 1994 p107)

Thus nurses often described a way of *being sure* that the needs of the patient were met eased the emotional burden of worry. Doing everything meant that the job was finished and the nurse could rest assured, with some sense of security and completion. Important in this reference are the words chosen by the nurse, particularly "*Secure, safe and warm*". These represent a definition of nursing and approximate to total care which some contemporary commentators have equated with "new nursing" (Salvage 1990). It is ironic to note, that this form of interaction, could in essence be more cost effective in terms of the preventative component of the interaction and the early detection of health problems.

Idiosyncratic Care

It was customary for District Nurses to decide what level of care was provided to patients in their own patch and this decision most often went unchallenged. This system of work produced a culture of individuality in which care could vary from patch to patch, practice to practice and even patient to patient. This finding has been reported elsewhere in the literature (Luker and Perkins 1988; Luker and Kenrick 1992; Audit Commission 1992). The nature of the system of organisation produced a territorial response in which decisions about care were most often left to the discretion of the individual Nurse: -

> *"I decided what was provided and that depended on what was available, the team etc ... my patch was my own and sometimes Nurses covering would complain about having to do certain things, like getting people up – but I told them that I had made the decision and although they didn't like it, they still did it. After all, they didn't know the patient and I did." Observation – Sister Area 1*

Important in this quote was the personal nature of the decision making process and the reference to control and the ability to stay with the decisions even if colleagues complained or challenged her decision.

In some situations, cross fertilisation of care and exposure to different methods of work came from covering for other nurses at times of staff shortage, weekend work or holiday cover. Whilst this may have exposed the nurse to new ways of working, differences in approach were often attributed to individualistic factors ascribed to the regular nurse and her appraisal of the situation rather than good practice: -

> *"We had very little understanding of what others were doing, except when we covered for them from time to time. But then you just assumed that they were doing things for a good reason and as you were temporary then you didn't question it really. You made your own decisions about what to provide and people didn't question it" Observation – Sister Area 3*
>
> .

The assumption generally made when covering and seeing practice that deviated from the norm was that the regular nurse had made the decision to provide that aspect of care for some unknown reason. The temporary cover and the fact that the incoming nurse did not have access to wider information militated against questioning the decision making process of the regular nurse

for both positive and negative reasons, that is finding out the reasons for good practice or confronting poor practice. Also the system of being attached meant that the GP's surgery that she was covering may have been unfamiliar to her. It was generally the case, and certainly a rule of order that when passing over patients to colleagues, it was assumed that everything would be done in line with accepted practice in that particular area. This often meant that the incoming nurse should, if this rule held good, not have to change or alter the prescribed treatment. Good reason was good enough. This may be why one study described collegiality in district nurses as essentially lacking in confrontation (Griffiths 1996; Griffiths and Luker 1997). These historical data indicate that confrontation and change was often remembered as being highly dependent on individual doctor's prescriptions as the evidence base and power for nurses' prescribing was subject to forces often out of the control of nurses eg doctor preferences, knowledge of the nurse, inter-personal relationships between doctors and nurses. When Griffiths (1996) suggested that the etiquette of district nursing worked against best practice, it appeared from the data presented in this study, that the lack of confrontation was also associated with the factors external to the nurse's work.

This state of affairs was further compounded by the fact that nursing notes at this time were scant and communication between nurses was haphazard instructional and were in the form of oral communication: -

> *"We weren't so hot on paper work really, nursing notes were informal, just a diagnosis and description of what we were doing" Observation – Sister Area 1*

Seemingly then, the assumption of good reason was good enough to continue with the prescribed intervention and challenge was rare. It is hardly surprising that variations in care were likely to exist, both within and between teams of nurses.

Other factors were involved in maintaining idiosyncratic or traditional care. In the following excerpt this nurse indicated that the system of work organisation at the time may have prevented her from offering the best to her patients: -

> *"you know, like erm, like just talking to people about new treatments and thing that are going on, you try your best to keep up to date but you know, you came to rely on your own experience and that is not always a good thing really, what if you just don't know?" Interview – Sister Area 3.*

One effect of lone work was that some participants questioned their own competence and professional knowledge when reflecting on their recent history. Some referred to the idea that within the hospital order, there would invariably be cross fertilisation of ideas and practice which would have the effect of providing opportunities to develop skills or at least offer a comparison. It was noted that in the community there was little opportunity for this type of interaction.

Nurses often had to trust and rely on their own experience as the bench mark for good practice. In the latter excerpt, the nurse described a situation in which she indicated that there was scope to be out of touch with up to date

practice and that situation was worrying for her. This is particularly important as there has been a code of professional conduct which insists on practice being appropriate and responsible since 1987. It is also interesting to note that many participants internalised the code of conduct and acknowledged that responsibility in some way was theirs. Foucault (1977) argues that codes of conduct and professional rules are a means of disciplining and controlling professional groups. Here it can be seen that participants in this study castigated themselves for being out of touch with good practice.

Despite the lack of adequate educational support and infrastructure, it can be seen that this nurse like many of her colleagues accepted responsibility for being off the mark with regard to contemporary practice. The irony of this situation was that in all four study sites, opportunities for practice development, until relatively recently were extremely limited (Field work diary 1997, 1998). Two of the three study sites had only developed systems of practice development and continuing education as late as 1992 more as a response to the General Practitioner contract and demands for a suitably practically skilled nursing service. Even when robust systems of in-service "education" were established, they concentrated almost entirely on practical skills training such as catheterisation techniques and venepuncture (Fieldwork diary 1998, 1999). Prior to this there was little opportunity for continuing development of practice or skills update above what the practitioner themselves initiated.

A number of the nurses in this study suggested that once they had got the "course" it was assumed that they were fit to practise and correspondingly would stay fit to practise. As one nurse proposed: -

> *"I think they thought that you would just continue to develop and change by osmosis, you know you had the course (District Nurse certificate) and so you knew it all! But in the community it didn't work that way. We work with doctors that are worse than we are in terms of treatments and dressing and that, and we didn't see anyone else really so we just carried on." Interview – sister area 3.*

Another nurse recalled feeling like she "muddled through" many years on the community in terms of keeping herself abreast of changes in practice. Others reported that the main way that they changed their practice and appreciated the use of new wound care treatment was a consequence of being met with new applications and dressings when patients were discharged from hospital to their care. Another remembered having to rely on covering for other district nurses, particularly younger, recently hospital based nurses to provide her with the opportunity for seeing how different practitioners approached common problems. This was her only opportunity to for exposure to diverse methods of treatment.

This latter strategy was precarious as when covering for another nurse there was little opportunity to discover the justification or the theoretical underpinnings of the colleague's choice. There was a general assumption that deviations in practice were seen to be the result of some external factors rather than sound evidence. What these accounts indicate is that for many nurses in the community, practice development, innovation and change

occurred through informal processes, vicariously and by chance rather than by design. There is evidence in the literature to support these findings. Kenrick and Luker (1995) observed: -

> "the fact that community nurses are based in clinics, health centres and GP surgeries meant that they are less likely to have use of resource centres where they can easily access up to date clinical information." P3.

It is also suggested by other commentators that district nurses' work has been perhaps the most under researched group of nursing staff (Kenrick and Luker 1995; Griffiths 1995; 1996). In fact it is noted that even the most commonly performed nursing activities undertaken in the community (eg eye care, venepuncture) have a variable evidence base and scant research support (Griffiths 1995). So it seems that even if access to educational materials was available and continuing support customary, then there would be little appropriate information to support district nursing practice.

It has been argued therefore that community nursing practice at this time was largely based on experiential knowledge (Luker and Kenrick 1992) a consequence of which is that district nurses have had difficulty articulating and describing their decision making processes, let alone the evidence to support them. One commentator opines that the nurse education system has therefore failed community nurses (McIntosh 1996). Foucault (1977) argues that knowledge and power are linked in a dynamic and intertwined way. Without access to knowledge it is difficult to command and exercise power.

Therefore the act of denying, restricting and failing to provide access to professional knowledge systems and the funding of specific research, may have served to keep district nurses in a relatively subordinate position. It is hard to argue a case for your work when there is at best scant evidence and at worse none to support the content and context or work in the community. In an interesting juxtaposition one nurse highlights the quandary which beset nurses: -

> *"I think it's (the GP contract) equipped us a lot more to talk about what we do. I don't think we could have even begun to have a conversation about what community nursing was 10 even 5 years ago because I don't think many of us really understood what it was at all" Interview Sister – Area 2.*

Given these data, it is hardly surprising that successive audits of district nursing work have found worrying differences in the content of their work, both between geographical areas and even within the same District Health Authority (DOH 1988; 1994; Audit Commission 1992; 1999). Research also suggested that the decision making processes involved in district nurses' work were subjective, variable, reliant on informal and experiential learning and open to wide variation (Luker and Perkins 1988; Luker and Kenrick 1992; McIntosh 1996).

Moving On - Knowing the Patient

For many nurses in this study the changes that were occurring in their role as district nurses was illustrated in the loss of the bath from the work of

participants. Losing the bath occurred as a direct result of the Community Care Legislation (DOH 1989) which became mandatory in 1993 following the publication and enactment of the Community Care Act (1990). The main thrust of this act was the formal organisation of a divide between health and social care which forced district nurses to consider the boundaries of their work (Griffiths 1996). The notion of social care was introduced which separated out what could at times be a cohesive if somewhat arbitrary system of care (Griffiths 1996; 1998).

All of the participants in the study reported here, referred to this process as the focal point of change although it had occurred/was occurring at different take off points across the various sites. The loss of this aspect of nursing work, in which the experienced district nurse used her talents of assessment and observation had left district nurses with an altered perception of their work: -

> *"I think also you've got to remember that if you are doing hands on care and you are not just washing somebody you are obviously checking all their body, you are talking to them, you get closer to them, you know you do find out more problems" Interview sister – area 1*

And another nurse: -

> *"When you are washing somebody, it requires all your skills to do it properly, there is a vast difference between even an auxiliary nurse and district nurse so the difference between nurses and carer is immense. People have forgotten about intimacy and stuff like that really, about breaking down barriers and the things that you talk about when you are working in that way, fears, anxieties and all of that" Staff Nurse – Area 3.*

It was suggested that bathing patients gave the nurse an opportunity to assess, establish and maintain a relationship and oversee the patient's condition. The bath was often the way in which participants reported that they secured a relationship with patients through which they could monitor psychological factors which could affect the patient, their carers or their social environment. The closeness and the intimacy associated with this form of care was highly valued by many of the nurses in this study. The second nurse highlighted that many of her colleagues had forgotten these traditional skills and had developed others in their place.

It is interesting to note the contrasts which occur in the nursing literature around this finding. Many commentators on contemporary nursing practice espouse that the closeness and intimacy associated with this form of work as the challenge of "New Nursing" (Meutzel 1988; Salvage 1990; 1995). Indeed, what were described in the above excepts as "traditional skills" are those very skills which some would argue have the ability to transform nursing into a professional discipline distinct from the discourse imposed by medicine (Salvage 1990; McMahon 1991). Others however are less sure of the revolutionary or even evolutionary potential of the re-found traditional skills of new nursing (Luker 1995). What is a noteworthy juxtaposition is the comparison between the community and acute/secondary care philosophies. In the community, these data indicate a distinct move away from basic care (bathing and hygiene) whilst in acute care the contrary seems to be the trend (Salvage 1995). Within Nursing Development Units, it is suggested that the

closeness and meaningful relationships, established through continuity of carer, hold the therapeutic potential to develop excellence in nursing care (Mc Mahon 1991; Salvage 1990; 1995). However, the extent to which this philosophy of care can be truly adopted in mainstream acute care setting is debatable where a para-medical model of care due to pressures of patient turnover is suggested to exist (Bergen 1999; Perry 1993).

More pragmatic, rather than idealistic commentators have accepted that the philosophy of contemporary new nursing rarely occurs in practice (Bergen 1999). Indeed, one author who espouses this philosophy found through ethnographic research which compared a nursing development unit and a traditionally organised medical ward that there was little difference in the wards in the nurses' view of the quality of their care (Salvage 1995). More important to the nurses in this study were the local conditions of practice, resources available to them and the control they had over the flow of their work, rather than their philosophy of care. These data are supported by those presented and suggested by other commentators on the organisation of nurses' work (Salvage 1995; Bergen 1999; Edwards and Hale 1999).

The data from this study indicate that this therapeutic potential of holistic care was well known to district nurses. The skills encompassed in providing this form of care were always appreciated (Griffiths 1996) and in the case of terminal care, district nurses actively seek to develop this form of intimacy and "knowing" as a way of not only enhancing but securing quality care (Luker et al 2000). It may be argued that in comparison to their hospital colleagues,

some district nurses had had the experience of total care, so often associated with new nursing and were in fact in the process of losing this element of their work.

It is important to the post-modern orientation of research to link elements of research through juxtaposition (Marcus 1998). The following long piece of observation depicts how skilful nursing or artistry (Mc Intosh 1996) can still feature in the work of district nurses in the community but it is the exception rather than the rule. My own reaction to this excerpt clearly depicts how moved I was by this interaction: -

> *"(name) approached the door of the house and knocked, waiting by the door. An elderly woman opened the door and (she) greeted her warmly, let her lead us through the kitchen into the living room where a man was sat in a chair next to a small oxygen machine. He was wearing pyjamas and had oxygen nasal spec's on. The nurse walked towards him and placed a hand on his arm. She asked him "How are you?" and then knelt down on the floor, the man answered "I'm OK." She looked at him intently seemingly scrutinising his appearance, before saying "You look slightly better today ..." She paused and waited ... The nurse leaned over from her kneeling position to get a large bag of equipment which was at the side of the patient and took out the equipment she needed and placed it on the floor at the foot of the patient...She turned to the man's wife and said "How have you been during the night?" The patients wife replied 'OK but he wakes during the night and has to read ... last night he woke at 3am and wanted an encyclopaedia, I had to find it in the dark. The nurse smiled sympathetically and raised her shoulders. Mrs ___ continued "Sometimes I have to give him his oxygen during the night as he gets very breathless, that's why I sleep on the couch." The nurse maintained eye contact with Mrs ___ and she continued "But we have good days and nights", reacting against emerging emotions, the nurse observed this and said "You do very well ... it must be hard on your own." Sensitively and sympathetically acknowledging the wife's struggle. She paused, the wife smiled and (name) didn't, but continued to face the woman for a period of time and then placed her hand on the woman's shoulder. The nurse and Mrs*

> *___ broke the contact simultaneously and (name) walked into the kitchen to wash her hands. She returned, knelt at the patient's feet, She helped him undress and covered the exposed parts of his body as she systematically began to wash the man with the equipment she had collected. She was incredibly tender during this process and the man's wife sat nearby watching her. She touched his skin sensitively, using her hands to massage his legs, chest and back. She helped the man get into clean pyjamas. She stood up asking the patient "Do you want to go into bed?" He nodded the affirmative.*
>
> *(Name) asked me to help and I went over the bed to arrange the sheets and quilt. I took off my cardigan and watch and walked with her to the patient. Placing our hands under his arms we lifted him out of his chair, he needed gentle assistance rather that a lift. She took the opportunity to look at the man's buttocks and sacrum and with her finger depressed his sacral area, slowly inch by inch we moved with the man toward the bed. (Name) repeatedly said "It's OK take your time ... go easy ..." She positioned him so he sat at the top of the bed and whilst I supported his top half, (she) lifted his legs into the bed. Immediately, she turned his oxygen mask on and replaced his oxygen specs around his ears. The man was breathless. She arranged his sheets and quilt at his waist and stood near to him without speaking until his rapid breathing settled. Satisfied, she asked "Are you comfortable now?" The man nodded and closed his eyes. (name) touched his hand and turned away. Observation – Sister Area 1.*

This quote is noteworthy for a number of reasons, not least for its historical value in recording a disappearing aspect of district nurse's work. The tenderness and care with which the nurse attends to both the patient and his wife are clearly evident. During the procedure, she was able to show gentleness and warmth to both the man and his wife. For some this is the quintessential essence of nursing (Baly 1986; Manthey 1991; McMahon 1991). In summary the excerpt presented above, exemplifies what some nurses in this study described as "lost skills". It is argued that this form of trust represents a significant investment of faith by the patient in the abilities of the nurse (de-Swaan 1990; Lupton 1996). Associated with this trust are the joint

risks of vulnerability and anxiety (Lupton 1996) which were clearly managed competently by the nurse. Others have argued that many patients, by the nature and severity of their illness, are "people who are forced to trust" (Cassell 1991, P76). The importance here was the nurse's response to this trust and the experience she gave to both the patient and his wife. For example, the nurse could easily have dismissed (active strategy) or even missed (through a lack of empathy and understanding) the sadness in the woman's voice. She could have rushed her patient. Instead, the above excerpt highlights the confident and competent way in which the nurse managed these extremes of emotions and regulated the symbiotic relationship of trust and anxiety (Giddens 1990) secured through her sensitive responses.

This form of work has been described in nursing literature as intuition based on expertise (Benner and Tanner 1987) and in post-modern sociological writing as "embodied knowledge" (Lupton 1996) which has the peculiar feature of often not being exercised through calculation but rather at the level of "gut feeling" (Gordon 1988). Perhaps the most pertinent study of what this type of interaction may mean for patients is provided through a post-modern analysis of a cancer ward (de-Swaan 1990) in which the author highlighted the symbolic importance that this form of contact has for patients: -

> "To patients it means much when doctors and nurses know how to handle their wound competently and without fear. The nurse patiently washing a dilapidated patient, changing his clothes, is also the one who dares touch him without disgust or fear, who quietly and competently handles the body which so torments and frightens the patient ... in doing so liberating the patient for the moment from their isolation." (de-Swaan 1990 p48)

It is suggested here that the competent and confident management of ill patients by skilled professionals can do much to relieve the tension and isolating effects of severe and enduring illness, and the latter excerpt supports these findings.

For many nurses in this study, this type of relationship could only be achieved through a process of embodied knowledge which apart from the rare exception of terminal care nurses reported that it was seemingly slipping from the general repertoire of district nursing skills. For many nurses, the loss of contact with patients presented a challenge as the way in which their knowledge of the patient was acquired was usually secured by implicit or tacit means, where the nurse had a legitimate mechanism through which she could obtain information. This finding is reminiscent of those presented by May (1995) in which he suggests that nurses know the patient by how they look as well as by what they say. In other studies, it has been suggested that this surveillance process (May 1991; 1995; Lupton 1996) requires hospital based nurses and doctors to adopt direct strategies of inquiry to develop an understanding of the patient as a psychosocial being in order that the practice of treating the individual and exposing the patients personal identity could be achieved through the identification and resolution of psycho-social problems (Armstrong 1983; May 1992). In the study reported here, these active strategies adopted by hospital staff to achieve holistic treatment were not adopted by district nurses: -

> *"We can't help but be holistic, we deal with families in their own home and we SEE and we KNOW, you don't have to ask questions about what they are like at home" Observation – Sister Area 1.*

This form of knowing had great implications for the delivery of care as the agenda for the gathering of information belonged to the nurse. It is obvious that in this situation that her patients effectively are exposed to a nursing gaze (May 1995) and had little control or choice about the information she observed and the inferences she made as a consequence of this. This differs from the studies reported above in that hospital patients have some choice over the information they offer to nurses in that the patient may be viewed as being more powerful because he or she can choose to divulge personal information, and can to some extent, control what is known about them and their private lives (Bloor and Mc Intosh 1990; May 1995). In this situation, it appears that the patient had little control over many aspects of what was known about him or her and the nurse could and did, in effect control the agenda of the information and consequently her work with patients.

Knowing About

For some Nurses in this study observing and dealing with the social represented a unique form of "knowing the patient" that was increasingly replaced by a "knowing about the patient." Participants in this study felt that this was the major change in their role as district nurses which occurred directly as a result of health and social care divide. One care manager illustrated this point: -

> *"we used to really know the patient well, we would see them, wash them, not all the time – perhaps once a week and the auxies would do the rest, but we would notice subtle changes and do things earlier, at best now we know about them and we get to know them again when things have gone badly" Interview – sister area 2.*

There is some evidence to support this finding. In one qualitative study of 22 hospital based staff nurses (May 1991) knowing the patient and his or her social circumstances was found to be of central importance in the process of providing high quality care and evaluating care for the participants of the study. This finding also finds support in a recent qualitative study of district nurses which suggested that knowing the patient at home was integral to the provision of quality care in the community (Luker et al 2000). This embodied (direct awareness) knowledge was important to nurses in this study because it differed from medical knowledge. The data presented here suggest that district nurses had become less reliant on embodied knowledge and more dependent on secondary information. Thus the "implicit or ineffable" knowing (Gordon 1988) which characterised district nurses professional knowledge was noted to be disappearing from the work of the nurses in this study.

Knowing by Proxy

It was frequently highlighted by participants that this change in the work and organisation of workloads was associated with a loss of intimacy and control of the illness trajectory of the patient and a loss of trust in the nurse by the patient: -

> *"It comes down to something as simple as that, trust, it is a very intimate thing to do for someone, erm, and I think they trust you more if you know them in that way, erm, and you are total care then aren't you? Not just bits of the patient." Interview – Staff Nurse Area 3.*

It has been argued that the form of trust represented in this excerpt has been described as "mundane trust" (Daniel 1998) that is, a form of trust that is implicit in everyday life and characterised by symbols such as caring for, caring about and the performance of symbolic tasks related to professional work (Daniel 1998; Lupton 1996). More importantly, it is argued that trust arises in a relationship and is discovered through mutual experience (Daniel 1996) which these data suggest was disappearing. Perhaps the most pertinent finding from Daniel's study was the effect of the absence of this form of trust. It is suggested that a lack of mundane belief prevents "the other's attempt to provide a service" (Daniel 1996, p211).

It is not surprising that some district nurses equated the lack of trust and relationship with patients with problems in the caring for patients. The point made by this district nurse (and some of her colleagues) was that total care, even if it was supplied by different member of the district nursing team involved a more holistic as opposed to a disjointed approach to caring. The following excerpt highlights the difficulties that some nurses suggested hindered their work with patients: -

> "*DN: it is so much harder now because we don't know the patients like we used to, harder to know what to do and how far to go, you have to trust someone to be able to ask personal questions or make comments about home circumstances. Sometimes you don't know the patient well enough to know how far you can go and that stops you offering some of the things that you know, you might be able to help with. Sometimes they just don't trust you enough to tell you things, you know, they don't see you often enough.*

SS: That sounds like a problem for you, something that is difficult, almost like you are saying it is hard to provide care sometimes 'cos you just don't know the patient well enough to know what to offer? And something about trusting each other?

DN: yeah, yeah you know, I have, I do find it hard sometimes particularly the way that we work and organise the workload now" Interview – Sister area 4.

It is interesting to note that in this excerpt, this sister's words encapsulated a shift in knowing and trust, which have been described in the literature as essential characteristics of good nurse-patient relationships (May 1991; Radwin 1996; Luker et al 2000). This second hand knowledge about the patient was repeatedly described by the participants in this study as information that they could not have confidence in or that they trusted less than first hand reflection and investigation or observation of the patient. The following excerpt contrasts with the description and observation of a skilled bath presented earlier: -

"(Name)took herself to the patients bedroom and opened the door. The social services carer was in the bathroom with the patient as this was a Joint Visit in which social services looked after the General Care and health looked after her health related care in this case the pressure sores that the woman had had for a long time. (name) gathered her equipment which was stored in a corner of the room in a large box which was full of equipment and dressing material. There was a letter waiting for (name) in the box which was a communication from the hospice which detailed the dressings that they were applying to patient. It indicated to (name) that there had been no change in the treatment The bedroom had a hospital bed in it which was equipped with an over bed sling assist the husband in turning the patient during the night. As (name) was finishing collecting the equipment, the social services carer, a young girl of about 19, brought the patient out of the shower room in a wheel chair in to the bedroom. (name) bid her hello and asked how she was, which the carer answered " she is OK". Between herself

> *and the carer they fitted the woman's sling and hoist and lifted her carefully on the bed. The carer went around to the side where the patient was facing and (name) went to wash her hands. On her return she commenced the dressing and did not seem pleased with what she saw At this point (name) lifted the patients buttocks high on the bed, and both the carers scrutinised the area. The women's face at this point was contorted with pain but neither of the carers were able to see. She commenced the dressing following the usual procedure, cleaning the area with saline and then applying comfeel to the area. She secured the area with two pads and then taped the dressing into place. Between them they dressed the woman and lifted her out of the bed using the hoist into a chair and sat her onto a foam pillow which she seemed reluctant to use. Throughout the above there was no attempt to talk to the patient and they did not inform her of any of the procedure. The carer wheeled her into the living room and (name) washed her hands and cleared the equipment away. She walked into the hall and shouted "Goodbye" to the patient and her husband who was sat on the chair in the living room waiting for his wife." Observation – Sister Area 1*

It appeared in the data presented here, that the rules between nursing and social services carers' were formalised and highly co-ordinated so that there was no overlap between the two services. The nurse performed the medical task and the social service carer performed all of the rest of the basic care for the patient. These data indicate that for some nurses a radical change had occurred in how they deliver care. In the recent past for example, this women because of her many problems and deteriorating medical condition might have received a bath from the district nursing service (Griffiths 1996; Luker et al 2000). It is clear that this district nurse saw her role as solely technical, task oriented and highly focussed. That is not to say that during this procedure she was not observing the patient and her condition, but it appears from this piece of observation that little explicit data was collected, other than the condition of the wound and *its* treatment.

New Skills

The data suggest that for many district nurses this new way of working relied heavily on reported knowledge about the patient from the allied carer. Thus, new skills were those that encompassed technical tasks rather than social tasks. There is support for these findings in the nursing literature. It has been argued that the radical re-professionalisation of nurses has resulted in dramatic restructuring of the content and boundaries of nurses work, which to a great degree has gone unchallenged (Porter-O'Grady 1993). In one study, it was suggested that this flexibility has resulted in de-professionalisation of nurses where high volume low complexity jobs are carried out by some other flexible but numerically large group of peripheral workers (RCN 1992). The data presented here, suggest that a significant part of district nurses' work had been passed on to other groups of workers. Some argue that the "ditching of dirty work" is an essential part of the professionalisation process which is necessary in the re-construction of a profession (Ramprogus 1995). Others have argued that the erosion of care has produced a situation in which the nurse is faced with the dichotomy of the division between the technical and intellectual aspects of care (Bergen 1999). These data illustrated this process in action.

For many nurses in this study, the division between the technical care and intellectual involvement in the provision of care were becoming increasingly polarised. It is suggested that the consequence of this form of organisation

erodes the potential nursing impact on care, thereby reducing the possibility of a truly therapeutic approach to nursing (Mc Mahon and Pearson 1992; Morrison and Cowley 1999). The following sections consider this further.

Defining Skills

District nurses were increasingly focussing on task oriented work. Task and skills were used simultaneously by nurses in this study to define their work and the parameters of their interventions with patients. It is interesting to note that, during the course of the study, district nurses had great difficulty in defining what they saw as their work and their role, the only certainty was that it was not "social bathing" a position noted in previous research (Griffiths 1996; 1998).

For some nurses in this study, their perception and personal philosophy was espoused to be one of holism: -

> *DN: I think it changes as well, doesn't it, erm, it's supporting people really to the World Health Organisations definition of health it's not just the absence of disease it's, erm, it's to support health and support healthy lifestyles, to support technological intervention, to support health, all those sort of things," Interview – Sister Area 2.*

It is interesting to note that in this nurses' definition of her care approach the notion of support to technology was used along side the notion of healthy lifestyles. The discourse of technology and the re-skilling of the professions

has received a variable response in the literature. There are some who argue that the re-skilling of the workers is effectively achieved by pulling workers away from traditional craft work (Braverman 1974). The effect of this type of change is that workers in effect lose their control over the work process as their traditional and craft based skills are replaced by systematic task oriented work (Braverman 1974; Watson 1997). In some ways the data presented so far is supported by this proposition. Others have argued that modern organisations have moved to post-fordist style of management and organisation in which the workforce are encouraged to move away from traditional practices and adapt and change to become flexible (Pollert 1988; Burrows and Loader 1994). The data reported here have greater resonance with these ideas. These data suggest that nurses sometimes operate at the core of the workforce, assessing patients and providing some of the necessary care but more importantly, they co-ordinated peripheral workers to take on the less skilled work: -

> *"I suppose that we are holistic now, you know, more than before, in terms of what we do we do most things now, more skilled stuff like drips and drains, but we also coordinator the care package sometimes – you know doing the expert work and getting others to do the basic work" Interview – Sister Area 1.*

In this case the notion of holism is taken as being an extension or incorporation of the technical aspects of her role, which may have previously been done either in the acute sector or by community specialists. It could be suggested that the term holism, in common parlance among district nurses was related more to the prestigious or interesting work than the romantic

notions of nurse theorists' which has dominated the recent nursing literature (Manthey 1991; McMahon 1991).

However, for others in the study this sense of holism, holistic care or being involved with the patient was a fragile notion as they realised that they are more holistic in thought rather than in deed: -

> *"SS: Sort of going in and doing the task?*
>
> *DN: Yeah, but I mean, I hope we don't go back to task orientation really do, I mean we are trained to view people in a holistic manner but it is very difficult to do that on a short time scale, you know, especially because we do put down like a certain task that we are going in to do but really as a nurse you should be looking at everything, you shouldn't just be doing that one task.*
>
> *SS: Mmm.*
>
> *DN: I hope we don't we go back to task orientation (laughs). But the reality is, (voice becomes softer and puts head down) I suppose, we have done really haven't we?" Interview – Sister Area 3.*

For some nurses there was a realisation that work in the community had changed towards a more task oriented approach. The notion of holism was fragile, the idea of total care (except in the care of the terminally ill) was rapidly becoming a thing of the past. It seemed then, that flexible working and skills allocation were the order of the day.

In many cases the nurse assessed and prescribed care but was often dissociated from the execution of the task. These data then, lend support to

those findings in the literature which suggest that the contemporary organisation of nurses' work has moved away from the tradition of holism to a task oriented form of care (Bradshaw 1995; Edwards and Hale 1999). Flexibility in care provision has eroded the conventional practice of nursing. It could be argued here, that traditionally district nursing has been the last bastion of holistic nursing practice (Baly 1986; Griffiths 1996) to where many practitioners moved to escape the task orientation management role associated with hospital nursing (Reedy et al 1980a; 1980b). These data illustrate that to some degree, the organisation of district nursing was coming full circle, with the emphasis on skilled (technical tasks), a para-medical discourse based on skills and the best use of skilled professionals in the community. Task orientation was reported to be returning.

Summary

The data presented here confirm that district nurses have in the past undertaken work for which they were reputedly over qualified. However, this work was a result of high level of expectation and sometimes coercion alongside a loosely defined and delineated role. The continuing education and development of district nurses was scant and consequently the levels of skill and the services offered to patients in the community was very often idiosyncratic. These data also confirm earlier studies which suggested that the content of district nurses' work varied not only from area to area but even within the same geographical region. They also help to fill the gap left by quantitative studies by offering some insights into the reasons why variations in the services provided by district existed in the past.

The transformation that has occurred since the introduction of the Community Care Act (DOH 1990), has produced a change in the nature of the nurse patient relationship in the community. These changes were often recounted as a shift from *knowing the patient*, *being sure* and *certain* to a *knowing about the patient*, and a reliance on second hand information and knowledge and a return to task oriented work.

Chapter 7 - Findings

Introduction

Whilst the previous chapter highlighted how district nurses were organised and worked in the recent past this chapter outlines the recent managerial and organisational changes that have affected the participants of this study. Against a backdrop of intense organisational change, this chapter aims to report how these changes have affected (are affecting) the culture and working practices of district nurses.

Organising District Nursing Basing – Bringing them in from the cold

Neighbourhood Nursing (Cumberledge Report, DOH 1986b) was implemented across the study sites soon after its publication, whilst the change over to General Practitioner Attachment following the community care legislation (DOH 1989) was implemented at various time points across the study sites and even at different periods within the same District Health Authority. For example in site 3, although a neighbourhood manager was appointed to oversee the work of district nurses in that area, the actual practice of neighbourhood teams did not occur. At the start of the study therefore, some nurses had been "attached" rather than "patch based" for up to 5 years, others had only experienced GP attachment proper for 1 year. One nurse still worked half on a patch and half attached, as two of her

General Practitioners "refused to go fundholding". Area 1, a wealthy suburb of a major city, had a high percentage of first wave fundholding practices of all the study sites and therefore they had experienced the most upheaval as they had previously fully embraced the neighbourhood model. The implications of the General Practitioner Contract arrangements (DoH1989) and the subsequent GP contract arrangements of 1993, meant that for some nurses the working practices changed quickly from the Neighbourhood Model (working with multiple GPs covering a geographical area) to GP attachment (working for one group of GPs covering a practice population) with little time to adjust to the new way of working. For other participants, they experienced colleagues going through the change process and felt a sense of trepidation at their impending attachment. One nurse summarises her reaction to attachment thus: -

> *"It was like being dragged in from the cold and micro-waved so that you would thaw out quickly, I really had to hit the ground running" Interview – Sister area 3..*

When attachment came quickly district nurses' work changed dramatically. This process caused some nurses considerable distress. Some participants described how the content of their workload changed suddenly, not dramatically, but significantly. The following extract from a lunch time meeting during a period of observation, captures the momentum and sense of bewilderment and almost confusion present within one team: -

> *"We began a conversation about the way things had changed in relation to work practices and (name1) said 'well I've been attached, detached, patched and reattached' We all laughed.*

> *(name2) said 'I've been patched and attached' and then (name3) said 'I've only ever been attached – but it has been with three different surgeries and three different sets of doctors' The final nurse said, 'I've been out on my own in the back of beyond for years, with a group of 3 sets of GPs so I guess I've been attached and patched at the same time!' One nurse said 'Jesus! This has all happened in ten years, it is no wonder we don't know whether we are coming or going!' The laughter stopped." Observation Sister – Area 1.*

It is important to note that at the end of this interaction, I felt like there had been a real moment of realisation at just how much change had occurred within this team in a relatively short period of time.

In study area 1, a large rural area, the district nurses had been used to working within their own patch, often in isolation of other teams of nurses meeting only on an infrequent basis. In this particular situation, they went through two forms of basing, attachment to a GP group and also centralisation of the whole District Nursing team for that particular area. Therefore, they were amalgamated as a team of nurses within a centrally designated office, under the direct supervision of a nurse manager. This form of change, from working in isolation to large group working, caused and still causes many difficulties for individual nurses used to working alone. The manager of this particular team recounted how she pulled the teams together: -

> *"They were all very territorial really when we got together as a team, they were not used to being managed and we had a collection of teams, small teams working together. They protected their own patches and their own work and I had to break through that really, I am still doing that now" Nurse Manager – Area 1*

Breaking through for this nurse manager meant breaking in. In order to manage and organise her team she had to find out about the structure and content of their work. The chosen organisational strategy was one of close observation and centralisation making the work of the team visible and open to surveillance. The extent of this is captured by one nurse in the following quote from field notes: -

> *"When we were all brought together it was quite shocking really, cos although we all sort of knew each other, we really had no idea about how everyone worked and what they did. So for a time we were all watching and listening and checking out tentatively so that we could see what others were doing. I was really afraid of being judged. You just didn't know really what was going on with other people. What made it worse was that the skill mix has just happened and you know, you had to justify what you were doing. That was scary." Observation – Sister Area 1*

For other nurses in this study, basing seemed not to be much of an upheaval. Two of the study sites were inner city areas where large practices provided services to large local populations. There was little change in practice other than the fact that a district nurse may have shed or gained a GP in the process of re-organisation. The contrast between the different sites is the subject of the following sections.

Gaining Tight Control

Hands Off Management

District nursing work of the recent past was often recalled as "autonomous work" by participants in this study. Autonomy was equated with freedom from managerial control or observation and many of the participants reported that a very loose form of management was applied to their work. As the previous chapter outlined, there was considerable scope for idiosyncrasies in the provision of district nursing services. One reason for this was that nurse managers were seldom encountered during the course of the nurses' work. The system of patch management produced loosely managed discrete units of workers who were left to "get on with it". Sociologists have described this type of work organisation as the "semi-autonomous work group" which is: -

> "The grouping of individual jobs to focus work activities on a general 'whole task' with work group members being given the discretion over how the task is completed" (Watson 1997 p256)

A semi-autonomous work group is one form of organisation in which the smallest number of personnel possible are aggregated into a team to perform a set of designated tasks (Rice 1958). It is form of humanistic management based on trust, in which the team are allowed a level of autonomy to complete a set of designated tasks. In this situation, historically, district nurses were left to manage and respond to the task of continuing care of patients in the community. There is some support in the literature for this type of

organisation. It was suggested that district nurses in the past were left largely to their own devices, to coordinate and manage both the demand and supply of their services (Jupp 1971). They were, in effect a frontline health care service (Jupp1971). Essential to this notion and referred to by many participants in this study was the control they had over the completion of their work.

The notion of being semi-autonomous rather than autonomous is important as autonomy implies an idea of control and freedom whereas semi-autonomous implies that restrictions are in operation which prevent true responsibility and autonomous practice.

In this situation, district nurses did not have control over their workload. District nurses were (and still are) referral dependent and they did not have choice or control over who were their patients and so the content of their work was controlled externally, either by GPs or hospital based doctors. Very often the content of their work changed as new tasks came their way (Mc Intosh and Dingwall 1978). Indeed, it has been suggested that one feature of the semi-autonomous work group is that it is flexible and adaptable as the group effort provides a collaborative approach to solving new problems and approaching new challenges (Watson 1994). How the group chose to execute their work, the division of labour within their team and the way in which they planned work, was however left to their discretion.

It is important to juxtapose these findings which suggest that the district nurse had some control over the work tasks of her team with early research into district nurses' work. For example, in one land mark study of district nursing work, it was suggested that the role of team members was poorly differentiated and there was considerable abuse of the district enrolled nurse (Hockey 1972). One major finding in this study was that there was differentiation in the jobs allocated to different grades of district nurse but that this was "confusing and alarming". Perhaps this finding relates more to the fact that the nursing team were organised in a flexible way, which was undetectable by the research methods chosen by Hockey. The form of data collected by Hockey, does not give insight into the reasons or rationale for variation in the deployment of different grades. It may be argued that under supervision, the use of district enrolled nurses, allowed the district nurse to respond flexibly to the demands of the community population. It is interesting to note however, that if one compares the three major studies into district nurses work (Hockey 1966; 1972; Mc Intosh and Richardson 1976) who all used a system of task analysis as a methodology, it is striking to observe that the number of tasks described in each increases dramatically from the first to the last study.

This gives some weight perhaps to the notion that during this period of time (and perhaps beyond) district nurses work was expanding in terms of the structural content of their work. This is a feature of semi-autonomous work (Rice 1958) where the aim of this form of organisation is to ensure that there is flexibility within the work group to respond to technological change. Two

features of the findings of the above study are apposite to this form management and organisation. Firstly, it is reported that allowing teams to work in this way affords greater satisfaction over their work, and certainly these data indicated that district nurses recall the past with more contentment than the present. Secondly, where the group had established semi-autonomous status, then the unnecessary interference by management will be counter-productive to performance and execution of the task and their flexibility. The recent past for district nurses has been a time of change in roles and therefore, the pursuit of flexibility (Peters and Waterman 1982) involved a loose form of management control. In the following excerpt this nurse describes the relative freedom she experienced from bureaucracy: -

> *"In some ways it was good (patch work) and in others bad,*
>
> *SS: Can you give me some examples of good and bad things then?*
>
> *District Nurse: Well in lots of ways you escaped the bureaucracy of the hospital and I have to say that was my main reason for coming into the community, you know that I could get away from all of the management problems that you get in hospital, you know you get none of that out in the community, the only time you ever saw your manager was when you had done something wrong," Interview – Sister Area 2.*

What this District Nurse articulated was the often encountered motive for leaving hospital and choosing work in the community, a dislike for formal systems of organisation and bureaucracy. The community was well known to be an area of work where practitioners were only responsible for the management of direct patient care and a few, junior qualified and unqualified nurses. Other commentators have found that for many nurses this was their

reason for choosing community nursing (Griffiths 1996). The third pertinent point about this structure is that a small group of workers are able to respond to a local task, through their knowledge and understanding of local conditions. In doing so, their productivity and output increases (Rice 1958). Therefore, policy initiatives such as the Cumberledge Report (DHSS 1986b) can be seen to clearly support this managerial ethos of locally based small, responsive teams. It can be seen that these data illustrate the organisation of district nurses in the past, was organised around a managerial structure which produced a level of flexibility and small team responses to changing external demands. The essentially humanistic form of organisation was based on trust and flexibility of approach (Cole 1998). This is an interesting finding when juxtaposed with the data presented in the following sections.

Being Watched - Wrong place wrong time

For some nurses in this study, their experience of being managed was one of close scrutiny and direct observation, which contrasted strongly with the way participants had been managed in the past. In effect, the organisational structure changed from a distant, hands off approach to a more overt and structured form of management. For the manager of one team (also a practising district nurse) this enabled her to keep an eye on her staff, a large team of district nurses who worked in a huge geographical area. She was based in the health centre for part of her working week and so could "catch the team" when they come back to the clinic. In this way she could observe them, how often they were out and what time they returned. In doing this she

was able to exert a direct form of control which gave a very clear message of unacceptable behaviour as the following piece of observation shows: -

> *"I had arrived at the surgery and was waiting to go out and work with (name) she told me she needed to go and get some dressing packs from the office and I followed her in. One of the District Nursing Sisters was sat in the office and as (name) walked through the door she jumped to her feet. (Name) said*
>
> *'What are you doing here? No visits to do?'*
>
> *This was said in a jokey and almost flippant manner but the nurse looked red faced, embarrassed saying:*
>
> *'I just needed to check the address of a patient' she started to fumble through some notes and wrote something in her diary. (Name) stood watching her until she left the office. I felt very very uncomfortable as (Name) said –*
>
> *'You have to watch them all the time, you really do' Observation – Sister Area 1)*

This extract highlights important dynamics within this closely managed team. It is significant to note the behaviour of the district nurse, a practitioner with some 15 years of community nursing experience who behaved and reacted in way that was akin to a naughty school child. She flushed with embarrassment and looked guilty of some misdemeanour, as she was questioned in an accusatory manner. Similar strategies have been identified in midwifery practice where this form of action occurs among super-subordinates (Leap 1997). Important in this strategy was the level of mistrust. It was suggested that her staff needed to be watched and much of her time was devoted to this activity. It is interesting to note that this notion of suspicion is reflective of Taylorist style of organising. Taylor (1967) argued: -

> "Hardly a competent workman can be found in a large establishment, whether he works by the day or piece work ... who does not devote a considerable part of his time to studying just how slowly he can work and still convince his employer that he is going at a good pace." P42.

Other commentators have described this form of control as oppressive (Watson 1997) and merely a way of legitimising forms of surveillance aimed at making work more visible and therefore easier to control (Foucault 1977; Clegg 1990). It is important to highlight that the managers' suspicion of poor work performance and inappropriate use of time has been supported by widely circulated, often condemnatory official studies of District Nurses' work (Audit Commission 1992; 1999).

District nurses felt that they were also being watched whilst making visits. There are numerous examples from observation where participants articulated that it would not be done to be seen in an inappropriate place at an inappropriate time, the following excerpt indicates the power that this form of indirect surveillance had on the practices of district nurses: -

> "It was*10.30 am and we had been working since 8am, we had not had a drink and (name) said she was hungry. She said I need a drink and I have got it timed with the mobile café on the road up the way. We approached the café and (name) left the car running, ran to the van and collected two prepared cups of coffee and a bacon sandwich. She ran back to the car and gave them to me. We drove a short distance and she parked in a lay-by of a field off the main road. I was mesmerised by this behaviour and was about to ask a question when (name) said: -*
>
> *'It is ridiculous really the way we have to behave – but it would just not be done to be seen to stop at all'*

I asked 'Who would see you?'

'(Name of manager) or one of the girls, you just don't do it' (Observation –Sister Area 1)

What this excerpt shows was the direct effect and power of surveillance experienced by members of this team. It suggests an omnipotent presence and threat to her even when she was away from direct contact with her manager. She was genuinely frightened of being seen to be not working by either her manager or her colleagues and took a number of precautions to cover her tracks. This theme was a familiar occurrence among participants in this study. The extent of this felt surveillance extended into other areas of work.

Being Watched

At "lunch time" (a scheduled break and one that is not included in the working hours) all district nurses attempted to return to the base to check in, check up on work and messages and sort through outstanding business. The following excerpt represents a typical lunch time meeting: -

"I returned to the clinic with (name) and we entered the room. Three other District Nurses were there and there seemed to be a high level of noise and conversation between them. One nurse shouted

'the bloody mr (name) one of these days I will give him what for'

the two other nurses laughed. Another nurse entered and said 'I am going to have to miss some visits this afternoon I must phone them now to tell them (she seemed rushed)'. The other three nurses talked about the difficulties they were having with afternoon and problems patients. This was all done with quiet voices. The manager entered the room and the nurse who was

> *on the phone cancelling visits finished her conversation quickly and the other two nurses walked to their desk and began organising work in their diaries etc. I was struck by the sudden change in atmosphere. One nurse broke the silence by saying what 'a busy morning she had had' and another that 'I have hell and all to do this afternoon'. They ate and drank whilst phoning and collecting dressing packs, writing notes and taking messages. I was surprised at the level of this activity given that this was their lunch time break." PO Sister Area 1*

It was clear from this piece of observation that there was little time or space for lunch and never during my time observing these groups of nurses did I see this space uninterrupted or used as it should be. It is clear then that the rules of work for district nurses were that personal time was secondary to the business of work. There is evidence in the literature to support this. District nurses have repeatedly reported having to work many more than the officially contracted hours of work (Traynor and Wade 1994; Griffiths 1996). It is notable from this piece of observation that the presence of the manager had a powerful effect on the nurses in this team. What is difficult to convey in words was the atmospheric change when she entered the room. The conviviality and honesty altered dramatically when she intruded into this space. In this example the nurse who was cancelling appointments spoke quietly and stopped phoning her patients, spontaneous conversation ceased and other people retreated to their desks with evidence of business around them. This process was common to the majority of the meetings observed and was frequently recorded in my field notes (Field notes 8/98, 9/98 for example). In two of the study sites, the manager's presence in the room had a constraining effect on the interactions between the nurses. Consequently, for some the

lunch time meeting was reported to be an unsafe place and as one staff nurse indicated: -

> *"People don't say what they feel in the meetings, it is too easy to upset the applecart and so they can't say what they think, "*
>
> *I asked "who would you upset and how?"*
>
> *Hesitantly she said:- "It is the manager. She watches and listens to everything and checks up on you." Observation Staff Nurse – Area 1*

Participants in this situation were aware they were being watched. It is important to note however, that this meeting time was the only time when nurses could communicate with each other and in this situation the manager could observe the business of the day. This covert observation, which some have labelled "covert non physical hostility" (Freshwater 2000) effectively disciplined participants in this study to act in ways consistent with managerial demands. In effect, this strategy gave managers some knowledge and information, however subjective it may be. Similarly, the second manager reported "feeling the atmosphere" during lunch time meetings to observe the business of her nurses. It was evident then that proximity to subordinates and the surveillance of them (Foucault 1977) provided important information and an arena to confront and challenge. Many participants reported that the general tone was one of suspicion and observation, which they felt caused both stress and pressure. There is support for the effects of this form of organisation in the literature. In one study, it was found that the hardest acts of aggression to deal with were not physical aggression by other nurses but the "hostile undercurrent" that pervades some clinical areas (Farrel 1997). In

the data presented here, many nurses reported the situation of scrutiny as oppressive and coercive.

A consequence of this form of management was that nurses carefully avoided any possibility of open confrontation by hiding problems. When nurses adopted this tactic, they inevitably missed out on seeking support from the team. The effect of this form of organisation and management meant that a culture of coping was reinforced, where individual practitioners were forced to deal with their own problems and manage their own caseloads. It has been reported that a hostile environment fosters a culture in which nurses develop an unwillingness to help out and fail to offer support to colleagues as the order of the day is self management (Farrel 1997; Freshwater 2000). The lunch time meeting therefore was a place where nurses' decision making could, to some extent, be monitored and challenged. However, as the next section details, in some situations the challenge to the participants' decision making was sometimes more overt.

Challenging Autonomy

Proximity and knowledge of work practices enabled senior district nurses/managers to confront areas of practice that they saw as being inappropriate: -

> *"I have had to teach them by example really, sitting down with them and talking at the lunch time meeting and saying 'did you really need to do that?' 'Couldn't have someone else have done*

that' and make them just in a roundabout way think about it' Manager Area 4

In this excerpt the manager indicated how listening to her team gave her the necessary information to confront staff about their work. She underestimated the corporal effect of her power as many nurses interpret this form of interaction as punishing. This form of negative criticism has been shown to have a corporal effect on nurses' work (Farrel 1997). What is striking about this and other examples was the apparent coldness with which both managers addressed issues of work related problems. There was no attempt at support as confrontation and challenge seem to be guiding principles. Challenge was made publicly and these public meetings were sometimes an arena for attack and were used to openly admonish a member of the team. The following extract from field notes illustrate this practice: -

"I was in the office when (name of staff nurse) came in, she seemed sheepish, she is usually a gregarious, bright and quite a loud character. I knew immediately something was wrong. There were five of us sitting at the desk, the senior nurse and three other District Nurses, the staff nurse came in and sat down and there was a heavy silence. (senior nurse) broke the silence saying: -

'(name of staff nurse) doesn't like me, I make her cry, I tell her she is wrong and she doesn't like me'

I felt extremely uncomfortable with this statement and so did the other nurse who all looked either down or away from the managers eyes." Observation Sister – Area 1.

Following this piece of interaction I was in fact working with the staff nurse that afternoon and as soon as we left I asked her: -

> *"SS: How did you feel about what just happened?*
>
> *SN: (name of senior nurse) had a go at me last week. In front of all the other staff. It was a bit off when she said to you that (name of staff nurse) doesn't like me cos I make her cry. I get very worried. I keep wondering about my job" Observation Staff Nurse – Area 1.*

What is important to note in this excerpt was the fact that the dressing down was publicly administered as was the warning and comment that I was witness to. This gives a powerful message to the team about the authority of the managers who use this form of control. In Foucauldian terms, this public display of authority is corporal and punishing and it seemed from the many hours of observation spent with these two teams that no individual member of staff was beyond this form of admonishment. On one occasion, this form of public confrontation was applied to all members of the team. The following excerpt from an interview with a manager/senior nurse highlighted how she systematically took it upon herself directly to check the work of the district nursing sisters in her team: -

> *"Just last week I took it upon myself to find out what was going on with the team and their caseloads. So that is just what I did. I actually took their caseloads for a day. So then I was able to say to them when they returned 'why are you still visiting Mr (name) or Mrs (name) and do you think Mr (name) really needs three visits a week. They weren't able to answer me and so things changed. I didn't have to do it with the whole team as it soon got round what was going on." Manager – Area 1.*

It is little wonder then, that like many of her colleagues the following district nursing sister reacted in the following way: -

> *"You constantly feel like you are being judged, being watched and that you are not trusted even in the most basic of things. It is a terrible pressure to work under" Interview Sister – Area 1*

There is a plethora of literature which suggests that this form of management and organisation, where nurses feel attacked and judged causes discontent and job dissatisfaction and ultimately an exodus of staff from the clinical area (Churniss 1989; Mc Phail 1992; Farrel 1997; Mc Kenna 1998; Freshwater 2000). Indeed, it is suggested that this is the consequences of being excluded from power and decision making that produces a system in which frustration and aggression are turned against peers rather than the oppressors (Fanon 1967). These data support this assertion and the result was that nurses had to develop strategies to protect themselves from both peer and managerial duress. The contradiction here is captured well in the following comment: -

> "It is paradoxical that within a discipline that has "caring" for others as its main focus employee relationships are so poor" (Farrel 1997, p 507).

Watching Your Back

Many nurses who were subjected to both managerial and peer scrutiny described themselves as having to constantly "watch their back" : -

> *"There is a general uneasiness among the team, you always have to watch your back so you can't express yourself freely in the team because you can't been seen to be not coping, no that wouldn't be done really, " Interview Staff Nurse – Area 4*

and another nurse: -

> *"After leaving the clinic (name) indicated that she felt it was sometimes very difficult to talk in the offices because of the managers presence. She talked about the fact that their support tended to come from telephone calls made late at night, where people were organising their workloads outside of hours but importantly away from 'the eyes and ears of their manager'" Observation Sister – Area 1*

Foucault (1977) reminds us that where there is power there is resistance. One of the main ways that District Nurses resisted the intense scrutinising power detailed above was by "playing the busy game". This process was captured by a staff nurse new to the team and one who was able to see through the strategy: -

> *"They all hold on to their patients as if they are precious, they won't hand them over. No one really says what they are feeling, they just come in and report on certain patients, everyone comes in and says 'what a morning I have had' and how busy they are'" Interview Staff Nurse Area 1*

The rule was that nurses had to be constantly on the go and had to manage their own workload, even if the demands were excessive. Importantly this strategy was one of display in which the main target was not only their manager but also their peers. Failing to cope seemed to be a cardinal sin within this team and was one that was dealt with severely: -

> *"You should have been with me last week, there were two people off sick, I had to manage their caseloads on my own sharing with one of the other staff nurses, at the end of the week I left two patients not done, not serious patients and when I got back in here on Tuesday (name of manager) had a go" Interview Sister – Area 1.*

To be slack was not acceptable, to take time out was frowned upon. One novice staff nurse recalled how she had recently confronted the process of busyness and received a frosty reception from her colleagues: -

> *"People say that they are really busy and I say 'well let me help you out' and they reply 'oh I'm fine now' but they can't be that busy then otherwise they would hand over. They don't and I shouldn't tell people when I have made a balls up. I will go in and say I've made a balls up. But I don't think that other people do. I think it is held against me* (offering and off-loading) *by the team. There are tensions in the team and things aren't said ... but I just say it ... I think I shouldn't" Observation Staff Nurse – Area 1.*

This maverick staff nurse had yet to learn the rules of the team and like one of her staff nurse colleagues quoted above she frequently received public admonishment. She had not learned that most of the confessing of misdemeanours took place in private. A more experienced nurse detailed the common way of avoiding detection and therefore criticism: -

"DN: Well you have to manage as best you can and you can't be handing over all the time unless there is some really good reason for you to do so, like a lot of long term or terminally ill patients that have come on to your books really. It is really important to manage and share in the team first and then you can look to hand over, but then the patient needs to be really well sorted, stable and very straight forwards, like a blood or something, a simple dressing or a check, nothing that is going to change. You can also ask a colleague to go and see something if you are unsure and you know that they are good at a certain thing or something, but only if they are in the area that the patient is in.

SS: It seems that when there is the opportunity for someone to take on they will do, but there are occasions when they are all as busy as each other and a case of erm we all just have to manage

DN: and you know no disrespect to anyone really, in particular but I don't think we get an awful lot of higher management support anyway, it is very much that you have to manage to get on with all yourself, you know a lot of organising is done outside of work to make sure that you can get through the work really and that things don't get left undone. You know, you would never expose someone for not doing things you would manage to come up with some excuse to support you colleague if a doctor asked why things were not done

SS: Can you give me an example?

DN: Like going in and saying oh (name) was very busy yesterday afternoon with a terminal or something, they don't know what's on your caseload so you can get away with it usually." Inteview – Sister Area 4

In this excerpt, both the corporal and beneficial effects of teamwork can be seen. It was commonplace for telephone calls to be made asking for advice about complex treatments, doing extra patients when the workload was high, passing over non-complex patients outside of work hours. The rule in this situation was clearly that any patients passed over to colleagues had to be

simple work, requiring little extra support other than the task and certainly no complex interventions. These data give some support to the idea that peer scrutiny and surveillance was effective in coercing district nurses into a particular set of rules and action similar to the peer pressure described elsewhere in the literature (Farrel 1997; Freshwater 2000). This finding also has echoes with the etiquette or ritualised rules found among district nurses in an earlier ethnographic study (Griffiths 1996).

Whilst the lunch time meeting was largely a place where care was exercised in disclosure, for some nurses it offered them a place where they could confess or report anticipated difficulties. This strategy was for some, a way of preparing the ground in the face of a possible complaint by telling a colleague about actual or potential problems with patients. In some situations, if there had been a particular problem with a patient that may result in a complaint, then the presence of the manager in the office could be beneficial: -

> *". you are constantly worried what is going to happen to you really, and you try to pre-empt that in some way you have to make sure that you cover your back either by telling your colleagues at the lunch time meeting or writing it down in your own diary and things and telling your manger so that you can get your side of the story in first, because people do complain about things and that the reality." Interview – Sister Area 3.*

Thus the scrutiny of a manager, in some situations could be useful in putting the nurses side of the story first and thereby preventing the patient or complainant having the upper hand. This strategy was used commonly when cover was unavailable to complete work and work was left unfinished.

Indirect Supervision

There was a unanimous opinion among the district nurses in this study that the indirect supervision of their work had increased dramatically over the recent years prior to the commencement of this study. For all of the participants this indirect supervision was most usually associated with a dramatic increase in the written documentation and recording of interventions they undertook with patients: -

> *"Well the paper work has just increased and increased and it is this and that, assessment, writing, patient held notes, documentation this, documentation that, palmtops, Koerner, and all the rest of it really. It is just more and more work" Interview – Sister Area 1.*

Although it was overwhelmingly agreed that indirect surveillance of nurses' work had occurred, it is interesting to note that throughout the course of field work, important differences occurred across the four sites. In one site, where there was close and tight management by Trust managers, note keeping was more informal and although the notes were held by patients, there seemed to be less importance placed on writing them in full or recording daily visits. Indeed, on many visits with nurses in this particular site, I seldom observed notes being consulted or signed, or changes made to the documentation held in patients' homes (field notes September 1997, June 1998). This is an important and incongruous finding. Among the nurses in this particular area, the felt sense was that complaints could happen and that the patients were more litigious, I would have expected that they would be more rather than less vigilant in their record keeping. In fact, the contrary situation seemed to be

the order of the day, that the modus operandi was one of relative economy in note and record keeping. It was noted that apart from the detail of the initial assessment form, little was recorded on a daily basis, care plans were seldom signed and only ever consulted if a nurse was *filling in* for a colleague whom she did not know or was unsure about the treatment.

There are a number of possible explanations for this anomaly. Firstly, the peculiar distinction in the management of nurses in this area was that they operated a "personal caseload" system. That is, once allocated, patients were generally visited by the same district nurse throughout the course and duration of their treatment. Therefore, it was less likely that notes needed to be kept as a communication tool for others to follow and read as cross visiting of colleagues' patients occurred less frequently in this area than in the other three sites studied. Secondly, the nurses in this area were more aware that patients would read their notes (the majority being from higher, rather than low, social classes) and correspondingly a working rule was the less information kept in the notes the better. This point was alluded to by one district nurse who indicated: -

> *"They read everything that you leave and so it makes it difficult for you to know what to write, so I tend to avoid writing in the notes and just put the bare minimum. It is not just them it is their family and friends and you never know who is reading them.*
>
> *SS What might the problem be with writing then?*
>
> *DN: Well you never know what they do for a living do you? They could be doctors or anything." Interview – Sister Area 1*

Here it seemed that the threat was related to the idea that some significant other might scrutinise what was written and could correspondingly find that practice did not meet the prescribed care. This situation has been noted for some time in the literature. It has been suggested that the process of personal accountability has made nurses reluctant to commit elaborate plans of care to paper (de-la Cuesta 1983; Allen 1998). This has the potential of exposing the nurse to confrontation and problems in the delivery of care. The feeling relayed here was that the nurse may have been under scrutiny not only from the patient but from others who happened to take an interest in the notes. In a difficult situation, where a plan of care could not be followed due to time constraints, unexpected work etc, detailed plans might potentially expose the nurse to the risk of complaints if a patient was aware of what should be done. Minimal notes and less detailed plans therefore had obvious advantages in that the risk of exposure was minimised.

It is also important to note that unlike hospital notes, often generated by computer and standardised in format (Allen 1998) community nursing notes are held in the patient's home and as such are open to close and detailed scrutiny. The sense of risk associated with this is captured in the following excerpt for an experienced district nurse:-

> *"well I think that it's a lot more worrying because at the end of the day you wonder if you've done everything. I didn't find I used to have to write anything down. I don't think that has got an awful lot to do with age because if you've done the job for so many years it's you know, it is not writing it down so that I might forget it, it is just this, everyone has this fear of, OH MY GOD have I done that right!" Interview – Sister Area 1.*

"Doing it right" and the potential scrutiny of notes produced a real source of hazard. Minimal note keeping then would counteract the risk associated with being found out. It was not just scrutiny from the family or carers that presented a risk to the district nurse. A third explanation for this fear might be related to the fact that the nurses in this area were often scrutinised by their manager and the Trust who inspect or audit their caseloads and record keeping. The standard of case notes and recording in this particular area had so far not received close attention by the managers of district nurses. However, a threat had been made: -

> *"Erm, I think that we are watched from above about record keeping and I think there has been and last year when we were in the middle of crisis staff wise, there were some talks about erm sort of swooping on and checking our notes which makes you feel intimidated and threatened and you know perhaps it might be useful if people did some clinical supervision and came and talked to us" Interview – Staff Nurse Area 1.*

It is clear from this quote that this staff nurse knew that the risk of audit would expose bad practice in record keeping and would potentially threaten her position. She used the words *"swooping on"* which indicated a method of inspection in which she would have little say and which would be executed without her knowledge. This represented a serious threat both to her and her colleagues.

Within this closely managed team (team 1) the danger of further surveillance and checking was enough to increase the feelings of intimidation. The

following quote from an interview with a newly qualified district nurse (who had spent 3 years working on the community as a staff nurse and returned to a sister's post) indicated the following: -

> *"SS: I was just asking you about what ways you feel your role has changed from being a staff nurse to a sister?"*
>
> *DN: I feel it has just made me reflect a bit more and I have pulled my socks up, perhaps I was getting a bit slack, in mainly, nothing clinical, I think that clinically I was alright, I felt I was pretty good and everything and quite confident, but I think it made me reflect on accountability, and documentation and the need for this and the need for that." Interview sister area 1.*

What was noteworthy in this excerpt was that this district nurse felt that "*the course*" (district nurse training) equipped her more for the accountability of her role than for the clinical development often associated with the transition from staff nurse to sister. It is also interesting to note, that in observation, this sister seemed particularly more vigilant about record keeping than her colleagues (field notes July 1999) in so much as records were checked and amended on a daily basis and kept up to date. Foucault (1977) suggests that the right and proper form of training in contemporary society socialises subjects into a system of sub-ordinance through the means of correct training and examination. It can be proffered, from the data presented here, that the practical effect of this robust training establishes systems of surveillance that serve to expose the work of district nurses. The juxtaposition of this nurse with her colleagues is important. In this site (area 1) the majority of the district nurses had trained many years ago, indeed one qualified 25 years ago as a district nurse. It shows how this nurses' experience of contemporary

education was one of fear evoking mechanisms centred around legal practice, which related to feelings of professional accountability rather than the actual practical elements associated with nursing in the community.

In contrast to the above closely managed team, in areas where the direct organisation of community nurses was loosely organised, record keeping seemed to be afforded a much higher priority for the participants:-

> *"Well you see it has changed an awful lot really over the recent years with all the patient held notes and things and all of the documentation that has to be completed and everything that has to be done in the home and left with the patient. You just can't get away from it really and that has really changed a lot. There is masses of it to do now and it all has to be done NOW NOW NOW (SHOUTS) type of thing. It used to be that we just left informal notes and sort of let people know what we had done but now it is all written down" Interview Sister Area 2.*

In this particular case, this district nursing sister worked in an area where there was little direct managerial supervision of her work. She worked independently of her manager, whom she saw on "*high day and low days*" or when "*I am in trouble*". In an otherwise informal practice, that is, where inter-professional relationships (medical and nursing staff) and intra-professional relationships (nurse-nurse) are ostensibly collegial, she recorded this aspect of her work as particularly burdensome, yet essential. She represented some of the nurses in this study in describing the masses of written documentation that needed to be completed.

For some people the experience of record keeping was equated to the business of district nursing in a way that was akin to a contract: -

> *"SS: Are you saying that your relationship with patients is more of a business than it was?*
>
> *DN: Yes, it is more of a, err a written thing and if that's a business yeah. It's more of a very much, if you haven't written it down you haven't done it, so be careful of what you write down, it's all about being accountable" Interview – Staff Nurse Area 3.*

The data indicate that the practicalities of record keeping were not analogous to the romantic notion often espoused in nursing literature of good information for the sake of improving patient care. Rather it was a clear business relationship, fuelled by threat and risk in which nurses often discussed records as a vehicle through which they could be challenged by authority figures.

This finding has echoes with recent research in this area which suggest that the nursing process and documentation are the way in which nurses seek to protect themselves by documenting everything (Annandale 1995; Allen 1998). It is interesting to note, that case notes per se are not considered to be concrete evidence in the event of litigation (Dimond 1997). Rather, they are supplementary evidence that may support a case but are not considered evidence in their own right but are "hearsay evidence" (Dimond 1997). It is the cross examination of the practitioner which is considered evidence and only when credibility is established may the nursing records be taken as good evidence. Despite this there is a strong dictate from both within the local organisation of nurses and the professional body that governs nurses' work

(UKCC 1992) which emphasises the statutory importance of record keeping. One nurse suggested this: -

> *"We have got to keep up with our record keeping and the UKCC. I always think it goes back to when I was a child, if you do things properly, by the book the way that you are taught to, when things happen, then things won't fall back on you, and I often turn around to my team and say remember 'ALWAYS WATCH YOUR BACK' (emphasises) now if anything was to happen and our case notes weren't up to date and legible then we wouldn't have leg to stand on, if we had a problem with a patient." Interview – Sister Area 4.*

This district nurse reacted to the threat of litigation and complaints with a hyper-vigilance and ensured that this ethos pervaded her team. It exemplified the coercive effect of discipline, in the second meaning of the word, that of control (rather than an organised or regulated body) or professional regulation. The following excerpt is taken from an interview with a staff nurse from her team who was new to community work: -

> *"DN: for me it is all to do with documentation, it has got to be spot on and I would say that everything and anything, just gets written down and that is there to support you and back you up and any appointments, you have got to make sure that you report it back, err, I say communication has got to be a priority out here, I know it is in hospital but out here even more so, cos it is you and you are autonomous and responsible for what you do and I think more so, even though it is the same in the hospital, yeah it is them and you and you know, good documentation and you know report straight away if there is a problem" Interview staff Nurse area 4.*

Unlike hospitals, this nurse suggested that her responsibility for prescribed care was felt acutely. She was, in reality, the sole provider and prescriber of

care. These issues of autonomy and responsibility represented the controlling mechanisms and the often cited reason and rule was that at the end of the day the buck stops with the nurse. These findings are similar to those found by Griffiths (1996) who suggested that autonomous work was often equated, as the data from the study presented here suggest, with responsibility and a lack of managerial support.

For some participants in this study the distance of the immediate manager did not make the surveillance process less controlling. Another staff nurse recalls how worried she could be about record keeping: -

> *"I don't know about you, but some days I feel more confident than others as, and I'll go and I'll think, yeah that's fine I'll do this today and that night, and I think they should be seen because as soon as I put my head on the pillow I go 'Oh my god, did I write that down, and the next day I'll go in and check and that's on my own work and at the time I've based it on, you know, proper things, the colour of the wound, so whatever I have based it on the criteria I still worry" Interview – Staff Nurse Area 3.*

This nurse worked in a single-handed practice with one other trained nurse (sister) and a part-time nursing auxiliary. In spite of the fact that they work very closely together there was still an intense fear in which she felt that her best may not be good enough or a mistake would be detected. It is also noteworthy that the threat does not come from her colleagues but from the fact that at any time, her decisions may be examined by someone and her decision challenged. She feared the worst. Another nurse from the same area in the study indicated that this was not an unsubstantiated fear: -

> "SS: *Are you saying that somebody is constantly scrutinising you and your work, notes and that?*
>
> *DN: They, they well they are just taking notes from us, they are just taking notes, doing an audit on record keeping and they are taking notes from each team and they are auditing them so you just don't know when it will be your turn next and what they will find.*
>
> *SS: So that is where the sort of overlooking or checking is coming from then, your managers?*
>
> *DN: Yes. But simply because of litigation and things like that it is not for the benefit of the patient or the nurse it is in case any complaints come in or that so that they can say that this is what was done. I think that it is just so that they can keep and eye on us really – because it is all written isn't it." Interview – Staff Nurse Area 3.*

In all sites, the value of record keeping was seldom thought of as a tool to aid in the process of nursing patients but rather that the statutory requirement and legal aspects of recording care abound. This state of affairs was reinforced by statutory education provided by trust managers, as one sister suggested: -

> *"Well you see every course we go on and we go on quite a number, but there are, once a year or something updates on record keeping, and it frightens the living daylights out of people. Because it is all anecdotal a lot of it as well, you know, we don't hear that these things are true" Interview – Sister Area 3*

Here this nurse reported that she could see through the strategy of fear but none the less felt scared about the process of surveillance. The strategy adopted by the trust seemed to focus on the possibility or even probability that it was only a matter of time before someone was sued. Another nurse suggested this: -

> *"You know, at the end of it they put the fear of god in you about all the record keeping and stuff and you know, you come away from them thinking 'oh shit' what have I been doing, and 'oh my god, if they checked my notes I would be in for it' - but in reality I have been practising for years and have never had a complaint about me or even heard about complaints about other – well nothing serious anyway, just you know, not turning up on time or missing a visit and that. But it does frighten me more that they will find out things about my work rather than about how I keep records" Interview – sister area 3.*

Thus for a good many nurses in this study, particularly those who were loosely managed, the tight control of paperwork exerted a frightening and coercive pressure on their work. In the end the effect of this strategy was the production of adherence to record keeping through fear. It is interesting to highlight how one nurse attempted to challenge the information she was given whilst on a study day: -

> *"Then she (the facilitator) said well what does this mean, 'Care as plan?' And I said that you've carried out the care that's written in the plan at the beginning of the notes, and she said 'well what does that tell them about the care you have given?' I was really mad, I said 'it tells you that somebody has assessed the care and your plan of care is written on the form, once you have assessed it you make a plan... you write and you are saying that you've done exactly what it says on there' and she said 'that is not allowed, you can not write that' ... well I didn't know, she got really quite snotty with me in the end because I couldn't fathom it out ... well this is why people are getting bothered, so they are writing reams no, leg washed with warm water, new dressing, you are writing the same thing every visit you go which to my mind was the idea of a care plan was you didn't do that, so that now we are all mixed up" Interview – Staff Nurse Area 3.*

It is clear from the data presented in this section, that nurses see record keeping, note making and the related processes as a method of inspection

rather than a tool for enhancing patient care and communication. This has support in contemporary literature (Annandale 1995; Allen 1998).

Summary

What this chapter has shown is that district nursing work has come under increasing scrutiny and tighter control. The increase in surveillance was observed to be both covert and overt in nature. When surveillance was overt, hostile management tactics were used to discipline nurses into correct behaviour. However, this produced counter-strategies among nurses who actively resisted the process of detection and surveillance. District nurses, therefore sometimes resisted the coercive effects of management.

Perhaps the most poignant aspect of this chapter was the lack of formal support for district nurses who are known to undertake a difficult and demanding job of work. Instead, their reaction to management and organisation seemed more akin to a battle against a powerful enemy rather than an environment conducive to effective work.

The effect of re-organisation has been to make their work more visible and open to scrutiny and has secured in the district nursing work force an almost omnipresent, covertly hostile form of observation which pervades the working life of district nurses. Risk was associated with detection and whilst there was little evidence to suggest that nurses are actually being sued or subpoenaed in court, this threat was used very directly to secure the visibility of nurses work in the community.

This section highlighted the change process that has occurred in the organisation of district nurses and their work. The organisation of district nurse's work in the past was characterised by a distant and hands off form of management which participants related to autonomy and independent working. The attachment to a GP procured a more visible worker which Trust managers monitored either through direct or indirect surveillance techniques.

District nurse's work was reported to be equated with covert, non physical hostility, malevolent undercurrents and the risk of open, confrontational challenge of their work. Many participants felt that contemporary district nursing involved a considerable amount of "*watching your back*". The fear of detection was notably existent in the way in which their care in the home was recorded and correspondingly monitored. It was suggested that record keeping was the way in which the respective Trust managers had the potential to establish tight control over their work.

Chapter 8 - Findings

Introduction

It has long been suggested that district nurses have been working below grade and therefore below their commodity or skill level (Hockey 1966; 1972; Audit Commission1992; DoH 1998). However, it was not until relatively recently that the notion of economic value entered the language and discourse of district nursing work. The relative control and lack of overseeing of their work in the recent past meant that very few justifications were required from nurses for the decisions they made about the care they provided to patients. In contrast, throughout the time I spent in the field, almost all of the participants in this study talked frequently about their work in terms of finance and suggested that they had had this notion "drummed into" them by their Trust managers. The following sections highlight the growth and effects of commodification on district nurses' work.

You Cost Too Much

In contrast to the old system where nurses often had little or no interaction with managers, the contemporary organisation of district nurses was characterised by either direct or indirect encroachment of strong financial management into their work. In interview, one manager reported how she organised this process: -

> *"From time to time I just sit there with the budgets and I say 'look this is what I have to work with and this is what we have to do. It generally works with them, they can see that you mean business and that it is a business." Manager – Area 1.*

In this situation the manager gave a strong message to her staff that their interventions with patients could not continue without some reference to price and cost value. Inherent in this particular strategy was the idea and implicit threat that the team had to provide the contracted services within the specified budgetary limits otherwise there would be consequences, not least of which would be staffing changes, re-grading, skill mixing or ultimately job losses. This threat of change constantly overshadowed nurses' work (fieldwork notes 1998; 1999). Financial value was carefully and purposively introduced into the discourse and everyday language of district nursing as one sister suggested: -

> *"It is just too expensive to keep doing routine things with patients and that is the whole top and bottom of it really, you would need hundreds more District Nurses to carry on doing that part of the job." Observation – Sister Area 1.*

The integration of this new discourse into the language and practice of district nursing was not an easy process for managers to procure. Intra-professional relationships were (are) often tested and strained as managers variously attempted to secure the process of transformation. Another manager reflected on a recent row she had had with a staff nurse in her team in trying to get her to change her way of working: -

> *" I can remember (Name) having a real ding dong with me about something recently ... she wanted to keep this patient on and I didn't, she was adamant she should be doing it, and I was saying no, ... I mean everybody is territorial about what they do and I think that that's a difficulty, erm, I think that some of the message was, you know, do you really need somebody that's going to cost you £50 for that hour for that visit to do that! And I think that was the sort of message I was sort of putting into the arena" Manager – Area 4.*

The modus operandi employed by this manager is noteworthy. She had the authority and power to challenge her subordinate's decision. It was clearly a coercive discourse, as the implications were that there were patients "more deserving" of her skills. Participants were not given direct orders, guidelines or a checklist but rather encouraged to become what sociologists have termed self-reflexive (Foucault 1988; Giddens 1992; Sewell and Wilkinson 1992: May 1999; Knights and Mc Cabe 2000) in which power acts to control individuals through manipulation by a dominant discourse (Foucault 1977).

Other authors have argued that this form of pressure is common place in contemporary health care provision and have suggested that frontline practitioners are often confronted and coerced into being held responsible for their "countless day to day decisions" (Klein 1997, p508) centred around rationing the care they offer. The usual strategy, as illustrated in the above excerpt involved encouraging nurses to exercise discretion by painting a bleak picture of the resources available both to the individual and the team.

Within the literature in this area it is suggested that power-coercive strategies that use political and economic forces to secure change or re-organise work are only likely to produce some short term transformations and will be

counter-productive to the 'organisation' in the long term (Mc Phail 1997). In particular, it is suggested that change secured in this way may be superficial with deeply entrenched practices persisting in the light of the surface changes in work. This is particularly true when financial management dismisses professional affiliations and challenges the philosophical/humanistic ethos of caring (Fox 1995; Timpson 1996) as is clear in the following excerpt:-

> *"you know in some peoples view, in my view, these things are still nursing care, but you just can't keep doing them when you have not got the resources anymore, you have to change and think how much does this cost and who could do it better, but at the end of the day it is still what I would like to do as nursing" Interview – Staff Nurse Area 3.*

For some nurses the new discourse was essentially at odds with their professional ethos and deeply held values. Others commentators on organisational change have come to similar conclusions. In one study (where an ethnographic approach to enforced organisational change was adopted) changing the 'culture' of employees was the target of managers interventions. The author expressed 'deep concern' at the attempts and techniques used in the process of organisation to manipulate the thoughts and feelings of the workers (Kunda 1992). Coercive strategies, amongst them shame and guilt, were purposively employed by managers to secure a new corporate culture. The authors suggested that this resulted in surface changes among employees, with deeper held beliefs and feelings remaining the same. These findings have some resonance with the data presented here as nurses were often forced into making decisions about care which challenged their own

professional values. Importantly, those nurses who opposed the discourse were made to feel at odds with the system. If patients were denied care because of traditional practice, then the responsibility for this lay with the individual district nurse. In practice, this meant that managerial responsibility was devolved to individual care managers and they were "left to get on with it" (DN area 2). Throughout the period of this study, participant's caseloads increased, staffing levels fell or remained the same and changes occurred in the structure of district nursing work. The culture of individualism (Giddens 1994) pervaded many accounts of this process: -

> *"DN: you know, you are left to make far more decisions now about care and how to get around it, but you just haven't got the time and we certainly haven't got the staffing levels because 15 years ago when I started it was exactly the same staffing levels as now, there's no increase in nursing staff.*
>
> *SS: I remember when I was out with you one day that you said that even though there's been a massive increase in the practice population there's been no increase in nursing staff.*
>
> *DN: No, no, I mean the surgery I think is nearly 8,000 patients, nearly 10,000 patients now, whereas when I, 10 years ago there used to be like nearly 4, 5,000 but we still had 2 district nurses so really the work did have to be changed otherwise you wouldn't be able to cope with the demand." Interview – Sister Area 1.*

It was clear from the data that there was little attention paid to a structured approach to organisational change but rather change was secured through necessity rather than negotiation. One particular threat was the loss of status and money through regrading.

The Threat of Regrading

Throughout the data, participants referred to the 1992 audit of district nursing services (Audit Commission 1992) which essentially provoked a close examination of community nurses' work and in some areas a complete re-grading of district nurses teams. Many nurses lost their status and grade (Griffiths 1996). It is noteworthy here that the situation for district nurses was often privileged in comparison to their hospital colleagues. Traditionally district nurses, once they had completed the course, were invariably employed in a G grade post. G grade posts in the community were the norm. This is despite the fact that they may have had as little as 3 months or as was the case for most of the participants in this study 6 months training. In contrast, in hospitals the trend was towards decreasing the number of G grade nurses to a minimum. The threat of this organisational practice in acute care pervaded the thoughts of the participants in this study and was consistently referred to as a real danger which threatened district nurses' employment status and their sense of security: -

> *"The re-grading exercise has left us all very frightened for our jobs, you know, the thought that they can come and downgrade or skill mix us or whatever means that we have had to change to some degree, we can't stay the same because they have told us were weren't acting to grade" Interview – Sister Area 3.*

In this extract, this district nurse referred to the power and pressure exerted through the effects of the Audit Commission (Audit Commission 1992) in the threat that it produced to the work of district nurses. In particular, the report

suggested that the "traditional" form of work place organisation and grading, establishment or work force allocation was not compatible with the "new look" primary care and the demands made on it (Lightfoot et al 1992).

It was not surprising to find from the data that the effect of this, some seven years later on, was still experienced acutely by the participants of this study. All of the nurses in this study alluded to the fact that they had to change, that they and their work were both viewed as archaic and the discourse of inefficiency inherent in the Audit Commission report became part of the rhetoric used to re-organise district nursing.

The new order of economics threatened some participants' sense of security. Ontological security is defined as the "sense of continuity and order in events" (Giddens 1991, p243). Here we see the way in which security about work and indeed practice, was systematically and clearly threatened. Within the nursing profession there has been a move towards what one commentator has described as "professional cleansing" (Mc Kenna 1998) in which the effect on job security and morale of the commodification of nurses' work has been devastating. The data reported in this study, indicate that the threat of status change for district nurses supports these findings.

It is suggested that change secured in this way, through coercion, challenges human morality and existential security (Watson 1994; 1997; Giddens 1991) enters "deep and dangerous waters" (Watson 1997 p278) and is ethically dubious when the target is essentially people's souls (Wilmott 1995). Thus, it

was consistently observed that the prevailing discourse of economic value, occurring in the language and working practices of district nurses' work, served to confine and constrain traditional practices in favour of a new ethos of nursing work as a commodity, which further served to increase the productive potential of district nurses. The notion of discourse and its effect is well documented by sociologists (Foucault 1977; Watson 1997). Indeed, in an analysis of post-modern organisations, or post-modern "organisation," it is suggested that a change in discourse is essential to produce a form of organisation which is essentially flexible, based on reacting to niches and local circumstances and is characterised by personnel who are multi-skilled and adaptive (Clegg 1990). The main effect of the strategy was to produce a system of self surveillance among district nurses through which they question the value of their interventions with patients and look for alternatives in the provision of care and the mode of delivering care.

Clinical Effectiveness

It was not the Audit Commission report alone, that influenced the process of commodification for the participants of this study. The recent move to evidence based practice (Culyer 1994; DoH 1998; Baker and Kirk 1998) which has promoted a critical evaluation of what district nurses do and how it was done: -

> *"Well I think there is much more than lip service paid to clinical effectiveness now, and whether what you are doing is actually worthwhile doing, erm, I think the, well certainly the White Paper now, erm, we have to think about clinical effectiveness and best practice as well as what we can achieve in the time and caseload management." Interview – Sister Area 2.*

In certain situations this could mean balancing best or evidence based practice against the constraints of the workload: -

> *"And it is like this really, sometimes we know that the best treatment might be a daily dressing and all of that, with a particular type of dressing that is very good, but because of the resource thing, and the staffing levels you might put something on that is not as good but means that you go in to the patient less times a week. You have to juggle these things in your mind." Interview – Sister Area 3.*

It is notable in this extract that the nurse knew what best practice was and how to deal with certain conditions. In this case she used a less efficient, but not inefficient treatment, so that she could manage the demands of her caseload. The inherent problem here was that the level of skill and training of district nurses differs (Luker and Kenrick 1992). Therefore the individual practitioners' ability to make similar decisions could differ considerably. This process has been noted in the literature which suggests that rationing is in effect: -

> "a continuous process to reconcile competing claims on limited resources, a balancing act between optimising and satisfying treatment. It is about the exercise of judgement, not about the drawing up of lists of what should or should not be included in the NHS's menu" (Klein 1997, p508-9).

This was a persistent theme in the study reported here as the following sections detail.

The Mechanics of Rationing Care

Local level approaches to rationing care

It is argued in the literature, that health care policy makers shy away from national strategies which serve to exclude service users from health care provision (Hunter 1995; Klein 1997; Butler 1999). Instead it is more palatable to the public and politicians to set loose guidelines and control resources (at source) so that rationing becomes inevitable as resources are controlled so that demand outstrips supply (Hunter 1997; Butler 1999). This implicit form of rationing (Hunter 1995) or rationing by discretion (Lipsky 1980; Butler 1999) relies on individual practitioners exercising selection over what services are offered. One nurse indicated how this process of self surveillance and discipline has become integrated in to her role as a district nurse and has affected the services she could offer : -

> *"Yeah, I mean it's hard because you think well people who have got these chronic illnesses, I mean in a lot of eyes, and in my own eyes at one time it would have been classed as health, I would have thought well, they've got this awful illness they do need nurses, but it's just not affordable anymore – just can't do it. (She looked sad as she spoke)" Interview Sister Area 1.*

This extract highlights the nefarious nature of the decision making process. It was noteworthy that there were no concrete guidelines in the new system of work but rather a persistent ambiguity. In the latter excerpt, it was clear that this district nurse felt that her work had become commodified and she

realised, through a process of self surveillance or governmentality (Foucault 1977) that she had to justify her work to herself, her peers and her managers. In this way, it is clear that power was acting in a diffuse way, was essentially all around her and the mechanics were such that she was held to be able to account for her actions which were challengeable not only by her managers but also her colleagues.

Flexibility

For many community nurses the emphasis of care had changed from long term support and holistic care to more focussed, acute and short term interventions. This produced a response in which nurses felt that they had to adopt a very loose definition towards the provision of care. This is exemplified in the following quote : -

> *"If it needs our skills to do it, it's nursing! That's the only definition, if it doesn't need us to do it it's not, it's not a nursing need. ... but they would say well we are not emptying catheter bags now, but that did not need a level of skill of a registered nurse to empty a catheter bag but what it does need is a registered nurse to supervise, not to supervise because that indicates a presence doesn't it? But to ensure that this is done in the appropriate fashion" Interview – Sister Area 2.*

What is important about this quote is that it opens up scope for inequity in the service offered by district nurses. The situation could occur whereby patients in neighbouring localities or practices may receive different care and support based on the skills make up of the respective district nursing teams. It has already been noted that the skills and education of district nurses vary (Luker

and Kenrick 1992; Mc Intosh 1996). Similarly other nurses in this study describe their role in terms of skills which are largely unavailable in either the home or through social services care providers. The following excerpt is taken from an interview with a district nursing sister who recalled a recent meeting she had had with a social worker to discuss the care of an elderly infirm patient. She makes very clear the boundaries of her care in terms of the skills based definition she and her team have adopted: -

> *"Basically the only thing that I see as their job that was our job is washing patients and basically I think that if patients have got other problems be it a physical problem or psychological problem then we should be involved ... and they haven't got any pressure areas, you know, but once they have, then it's us ... when we are doing his bowels and catheter, and I said his pressure areas are not a problem, if they become a problem then we will go in. But they are wanting someone to feed him and I said well that's definitely not a nursing job – feeding (laughs at lot) ... his catheter and bowels are his problems and that was all I was prepared to do." Interview – Sister Area 3.*

What is notable about this particular excerpt (and the previous quote) is that district nurses appeared to decide on care by a process of exclusion rather than inclusion. Put simply, it was easier for participants to declare and state what they would not take on rather than what they would. In so far as could be gleaned from the participants of this study, the following seemed to be the exclusion criteria for the provision of district nursing interventions: -

- Chronic illness with no existing or new physical problems
- Stable condition without signs or risk of deterioration
- Feeding problems
- Problems with hygiene alone (without physical problems)
- Social Isolation

Whilst this list appears small, it effectively reduces the workload of district nurses enormously when compared to the data presented in chapter 4 of this study. In effect, it filters the "old chronics" (Sister – Area 2) who traditionally demanded much time and attention from district nursing teams.

It is argued that flexible organisation allows management to flex production up and down at the demand of the market (Atkinson 1984). The data here suggest that the nurse, as a multi-skilled worker with "functional flexibility" worked peripherally to the team, using the skills that were required of her. In this case, the nurse was well able to undertake the procedures necessary to complete the whole patient episode but handed over some aspects of her work to a peripheral, less skilled group whose job, like her own in this situation, was task related (simply bathing or feeding the patient) externally defined and prescribed by some other person.

> *"It is like we go in an do the work that social workers give us to do. They do the assessment and come up with the care package and that – you know, social services will do the bath x amount of times per week, homehelps will do this and that and you will do the pressure area care and the technical stuff like leg ulcers" Observation – Sister Area 4.*

The irony of this situation was that they could have taken on the responsibility for organising the care and if necessary she could have taken over the whole task. Clearly social services teams could not take on the skilled treatments undertaken by the nurse. This finding has support in the literature. Ross (1990) suggested in the new order of community care reforms that the chronic sick might receive less care as the upskilling effects of technical care for

district nurses (the consequence of competition for funds between acute and chronic services) means that the demands on district nursing services would increase. The new system therefore, would inevitably reduce the time available to district nurses to take on the coordinating and administrative roles associated with care management (Ross 1990). As a consequence of this it is suggested that the current system of organisation of nurses' work would potentially involve the management and co-ordination of care as well as its execution and therefore the co-ordination would inevitably, through pressure of work, be handed over to some other professional involved in the care package (Ross 1990; Edwards and Hale 1999; Vernon et al 2000). Therefore nurses may be relegated to the role of peripheral worker, employed solely to undertake high volume, repetitive tasks at the demand of some other organiser of care.

In the former excerpt, the nurse clearly worked as a peripheral worker undertaking tasks designated by some other (social worker) professional who had undertaken the assessment of the patient. She was called on to undertake task work, dressings and pressure area care. In other situations, however, nurses took on a central assessing role and enlisted peripheral workers to complete the package of care. The following excerpt highlights this process: -

> *"I mean I'll go to visit someone, an elderly lady and, with poor mobility, she lives alone, hasn't got much family support and I'll go in ... because the GP says she's not managing to get round very well can I just go and have a look at her, erm, when I go to visit that person, erm, I find out what basically her problems are, what basic, ... but when I ask them what the problem is they say*

> *their worse problem is something entirely different to the one we see it as, erm, the very obvious nursing problems like pressure sores and wound management, pain or symptom control, they are easily identified as nursing problems, the grey areas are usually around personal hygiene and things of that nature, so if I go and see someone, an elderly person who is not managing to care for their own personal hygiene, I will address the nursing problems and say to them, well the district nurses will come and help you with this, this and this but do you think perhaps it might be helpful if I ask a social worker to come out and see if you need any help to get washed and dressed, erm, or someone to help you get in and out of bed" Interview – Sister Area 3.*

It is clear from this excerpt that this nurses' priority was to act as the co-ordinator of this patients' care, keeping a total overview of the situation and correspondingly she managed the episode of need. She made the decisions about what care was needed for the woman and acted as the organiser of the care package, by involving other services. It is an interesting comparison with the former excerpt which showed that nurses could sometimes be on the periphery of care decisions.

For many nurses, the move to flexibility (a consequence of commodification) and the dual roles outlined above, produced a situation in which some participants were ambiguous about what their role actually entailed. There seemed to be a lack of certainty about their function and indeed sometimes about their title: -

> *"err, care managers as they are called now, Sisters then, care practitioners they all used to go out and wash people, erm, which to a degree was a waste of our skills ... all of that has gone now and we are doing more skilled nursing," Interview – sister area 3.*

This quote exemplifies not only the change in role but characterises a conceptual change in how some district nurses defined themselves as not necessarily the providers of care but sometimes the managers of care with some technical input to the patients' care. This change in name, encapsulated the way in which district nurses were beginning to see themselves in this study, sometimes less as nurses and more as managers of nursing care. In doing this there seems to be less need in the contemporary system to have a total involvement with the patient in their care. There is support for this in the literature (Griffiths 1996; Mc Intosh et al 2000).

Mixed Reactions

It was hardly surprising therefore that the data presented here indicated that the shift towards technological skills and functional flexibility has produced a mixed reaction among district nurses. It was clear that nurses' functional role could vacillate between the core organisation of work and peripheral toil. In many circumstances, both methods of working could exist simultaneously. Some nurses welcomed the change that was produced as a consequence of the introduction of techno-care and the demands made of them:-

> *"SS: How do you view the changes now?"*
>
> *"Very positively because erm ... I think people are actually looking at a district nurse, you know as a community worker, somebody that has got skills and abilities that you know they always had ... I can remember being considered the Nora Batty type you know, you went on the community and that was it, a bit like the old geriatric nurse, and now people are beginning to realise that we've got a lot skills and we are enhancing those skills all the time..." Interview – Sister Area 1.*

Here this district nurse alluded to the notion that the professional status of district nurses had changed as a consequence of taking on work previously undertaken in the acute sector but also that they receive kudos from their detachment from basic care. It is suggested in the literature that post-fordist organisation produces this change in status among core workers as their relative position in relation to peripheral workers increases (Atkinson 1984; Hurst and Zeitlin 1994). The hiving off of basic, unskilled work therefore elicited this change in status. In particular for some nurses it was suggested that this change in role allowed some participants to escape the mundane traditional work associated with chronic care:-

> *"I think it probably makes a more efficient use of the services and we will dump social care and we will now take on intravenous drug therapy and that sort of thing because our time has been cleared up, Erm, and because our minds aren't clouded in the same way by the burden of sort of chronic care, which was really very unskilled and probably de-skilled, erm, experienced nurses to a great extent because we were doing that." Observation – Sister Area 2.*

For some nurses the rhetoric of skilled work equated with technological dexterity. There was however, a recognition that this technology could pull nurses away from traditional care or intellectual care (Bradshaw 1995) but the perceived gain in professional status was felt to be worth the ache of leaving the old approach:-

> *"When it was first started, I thought it was very sad that we were losing that* (social care) *but now I feel that it is a good thing because we can spend our expertise and our training on doing tasks that we should be doing now, whereas before a lot of time was spent taking over things that weren't using all our skills." Observation – Sister Area 1.*

This form of job/skill differentiation has been described in the literature. Some authors suggests that the post-fordist organisation and the fetish of flexibility hides the reality of shedding labour, increasing workloads and the employment of sessional, temporary workers by conflating the effort intensification and cost controls into a new rhetoric (discourse) of re-skilled labour and flexibility (Pollert 1988; 1991). It could be argued from the data presented here, that the basic skills that nurses have, which are necessary for the execution of the total job are co-existent with the new skills required to respond to the increased needs of patients in the community. Therefore, the data presented here, support Pollerts' (1991) assertions that the reskilling debate merely hides an increase in production among employees, as participants alternated between the proficient managerial organisation of care and some skilled work and their more often encountered co-opted peripheral status. Some nurses acknowledged that the added skills they had developed and the move to more flexible working had been forced upon them:-

> *"It is not a matter of if we want to anymore, it is a matter of having to, you can't say no to referrals when they are already at home." Interview – Sister Area 3.*

Others found the way of working challenging and stimulating:-

> *"It is quite exciting at times not knowing what you are going to meet, it challenges you and you have to keep abreast of changes, you can't stagnate now" Observation – Sister Area 1*

Others suggested that the new techno-care system intimidating and daunting,

where the expectations on them and the interventions required with new patients who had increasing diversity of ailments, produced fear: -

> *"I just don't know what to do sometimes when I get a referral, I am sometimes really frightened about what I will meet when I get through the door. " Observation- Sister Area 1.*

However, the data presented here indicated that there was a culture in which the "new skills" and flexibility were accepted as the gold standard of district nursing care:-

> *"All the students here like me 'cos I've taken up new challenges and I am abreast of all the changes, I've done extra courses to keep up to date, dressings, drips and that erm, other District Nurses haven't done this they are so behind." Observation – Sister Area 2.*

It was clear that those who work in a more traditional way were admonished and held in poor esteem:-

> *"It's like they are still doing things very traditional over there, they are still doing bed baths and that – you find that there are a lot of people who just haven't changed over to the new way of thinking and they are sad. When a look at them I think 'God you are mad' we just don't do that any more." Interview – Sister Area 3.*

District Nurses were always aware of some group of nurses who were less technical than themselves! Most usually this was not a member of their own team but some other team in a neighbouring locality who were legendary in

their non-adherence to the new way of working. Tales were frequently recounted of unmanageable caseloads due to the retention of social care as the following except illustrates:-

> *"In (name) area the District Nurses are still doing bed baths as well as the technical care, they are at breaking point, highly stressed and completely overworked." Observation sister – area 3.*

This particularly observation made by this nurse further encouraged her to move away from traditional practice as the high risk consequences (Giddens 1994) of staying the same may have had serious and telling effects on her work and that of the team. The management of complex patients at home seemed to be the zenith of the new approach. This can be seen in the following exert from one nurse:-

> *"In the short term we can manage the care if we are freed from the long term social care, that's sort of how we survive, I think you'll find the District Nurses in other areas kept a lot of those, probably because they have a lot of older patients who are chronically sick, ... but I think they pay a price as a team for doing that because they can not take on more sophisticated thing HIV patients and IV stuff." Interview – Sister Area 2.*

These data illustrate that it was not a change that was not readily embraced by many district nurses but rather something that has had to be accepted. In the greater arena of change in the NHS, some nurses referred to this element of change using the analogy of a lost battle:-

> *"It has been a battle ... it's not a revolutionary thing, it is an evolutionary thing, we've gradually had to pass on, we've had to do this anyway so it's not been the case of we've chosen to, we had to ... I think that we have been forced to in many ways." (Interview sister area 2)*

It was clear that the process of skills commodification, the redefinition of skills and the change in community nurses' work has produced a system whereby what they offer patients has changed and may sometimes vary between teams and even within the same large team. This position has been repeatedly noted in the literature (Luker and Perkins 1988; Audit Commission 1992; 1999; Mc Intosh et al 2000).

Colliding Philosophies.

The extent to which the process and discourse of rationing by discretion had infiltrated and affected district nurses work was variable. Throughout the course of the study, it was noted that different nurses had embraced the discourse of rationing or resource management to varying degrees. Where one nurse may be well down the care management (rationing and referral) approach, a neighbouring team or nurse may still be providing traditional care. When competing philosophies occurred within the same team, the effect that this had on team dynamics was dramatic: -

> *"I was sat at a corner with sister x and her staff nurse, they were discussing their afternoon visits. Two other nurses were in the room and were soon joined by two further members of their team. Sister x was discussing the afternoon's work informing her staff that she had two joint assessments to do and allocating the staff nurse to visit the two terminals. She told the auxiliary to help out in the dressing clinic with one of the staff nurses. The second District Nurse tutted loudly and said 'I wish that we had the chance to take it easy this afternoon, we have all got 6 visits each still to do.' The second team started a discussion on the work and seemed to be trying to organise themselves in a rational way, occasionally they said things like:*
>
> *'we will just have to leave them 'til tomorrow, unless someone can fit them in'*
>
> *'Are any of you going near to x or y' (to the first sister)*
>
> *Sister x answered*
>
> *'is it an emergency? Cos we have got things that need to be done'*
>
> *This was done in such a way as to be audible to the first group of District Nurses, sister x gave me a knowing look which I understood to be sardonic as if she was used to this type of interaction and knew the script. " Observation – Sister Area 3.*

The decisions to work separately, caused many problems, agitation, resentment and aggression between teams. The second team oftentimes used a variety of strategies to enlist the help of the "under-worked" team, including highly charged emotional language, expression of stress and would frequently manipulate the conversation to elicit the disparity in workload. This particular care manager remained steadfast in her resistance to assist where she clearly viewed the problem as a fault of case management and refused to bail her colleagues out. In this way she frustrated the team, who resorted to hostile tactics, ostracising her and her team and made barbed comments. In an interview with one staff nurse from the second team, this point was

highlighted as she admonished the first sister in this excerpt for her lack of willingness to work with her team: -

> *"me, myself and I syndrome, as I call it, where I am getting a degree and I am going to do this and I say this and I say that, and they are like little dictators a lot of them now, and you can pick them out, they are very, very nice dictators, because they've got all the sociological terminology as well, where they will, get you by saying you give me your view, it doesn't count for nothing, they don't bother to help and just cos they try to organise in one way and we do it in another then they just won't help us out. You know it is self self self really." Interview – Staff Nurse Area 3.*

In this particular situation, the teams were actually working with different GPs but were based together in the same meeting room. It was noteworthy, that the manager of these two teams was also based in the health centre but rarely made an appearance in this space. Both groups of nurses made me aware of the fact that the manager knew of the tensions between the teams and effectively did little to solve the problems. It could be suggested then, that the manager's strategy was to leave well alone and allow the nurses to come to some compromise and change between them (hands off management). This situation was made even more tense as the sister who had adopted the more radical approach had kept her manager informed of her decisions and the change in care management that she had implemented.

However, the tensions between these two teams grew to such an extent that eventually the first care manager and her team were found alternative accommodation away from this communal area, but not without the situation escalating to a point where a fight between the groups nearly erupted: -

> *"SS: Right. How do you do that, how did you make them see the reason for the change, was it hard?*
>
> *DN: Very hard there were a couple of almost fist fights, we very nearly had a fist fight one day when we squared up to each other and had a stand up fight ... and I'm not very good at rows, I don't like rows," Interview – Sister Area 3.*

There is a body of nursing literature which examines the conflict that can exist between teams who are themselves oppressed. Based on the work of Franz Fanon (1967) a black liberationist Marxist, who studied the reasons why oppressed black minorities oppress each other, the concept of "horizontal violence" (Fanon 1967) was coined to explain intra group conflict. This concept has been adapted to explain the antagonisms and strife that can occur in nursing teams (Farrel 1997; Freshwater 2000). The above example demonstrates some aspects of horizontal violence as outlined in research conducted among nursing teams where non physical attacks described as "professional terrorism" (Farrel 1997; Freshwater 2000) take the form of back stabbing, negative criticism, unwillingness to help out and a lack of support for colleagues when they were experiencing difficulties. It has been suggested that when this strategy is used by a team, the most powerful in-fighter is the one who identifies with and uses the dominant management strategy as their standard of aspiration (Farrel 1997).

The sister in this excerpt favoured and implemented a care management approach, whilst her colleague operated a corporate caseload approach. In the former system of organisation, the senior sister or care manager, actively

engaged in assessment and planning of care and some delivery. She effectively overlooked the whole of the caseload and regularly reassessed the care plan involving other services when necessary.

The latter team by contrast, worked with a corporate caseload, where patients were allocated to nurses, irrespective of condition or the level of complexity of the treatment, based solely on the geographical location of the patient. So it could happen in this form of work organisation, that a very junior nurse could be asked to see a very "simple dressing" and a "complex terminal care" just because the patients happened to live close to each other. In contrast, the sister or manager of the service could effectively see basic care patients just because they may live near to a new patient who needs assessing. Many of the nurses who work using this corporate system report the inefficiencies of the approach in terms of the fact that patient was often treated by different nurses as the patient allocation arrangements seemed to be haphazard. It was this aspect that the district nurse in the former excerpt changed for her own team. In doing so she gained tight control over the caseload and was able to make decisions and evaluate the effectiveness of her care hence she could control her own workload. She had adopted the tight control over her team favoured by her manager and therefore was able to claim authority and withdraw her support from her colleagues who worked a different system. Foucault (1977) suggests that disciplinary power is not possessed as an entity in itself, concentrated in one group or person but rather acts through people as they exercise control over others. It was clear that the conflict between the teams showed the effect of the movement of power in producing tension and

ultimately change. Where these two styles of organisation occurred simultaneously, conflict invariably ensued. Variations in teamwork arrangements have been noted to feature in the literature (Mc Intosh et al 2000; Hallett and Pateman 2000)

In another area, the colliding philosophies within a team of nurses caused considerable distress and disharmony. In one area, two care managers jointly worked for one team of GPs. There approach to care differed considerably and although they had joint responsibility for half of the caseload each and shared the rest of the team members. One particular care manager, adopted the team care management approach, whilst the other care manager was more traditional in her style of organisation and the boundaries of her care were less defined. Interestingly, the difference in approach between these two nurses was encapsulated in the uniform they chose to wear whilst working. One care manager, along with the staff nurse and the auxiliary nurse chose not to wear uniforms whilst the second, "more traditional" sister continued wearing her navy blue sisters' dress. The caseload was split alphabetically and the corresponding care offered to patients differed according to who assessed the care. This caused considerable unrest between the two care managers let alone the rest of the team, who in essence had two different schemes of work. This tension is captured in the following piece of observation: -

> *"we approached the car and (name) began a conversation about the impending return of her colleague (name) and seemed distressed. She cried briefly and said 'We just don't get on at all and it is not fair. She has been away for a long while and things have been good between the team and the rest of us. Now she has come back she makes this demand and that demand and the other. The poor girls don't know which way to turn. The thing is that I can't confront her because (identifiable reason) ... and that is really hard. I will just have to grin and bear it really'."* *Interview – Sister Area 2.*

The obvious problem here was that the two ways of working produced chaos and conflict among the team. One care manager continued to bath patients who were "ill" whilst the other passed them over to social services care. The first care manager allocated work on the basis of the skills within the team whilst the second allocated work on a geographical basis. The first nurse organised the work of the auxiliary nurse so that she could do basic dressing whilst the second sister held firmly the rule that all such interventions had to be undertaken by qualified staff. Disharmony was common place among the team. It is interesting to note, that there were once again, no guidelines on how teams should be managed and this dual system seemed set to remain. Once again, it is not surprising that published evaluations of district nurses' work have found stark and startling variations in the content and context of the daily routines (Audit Commission 1992: 1999).

The consequence of the changes in community nursing has been that the impetus for change, whilst largely coming in the form of resource control, the actual mechanics of change has been left to nurses to organise themselves in response to the global restrictions placed on their work. The effect that this

has had on their work is that there are different and colliding philosophies of care which co-exist between, and within district nursing teams. This conflict was a direct consequence of the relatively loose style of organisation of community nurses, associated with tight financial control (Peters and Waterman 1982). The data suggest that the discourse of economics, effectiveness and efficiency had been accepted at different rates and in different ways by the participants of this study.

Rationing by Discretion

Setting the Agenda

Whilst rationing by exclusion was sometimes an overt process, rationing by discretion was a different strategy. When a patient was discharged into the community from acute or secondary care services, or even referred to district nurses by a General Practitioner, patients themselves had expectations of the care they would receive. This was particularly true of chronically ill patients discharged from hospital after an acute episode of care. Long term care patients were discharged from hospital, most often without a "social assessment" and there was an expectation that care would continue as before, notably from the district nurse. This district nursing sister highlights this: -

> *"when we go in to see them, they have usually been told that the District Nurse will see to them when they get home. So they expect us to do for them. They expect the same care from the community staff as they got in hospital, bathing the lot. I don't think that they (hospital staff) do it deliberately, I think they know that we don't do it (bathing) and that we organise it, but they don't tell the patient that, so we go in and they expect us to do it – that's the problem really." Observation – Sister Area 3.*

Another Nurse reported that expectations of her were high: -

> *"When you go and assess people when they first become chronic and can't manage care then they expect you to help them with everything, especially if they have had District Nursing care before in the past. It is mainly because they are given this expectation of us, it is how they see us, 'the bath nurse' even the doctor will say 'you are not managing very well, I will get the nurse to sort you out' they are not saying we will do it but that is what patients' hear" Interview – Sister Area 1*

Thus the perceived problem was not that either their hospital colleagues or doctors deliberately proffered unrealistic expectations but rather that the information that they gave to patients was sometimes misleading and discordant with contemporary working practices. There is a growing body of literature to support the idea that since the introduction of the health and social care divide, care in the community, particularly for elderly people has suffered (Ross and Bower 1995; Ross and Mac Kenzie 1996; DoH 1997; Vernon et al 2000). This has occurred despite a very early legislative pledge for seamless care between secondary and primary care services (DoH 1990; Vernon et al 2000). The data presented here suggest that newly discharged patients usually had a preconceived idea of what the District Nurse would offer which seemed more reminiscent of the way care was organised before the construction of the health and social care divide (DoH 1989; 1990): -

"DN: If I go and see someone, an elderly person who is not managing to care for their own personal hygiene, I will address the nursing problems and say to them, well the District Nurse will come and help you with this, this and this but do you think that perhaps it might be helpful if I ask a social worker to come out and see if you need any help to get washed and dressed, erm, or someone to help you get in and out of bed, and sometimes people jump at that, other times they just say, 'no I don't want strangers coming to my house,' and that can be difficult.

SS: And I guess that leaves you with a moral dilemma really – if they don't want what you offer them – how does that leave you feeling when that happens?

DN: I suppose I feel a bit shitty really, but then it's that persons' choice isn't it? Its about respect, giving the person information and they make their decision on the information I've given them" Interview – Sister Area 3.

It is interesting to note that like many of her colleagues, this nurse framed her discourse around a notion of respect, associated with patient choice. The reality of this situation was that the patient has little choice, in the absence of informal carers, it was either Social Services or nothing!

These accounts also highlight the power-ful situation that some nurses occupied. They selected out problems that related to their care agenda and constructed a contract with the patient which concentrated on the physical aspects of the illness. In some ways, this finding contradicts those presented in the previous chapter about the lack of control nurses have over their work. With limited resources, and against the prevailing and coercive pressures they encounter, nurses had little choice over what they could control. In the process, the patient becomes inscribed or labelled as the nurse takes control. This finding is reminiscent of the Foucauldian idea that power is not

possessed in one specific or identifiable entity in the structural relations of society (Foucault 1984). Rather power works through processes of ongoing subjectification of individuals. These data illustrate that nurses, who were the target of specific power relations themselves, further act to exercise power over their patients. In effect they had been recruited, through necessity and lack of choice, into wider strategies of power. They took control where they could. This demonstrates the circular or diffuse nature of power (Foucault 1977; 1988), rather than linear structure so often described in the literature (Giddens 1994). The following section explores this process further.

Focussing the Patient

A common feature of the assessment process was the narrowing down of the patients problems into solvable units or problems. The assessment process however, which reportedly viewed patients as holistic beings, ultimately concentrated on those problems for which there were solutions readily available either in house (physical care) or within easy access (social support). A consistent feature of the assessment process and subsequent interactions among district nurses was the lack of attention to psycho-social factors associated with health and illness. The following piece of observation illustrates this: -

"We approached the first house and (name) knocked and waited. A woman answered after some time and (name) greeted her warmly. She introduced herself as being "sent by Dr --- and the woman intimated that she come in. Name allowed the woman to walk ahead of her and watched as she walked into the living room the woman seemed unsteady on her feet and seemed unsure of her footing. (name) and I followed her into the living room. (name) looked around the living room - it was cluttered with a lot of furniture. The woman took some time to sit in a low chair and (name) was surveying the room. After she had sat down the woman said -

"I'm just finding it hard getting around on my legs now - I am scared that I am going to fall and won't be able to get up ..."

(nurse) replied:-

"What you need is a zimmer - have you seen them? they are those frames that you can steady yourself with - you know the ones? And your chair needs raising. How are you managing to go to the toilet?"

"Well I control what I drink really so that I don't have to go that often - it takes me a long time to go"

"Well we will get you a commode"

The woman seemed shocked

(name) engaged in some more conversation with the woman about her house informing her that she might have to take some things out of the living room and that she might have to make some more space. The conversation followed by (name) asking the woman about her family and "is there anyone who can come in and check on you - and we will come in and see you once a week"

The woman looked at her and said that she could ask - "her grand-daughters to come in and see to her"

(name) seemed pleased with this - she said that she would go away and order the things that she needed and that she would call back towards the end of the week with the equipment. She would have a word with the doctor. She got up to leave and told the woman that she "would see herself out". Observation – Sister Area 1.

This form of surveillance, undertaken without the patient consent, was not negotiated and did not involve the patient. As a consequence of this information this nurse gleaned was a snap shot of how the woman was at that particular time in her life. It was common practice for the district nurses to begin the assessment in this way. By the time the woman offered her perception of the problem, the decisions about intervention were largely decided. Negotiation and patient participation was characteristically absent from the assessment process and the assessment process was characteristically a one off visit. There is support in the literature for this finding. Vernon et al (2000) suggest that : -

> "The paradox of this approach to assessment is that decisions may have to be made about eligibility for assessment, based on information gained at the first contact, which may not reveal the true extent of a client's need" (Vernon et al 2000, p284)

It is interesting to note that this way of assessing patients is in direct contravention of the Guidelines for Professional Practice (UKCC 1992) which states clearly that nurses : -

> "must work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care; autonomy" (UKCC 1992 p13).

There is evidence to suggest that this assessment of need the community is generally poorly performed by all of the practitioners involved in the process (Ross and Mac kenzie 1996; DoH 1997; Vernon et al 2000). A striking feature of the latter excerpt is that whilst some physical needs were clearly identified, psycho-social factors did not figure in the interaction. Thorne and Robinson

(1988) identified three stages that chronically ill patients go through in forming a relationship with medical services. Important here is their notion of "Naïve Trust." In this situation, patients make assumptions based on pre-conceived ideas of what will be offered to them and confer a basic level of trust on health care professionals. Services seldom meet these assumptions and so the second stage is one of "disenchantment" followed by their final stage of "Guarded Alliance," in which the competing agenda's are reconciled in a compromised relationship. Giddens (1991) acknowledges that when trust is offered then: -

> "An individual who vests trust in others, or in a given abstract system, normally thereby recognises that she lacks the powers to influence them significantly" p193

There is a plethora of literature which suggests that the needs of people assessed in the community are not being met effectively (Twigg 1997; Mistiaen et al 1997; Vernon et al 2000). Particularly that the way in which district nurses assess patients needs is highly variably (DoH 1999; Vernon et al 2000). There is some literature which concurs with the findings presented here, which suggest that the assessment process impedes the course of recovery and can lead to unplanned readmission (Mistiaen 1997; Audit Commission 1999). It is clear from the excerpt above that a thorough assessment of needs was not performed by the nurse and the method used to acquire information was commonly nurse led. In the data presented here, the variations in services provided were related to the structure of the team, the professional background of the nurses and competencies they had. This may

account for the differences noted in the quality of district nurses' assessments of patients (DoH 1998). Lipsky (1980) provides great insight into this process.

In his classic study, Street Level Bureaucrats, Lipsky found that his subjects (public servants) always worked in circumstances where demand outweighed supply. He argued that local professionals are therefore forced to develop individual or team responses to the pressures they face. Inherent in this process is bias. Personal bias results where the services offered were made to fit the skills of the professional rather than the needs of the client group. Butler (1999) refers to this strategy as a form of "rationing by discretion," where services fall off the agenda of action through an implicit process rather than an explicit one.

Managing Care

Where there was an exception to the process highlighted in the latter section was when nurses adopted a care management approach rather than a care provision system of work. The following excerpt highlights this: -

> *"We arrived at the approximate area but name had difficulty locating the address. Eventually we decided to park near a block of flats and we found the address. She pressed the buzzer and a man came to the door. She introduced herself and showed her badge. She said.."I am the D.N. from the surgery, I have come to have a word with Mrs..." As we walked in she scrutinised how Mr... was walking and the pathway to the flat. She seemed to be taking a lot of information in. Name greeted the woman warmly. She introduced me and looked directly at the woman, who was sat in a high chair. She chose to sit on a sofa, slightly adjacent to the woman and lower than her. She looked at her and said..."I've just come to see if there is anything you need and if we can help... you have obviously fractured your*

wrist...what was the problem... how did it happen. The woman seemed eager to explain and talked about how she had brittle bones (osteoporosis) and was unsteady on her feet. She had:- "fallen one day because I lost my footing in the flat and had landed on my wrist" The conversation between the two of them flowed and name followed the patients lead checking out from time to time that the various aspects of what the woman was saying had been investigated:- "Is that an old problem?... does the doctor know about that?...what did he say it was?...does that stop you doing things? The conversation flowed easily and Name's questions seemed not to interrupt the woman. Eventually, when she had spoken enough name moved the conversation on saying.

"Well...with those problems, how do you usually cope with getting around and doing things for yourself?"

The woman described her strategies for getting around in detail and name constantly acknowledged the innovativeness of the woman. She scanned the flat intensely and then said...

I can see how difficult it might be to get around now 'cos you've only got one arm, it must be difficult to do it now...What is the main problem now?"

"It is just getting up and down to the toilet through there, I can't steady myself with just one arm, I think I need one of those walking things..." (Observation – sister area 2)

This rare exception exemplified what most nursing texts would describe as a good assessment of a patient's need. The many aspects of the woman's current situation were examined and recorded and the nurse seemed to have a mental map of the questions she needed to ask in order to elicit the information. The process of how she acquired this information was very different from the former excerpt (p 236) where the information gathering process seemed less about negotiation. The major difference between these two sites was the volume of work each nurse undertook. In the former situation, the nurse had an extremely busy caseload, including heavy and long term clients whilst the second nurse had fewer patients and was more

involved in managing care. It has been noted in the literature that the process of assessment will inevitably vary (Badger et al 1989; Vernon et al 2000) and the social interaction between nurse and patient, the similarities and differences in class and situation may account for some of this variation (Griffiths 1996). However, the data here suggest that the difference between these two nurses centred around the notion of controlling work. For example, another nurse suggested that sometimes she deliberately avoided asking certain questions: -

> *"sometimes I just don't ask certain things, just avoid issues that I think may be a problem.*
>
> *SS: Why is that?*
>
> *DN: Cos if they say something or tell you about a problem then you have to do something about it don't you" Observation – Sister Area 1.*

In this situation, this nurse suggested that she waited until the patient raised the problem before she acted. In doing so, she could in some ways control her work. This strategy had obvious implications for the equity of care in the community. It has been noted, that if evidence based practice is followed, then patients with the same or similar conditions or circumstances, should in effect receive the same level of care (Griffiths 1996; DoH 1998; Vernon et al 2000; Mc Intosh et al 2000). The data here instead indicated that there is considerable scope for differences in the assessment of need and consequently the care that patients receive.

Providing Care - Giving it all versus giving services drip wise

In some of the study areas, notably the more middle class areas, services were provided to patients in a carefully metered way. In the following excerpt this nurse described how she assessed her patients and held back on the services she could offer: -

> *"DN: Erm, I think what you do is in a way drip feed what you can provide so that you don't go in with all guns blaring and saying we can do this, erm, it depends on what, the person, if it's just a dressing I wouldn't go in and say, we've got this amount of time, we've got this, that and the other, but if it was somebody that you knew could deteriorate I would certainly say, well we've got, this is a day time number where you can contact me if you've got a problem, we have an evening service if you've got a problem, and we will review as you need, so in a way it's selective information to them.*
>
> *SS: Right. So you are sort of rationing what is available, because you've got finite resources haven't you?*
>
> *DN: Yeah. And it's got to be appropriate to what you are dealing with. So particularly in this area, where people are very middle class and as they deteriorate they have to start paying so you have to be careful otherwise they will become dependent on you and you end up do everything, so you offer the services you can bit by bit and then when you have reached your limit you have to start finding alternatives or get them to start thinking about alternatives other than you" Interview – Sister Area 1.*

In other examples, this carefully controlled strategy worked well due to the fact that patients could see that they were placing increasing demands on the service and the nurse would be seen to be stretching herself and the team. This made introducing the idea of external services easier to manage as the patient and the family could see that the team had done all that they could. The process of handing these patients over to social services care was

always difficult to secure and needed to be managed carefully as the following sister suggested: -

> *"It's always done in consultation, you can't just suddenly appear one day and say right that's it I'm not doing that, erm, in a way you start to drop subtle hints that, you know, things have to go change, or you know, their circumstances have changed, patients changed whatever, and you know, we are going to have to withdraw this part of our service, but you know, it may be appropriate that you have this agency for another part, err, and unfortunately there is a cost element. And the horrible bit is having to sort of point out and say well you are getting Attendance Allowance and that is basically what it is for." Interview – sister Area 1.*

Many nurses described this as a difficult process, particularly when withdrawing care would incur a financial penalty for the patient's family and this action could be a source of complaint against the nurse.

In one particular situation, a patient and his carer refused to let the district nurses withdraw their services and effectively demanded their continued attendance. One district nurse described the devastating effect this had on the team and their workload: -

> *"DN: Yeah, I mean we have some patients that we all end up caring for cos they are so demanding and it causes an awful lot of strain within the team, they can be lovely and we don't mind going in to see them at all, they take a lot of our nursing day, of our team nursing day, erm, lots of other agencies can be involved, and they can live at home and you know they should really be in a nursing home, because I think that it is above a certain amount of then Region won't pay for it, but they can take on the region and they can be very threatening can frighten us stiff with all sorts of things about accountability and they complain to the directorate and the trust every other day about what we are doing, and that is horrendous, it has caused big*

> *problems in the team in the last few months, we all get really anxious about those situations and it is really hard, hard to manage because essentially you feel bullied, it is a real problem.*
>
> *SS: What are the problems exactly?*
>
> *DN: ... we've sometimes felt really pressured by the other managers, but the upshot of it is that sometimes if you are patient or relative and you complain and threaten you get more." Interview – Sister Area 1.*

Situations such as this caused participants considerable strife. In some circumstances it meant that the team had to continue providing services even though they were stretched to the limit. Some patients made a stand and refused to let the district nursing services limit the care they offered by confronting the system and making demands of the trust and the directorate. In one situation a care manager and her colleagues reported feeling bullied into giving the service when a patient's partner simply refused to accept external, social services carers. In this situation it happened that two district nurses had to make three or four visits a day to do all aspects of the patient's care. The patient and the carer were able to do this as the exact definition of a district nurse's role and the loose management/flexibility gave some patients the power to demand services. The pressure from management secured their compliance.

The notion that individual practitioners make decisions about the provision of care has been noted previously (Hunter 1997; Klein 1997). This effectively hides the implicit rationing process implemented by management as they control resources and finances (Hunter 1997; Vernon et al 2000). The effect of this was that health care managers were generally protected from

complaints which could expose the rationing process. Here the senior managers in this area reacted to the potential exposure by insisting that the patient received the care from the district nursing service thereby avoiding potential bad publicity and even litigation. One nurse suggested that the recent televising of a popular serial about the work of district nurses who were particularly angelic (Sister area 1) had exposed an aspect of their work that did not fit their current practice. In her area, she suggested, patients expected her to fit the ideal model presented in the show. Another nurse from this area described the inequity that sometimes occurred when knowledgeable and often educated people challenge the system: -

> *"it is just dreadful, it is so unfair, talk about a two tier system, a wealthy person clicks their fingers, knows a few lawyers, frightens management, and we are all jumping through hoops, and we get these poor people who do really need care and get less than they deserve, that really racks people off," Interview – Sister Area 3.*

This nurse exposed the bias that could sometimes occur in the provision of care. Other nurses highlighted this: -

> *"IE: Yeah it's much more demanding. And I think they are a lot more read, they can access to the Internet and see what is available for them, demand a doctor, they are very vocal, they've got the money to do it, erm, so yes it does make a difference, well it doesn't make a difference, it shouldn't make a difference because I think everybody is, has an equal right to the same sort of service, but.*
>
> *IV: But they make more noise and generally get more, because they demand more?*
>
> *IE: They expect people to jump quicker.*

SS: Right.

DN: I think that is the thing.

SS: So what is the difference between that and sort of working class areas?

DN: I think, I think the thing is that a lot of working class people are grateful for what you give, err, it's let's be honest, some of them can be very abusive but, erm, when you go they are grateful to see you, you know, they appreciate the service that you give them, and I think that's the difference really that, erm, they are just glad to see you.

SS: Right.

DN: And if you are a day late, well we always try and phone up and let them know if we are going to be late, but they don't worry about it or demand it, you know, on that day," Interview – Sister Area 1.

It was commonly accepted that the provision and rationing of care in working class areas was easier to co-ordinate than in more affluent areas. Many nurses in this study agreed with the sister in the last excerpt. Constructing the agenda in working class area was relatively straight-forward and seldom met with opposition from patients and their relatives. The following excerpt was the result of an assessment that this district nurse undertook with a patient who had many problems. After careful and thorough assessment the nurse told the patient what she could expect from the district nursing service: -

"I know that I have to use the bottom half of my body to turn. I don't lift and I certainly don't bend over. The problem is I don't have anywhere to sit that can support me. I've tried sitting on that chair over there with cushions behind me but that doesn't seem to work. The other thing is I can't wash my hair and I would really like to wash it. They suggested in the hospital that I use dry shampoo but I don't like that.

(name) looked and said:-

"Well I think I can so something about that...I will have a word with the OT's and get back to you on that. and what I will do is I will bring you some tubinet to cover over the hard collar and make it more comfortable for you... you need to keep putting the pads on to keep that area dry."

"I will get in touch with the OT's and although I cannot guarantee I will get you a chair we can have a go... and perhaps they will have some suggestions on washing your hair" Observation – Sister Area2.

Here the nurse gave the patient responsibility for looking after her own condition and made it clear that district nursing input would be minimal. This was commonly observed in working class areas, where the nurses' intervention was short, directed and highly focussed. When working class patients refused to have social services care, it seemed that nurses were still able to withdraw care without the fear experienced by their colleagues in other areas: -

"DN: They (working class people) *are generally grateful for what ever you have done and do, so when you stop they are grateful for what you have done, in other areas it is not the same, some people, like in X* (a middle class residential area) *go mad if you try to stop going in" Observation – Staff Nurse Area 3.*

It was easier to keep to the nursing agenda in working class areas: -

"You do get people who get to crisis point before they realise that yes they have to have social services – they can not blackmail me in to going into doing it, because that is what they are trying to do blackmail you well if I can't have you I don't want anybody –

I: well what do you do if they say that to you?

IE: well nobody dies of muck do they, it is true, if they can wash their hands and face and their bum se daisy they can manage,

and if it is things well like I can't go in and cook peoples meals for them that is not my job that is not my role but there are other services I can involve" Interview – Sister Area 4.

The only time that conflict occurred during my time in the field in working class areas was when one nurse withdrew a social bath from an elderly patient who had been on the books for many years. She recounted the situation: -

"SS: how did you manage that with patients, I bet that was tough?

DN: It was very tough, I was threatened, I was threatened.

SS: Were you?

DN: Yeah physically threatened by one elderly lady, she was 86 and she was a fine woman for 86 and she actually threatened to hit me with her walking stick and, erm, I explained, I tried, you know, I tried to explain what I was doing and not to be rushed about it, to sort of let the patient know there was plenty of time to discuss this but, erm, if they didn't have any other nursing problems so I stopped it" Interview Sister Area 3.

The nurse in this situation was clearly not going to be pressured into providing care and was prepared to face the extreme anger of a long term patient.

The emotional impact of rationing

Some nurses highlighted that the withdrawal of care evoked strong emotional reactions. The following extract shows how the nurse can have some insight and empathy into the feelings patients may have about this aspect of their

care but also shows the determination with which this aspect of care is managed: -

> "DN: *You know, at the end of the day I wouldn't want some bit of kid with no training coming out to do my mother ... so I can understand how difficult it is for them, but at the end of the day it is a social services or nothing! You feel terrible, but that is the reality under this Government." Interview – Staff Nurse Area 4.*

Whilst decisions were difficult enough to make with new patients referred to the district nurse, cutting off from patients who have received care for long periods of time was even more difficult. The following extract exemplifies the difficulties in managing this change period, faced by many of the nurses in this study: -

> "DN: *The lady I told you about before who was very ill, with no nursing problems, but she has a malignancy, she has no family, she had osteoporosis which was her main problem, and I think she did morally blackmail me and it was the only time I did give in because I felt I had to really, and I thought, well I was trying to justify to myself, well she had a malignancy, and she is in a lot of pain although it wasn't the malignancy that was causing the problem it was the osteoporosis and the only sort of light in her life was that D or A going in once a week to do the bath and I think, I had lengthy discussions with the GP, and I think the GPs thinks I'm a hard hearted bitch, which I suppose I am in some ways, but, the GP sort of intervened on her behalf, can we keep her on, saying she's not like some of them others who malinger, this is what was said, but I said I'm not here to provide a service because people are nice, I'm here to provide a service to people who need a nursing service, and I was adamant that I wouldn't keep her on, but I didn't half have to do some soul searching over that, I really, really thought long and hard, and in the event I kept her, whether I kidded myself that, maybe I was being kind because I mean you can't base a service on being kind can you, I don't know truthfully whether I did keep her because I was being kind or whether it was because the GP had come quietly to me and said, do*

> *you think you could, I mean I didn't get any pressure it was like do us a favour do you think you could, I don't know whether I did sort of go along with that or whether I did keep her because deep down I feel she really did warrant keeping, I don't know, I think if I'm going to be honest I'd say I was being kind, which I think is better in this case isn't it." Interview – Sister Area 3.*

This extract is important for a number of reasons. It exemplified the decision making process commonly encountered among some nurses in this study. There was a clear distinction made in the nature of the patient's condition. The decision making process involved much soul searching and the nurse was set on standing by her decision, making a very negative attribution about herself – "a hard hearted bitch" in which she took responsibility for her decision and realised the implications of her actions among her colleagues. The deciding factor in breaking the rules was the intervention of the GP, which resulted in her changing her mind as "a favour" rather than through judgement.

The notion of malingerers represents a discourse in which patients were sometimes viewed as deserving or undeserving of the care provided by district nurses. However, there were some data which suggested that for some nurses this was not a decision based on patient need but rather on the nursing resources available: -

> "DN: *it is about being honest with yourself really, you just can't give the social care, we are told its not our role, but still we want to – we are the ones left with this awful dilemma, knowing people are not getting what they need" Interview – Staff Nurse Area 2.*

On the Cusp

The following excerpt illustrates how difficult the decision making process can be, particularly for those patients who are on the cusp of the payment for social services. In context, this nurse had been nursing this patient at home for a long period of time. The woman had multiple sclerosis and was deteriorating. After a regular period of respite care she returned home from hospital in much the same condition as she went in. This nurse realised the time was fast approaching when nursing home care will be the only option for the patient and her husband, as the demands on her time were increasing. It is a difficult decision as the man was resistant to this as he would have to pay for nursing home care and the nurse and carer have had conversations about this, which have been tense. This piece of observation follows a difficult conversation between the nurse and the patient's husband in which she suggested he think about his options for the future: -

> *"As we left the house, it was obvious that she was upset and disturbed and that the whole visit had affected her greatly. I asked*
>
> *SS: How are you, you look upset?"*
>
> *She replied*
>
> *'She is not too good, she usually comes out of hospital less spasmy than when she went in, she has physio in there and she usually works hard on her muscles and although she doesn't like it she usually come out much improved, this time she is worse. And that sore on her buttocks is getting worse but then is anyone going to do anything if you report it or get an appointment? It's been a nightmare really, they took her into hospital and they tried to catheterise her and she had terrible*

time with infections and clots and everything. Then they put her back into pads and left her the way she was. She is happy in pads and they want her to discuss it with a urologist ... ... you suggest long term care to them and they don't want it, they just don't want it (her voice raising and becoming faster)'

She went quiet and looked down at the floor of the car. I took the opportunity to reflect what feelings I had heard in her voice: -

SS 'It sounds like you are feeling helpless and sad and resentful

DN I am angry because they wouldn't speak to anyone about anything and he won't make a decision at all unless it is her decision ... he is worn out and you can see it ... he won't listen, it is because we are nurses and not doctors, I am sure of that ... they have more respect for doctors and they won't listen to nurses'

She became tearful and cried but continued to drive the car. I felt upset and angry. I asked her if there was anything that I could do to help the way she was feeling. She replied that we should stop and have a coffee. I agreed." Observation – Sister Area 1.

What this extract showed was the emotional impact of this type of work. It shows the limits of action of the nurse. She could suggest further action, offer solutions and alternatives but she felt that the decision to take the next step ultimately remained with the patient and her carer, who, in this situation have decided not to consider the option of long term care. For the nurse, she was still required to continue with the care which was taking more of her time in an already busy schedule. This excerpt also showed her concern for the carer, the woman and her own perceived powerlessness to move the situation on. This form of emotion work had a deep impact on participants – in this case the nurse was reduced to tears. Similar situations occurred throughout the process of data collection. Even when nurses successfully withdrew care the after effects were difficult to manage: -

> "DN: *It's hard because if you have sort of, erm, take this woman, she has got these social problems but not medical problems, she's so elderly, it's hard to say to her, sorry but your leg has healed I'm going now, I'll come back here talking and thinking, Oh that poor woman the way she was, so in away I'd like to have a little bit more power or be able to refer and set things up within our role or jointly a lot more joint work because you come to things like that and it's hard to, because you know it's wrong to walk away and leave someone like that but then, you know, what else can you do? You refer,*
>
> *SS: It's really hard to manage because you are left with a whole load of difficult feelings to manage?*
>
> DN: *Definitely, you know, it shouldn't be going on, it shouldn't be happening and you may refer and then you get someone at the end of the phone who goes, well it's not their fault, but you class them as an emergency or urgent and it's days and days down the line and still nothings done. This woman in particular, I am tempted to go knocking on her door, you know, just passing, say hello how are you, but you can't am I really saying that I'm someone else, or I am something else, so I've never actually gone back to her or to anyone really that we've discharged, I don't want them to feel that we can offer them something we can't, and then also, I know it sounds awful, but all the problems will get burdened onto me and I'll get totally bogged down with it and I'll be the one losing, you know, I'm not getting paid for it and it's not my role to that." Interview - Sister Area 2.*

This excerpt captured the way some nurses felt when they pass patients over to social care services. Importantly, she illustrated the common strategy among district nurses, that of if I don't know I don't have to worry. She had cut off and was left with feelings of guilt. She felt unable to do more without considerable burden on herself.

Keeping patients on

Whilst the rhetoric of rationing pervaded the work of district nurses, there were times when the rules were bent or ignored: -

> *"It is really hard sometimes cos you have to justify to yourself why you can do this particular thing for this particular patient, and all of that sort of thing,*
>
> *I: Can you give me an example of that?*
>
> *IE: Well I have this man and I can't say why I am still visiting him, but I know that I need to. So what I have to do is say that I am checking his pressure areas that they are red and he is becoming more and more immobile and I think that he is about to change or cross over, but they are sceptical of me and why I am doing the visits twice a week. I never pass him over to others, I know it costs too much for me to go but I have a relationship with him, he doesn't trust easily and I think I can just about justify why I am going. But that's it really, it is all about money not about care or concern." Interview – Sister Area 1.*

Here this district nurse 'felt' that she ought not to have continued with what was traditionally defined as an 'observational visit' (Griffiths 1996) but she staved off the inevitable discharge of the patient and continued to visit. Some nurses indicated that these decisions (to keep visiting without 'good reason') led to pressures and correspondingly they needed to hide these patients. As a consequence of this the most commonly used strategy to protect their decision was one of imminent risk - that the patient's condition could deteriorate. In doing this it legitimised the nurse's continued intervention. It is important to note that this strategy was perilous as her manager regularly checked and examined the caseloads of her staff and could easily have confronted her about the decision and could even have discharged this man

without her consent. This nurses' intuitive decision could procure disciplinary action. It is suggested in the literature on power and coercion that the process of commodification and expropriation does not occur without resistance (Giddens 1991;1994; Foucault 1974; 1977). Indeed Giddens suggests: -

> "(*commodification)* does not carry the day unopposed on either and individual or collective level. Even the most oppressed of individuals – perhaps in some ways particularly the most oppressed – react creatively and interpretatively to processes of commodification which impinge on their lives." (Giddens 1994, P199)

Here, it could be seen that this nurse, using criteria which to some degree still protects her work and the relationship with her patient, acts in a creative way against the discourse and coercive strategies which might otherwise have terminated her intervention. This finding supports the work of Lipsky (1980). In his ethnographic study of public service workers (teachers, social workers and nurses) or "street level bureaucrats" it was found that in situations where need exceeds the available resources public service providers become public policies in themselves (Lipsky 1980; Bergen 1999). That is, when the coercive effects of public policies which restrict or constrict what practitioners may offer to service users, nurses have to ration their services. However, the top down management strategy in reality allows for discretion and flexibility in resisting the pressures of resource constraints. In the preceding quote, it can be seen that this nurse was able to use the ambiguity of public policy to her and the patient's advantage. Another nurse describes the difficulties associated with justifying her continued presence with certain patients: -

> *"I don't think that a lot of us are very good at saying what we do in the home, and you know articulating it, you can take somebody out with you for a day, and they can see what you do and how you are, they don't see what goes on in you head, and if it is common sense or a gut feeling how do you put that into words? You don't know do you? Like you go into a house and notice that the flowers are dead or that there is something wrong with the smell of the house, you know that food hasn't been cooked or something, all of these things that the audit commission could not pick up, and it ... I think in some ways that we have done it to ourselves, not saying that we have stood back and let it happen, but I mean that there are so many of us that feel so strongly about it but erm it just, as I say you can't articulate you can't. So that is how they have been able to wash over us and get rid of what we all saw as nursing. Sister – Area 3.*

Here this nurse articulated the hidden or abstruse nature of nursing in the community. The problem here was that these decisions were difficult to defend. It is noted in the literature that intuition (Dreyfus and Dreyfus 1986; King and Appleton 1997) artistry (Mc Intosh 1996) or invisible work (Colliere 1986; Griffiths 1996) defies definition and explication and in the current climate of district nursing it was repeatedly found that this way of working was at odds with the pressure to justify work and interventions with patients. Many authors concur with this position that within the given medical, scientific and economic discourses there is little available vocabulary for nurses, as a largely female group, to express what they intuitively know (MacLeod 1993; Salvage 1995; King and Appleton 1997; Cioffi 1997). For other nurses in this study, the process of commodification or pricing of their skills led to sense of restriction, which most notably exhibited itself in the justification of work in terms of cost criteria and position in the team.

Breaking the Rules

In contrast it was sometimes noted during observation, that nurses sometimes had patients on their caseloads who did fit into the new way of working. Nearly all nursing caseloads had patients who received traditional care or were given care that could easily be provided by someone else. In some situations, the pressure came not from managers but from colleagues and peers. There are echoes here with the work of Farrel (1997) in which it was suggested that peer scrutiny could sometimes be felt as more punishing than managerial control over the work of nurses. In this case, these patients had to be hidden from colleagues and were seldom, if ever passed over for weekend work or for cover during the primary nurse's absence. In the following piece of observation, this nurse hid this patient from both her colleagues and her manager by organising his care so that she did not have to pass him over to any of her colleagues other than a junior staff nurse who would not question her : -

> *"We left the house and (name) introduced the next patient as a very "Young looking man". She indicated "It is very sad really, he lost his wife many years ago and has been on his own. He has had leg ulcers for many years and they have never really healed. He has had a lot of treatment for them but he has had them for many years since his early twenties or so. We have tried a lot of things and he manages his dressing himself. Some people have been to him and he carries on doing his own thing with them. One nurse said it was disgraceful that we continue to visit him but in the end she agreed that he would be better left."*
>
> *We arrived at the house and the man was in the garden doing his gardening. He indeed looked very young and fit and active.*

> *I felt unsure as to why he was having the services of a DN at home. (name) greeted him warmly and he her. They walked into the living room and he immediately made her a cup of tea as she went to collect her equipment which was stored in the corner of the room in a cupboard. He returned with a cup of tea for us both and a bowl of water which he placed on the floor in front of him. He placed his foot in the bowl and proceeded to pour the purple solution of potassium permanganate into it and then over the ulcer for some ten minutes, never pausing in the procedure. (name) gave the impression that she was watching the procedure intently, but was all the time engaging the man in very pleasant and relaxing chat about flowers, the garden and the weather. The seemed to be very at ease with each other and they seemed to talk rather a lot. The conversation flowed gently. I felt like I was an intruder in this situation. After some time, (name) dried his leg with a sterile towel and carefully and gently applied a dressing. equally as carefully she applied the compression stocking and smoothed it out with her hand. She was incredibly tender with him. She bid him farewell, and as she was leaving, he gave her a tray of plants, Lilly of the Valley, which she thanked him for profusely. She looked coy. She turned to me and looked embarrassed and gave me the flowers to carry back to the car.*
>
> *We drove back to the hospital, a very short distance quickly, during which time (name) only said :-*
>
> *"He is a very nice man and he needs a lot of support being on his own, he doesn't get out much and we seem to be doing some good visiting him." Observation – Sister Area 1.*

This quote is important for a number of reasons as it encapsulates many of the reasons why nurses kept some patients on the books when they did not fit the contemporary code of action. Firstly, patients may be borderline referrals to other services, ie, needy but not sufficiently so to warrant extra help. This was particularly important and evident if the nurse did not have the skill or training to assess psychiatric morbidity. Secondly, patients were sometimes non compliant and therefore non responsive to treatment. Thirdly, there was occasionally some interpersonal attraction or affinity between the nurse and the patient which kept nurses involved, even when their work had finished.

Fourthly, there were sometimes pleasant rewards for this type of work. In a working day which was usually characterised by a lack of gratitude and recognition these gifts were gratefully received by district nurses. Finally, the inclusion of such patients in the caseload allowed nurses to have some slack in their working day, this district nurse could increase the number of her visits to this patient when referrals were low and decrease them when she was busy, thereby maintaining the number of visits expected of her.

Bending the rules – Risk taking, in the patients' best interests

Despite the inherent risk associated with caring in the community some of the nurses in this study would bend the rules, particularly when they felt that the patient would suffer as consequence of their refusal to take a chance: -

> *"DN: I mean there are all sorts of logistic things like medication, and you know you are not supposed to travel with drugs in your car and you know, and we have to bend those rules, because how do you get drugs to patients who are immobile and live in the middle of nowhere, you know, and your surgery is a dispensing surgery, and you are going out to the patients house and you know there all those sort of pressures, but that is no different to how District Nursing has always been, always has been to bend the rules and certain medication it is all written down and you can't always follow it through because people are individuals, erm ... there is the moving and handling, risk and things like that and that we have got to refuse to care for these people, when they won't have a hospital bed in the house because then we are stooping, so we have to tell them that we are not going to care for them, but I have not done that once yet, you know there are those sort of risks that we are under all the time, but the protocol says one thing but the patients' funny little bedroom with the step down to bathroom, and the you know and it is their lifestyle, but that has always been there .. " Interview – Sister Area 3.*

Such situations of risk have been noted previously in the literature (Griffiths 1996) where nurses would risk their own personal safety, in this case the possibility of a back injury, rather than fail to provide care. The inherent risk here, was that if damage or an injury occurred then the responsibility lay with the practitioner rather than with the employing authority as the nurse should have undertaken an assessment of risk and implemented preventative measures to protect herself and the patient before doing the care (Dimond 1997). This form of risk taking contrasts with the idea of playing it safe where nurses erred on the side of caution when they met with technological or difficult treatments. In the latter situation, the nurse could do the patient harm by undertaking a procedure with which she was unfamiliar. In the data presented here, it was the nurse that was in danger, even if this danger could be a serious back injury! It appeared then, that in the calculation of risk, it was the technological aspects of care and damage to the patient took precedence over personal injury in the thinking of many subjects. For the nurses in this study however, access to the necessary equipment, particularly in the period immediately following discharge was consistently reported to be problematic and therefore risks were often taken. One staff nurse reported how she dealt with the threat of risk: -

> *"You are protecting yourself from litigation and, I don't know, you know, some of us, some people are really paranoid, you know, you get to the stage where you think, sod it if they get me they get me, I do anyway.*
>
> *SS: So you just go ahead and take risks then?*
>
> *SN: The rumour is we all do but we don't say anything about it"*
> *Interview – Staff Nurse Area 3*

Here this experienced but unqualified district nurse, suggested that she adopted a rather maverick attitude to risk to herself, despite the feeling that she could at any time "be got" or punished by her managers for not following protocols. Many nurses' indicated how they found the protocols and procedures associated with risk assessment tiresome and laborious: -

> *"we don't have time to do all that rubbish, you know all these stupid forms that you do if you have got a ambulant patient that you are just removing sutures, or you have got to register them cos you are going to go for few time, you have got to do a moving and handling form, otherwise you can be shot even though they are as ambulant as you or I, you know and there is all this crap that they are sending down to us, and it is just twoddle really and it is just giving the auditors, that didn't want to leave after they have had children, and came back to that job... (laughs) but at the end of the day, I know that I am taking risk with myself cos if anything happens its me that will get it really. But if I spent all my time filling in all the forms that I am supposed to then I would never get to see a patient. That's the thing really. That's the decision you make, paper work or clinical work." Interview – Sister Area 1.*

Like many of her colleagues, this nurse knew very well the consequences of not adhering to the rules could be severe for her. For many nurses it was suggested that the whole system of monitoring was more to do with protecting the Trust than protecting the nurse. For some nurses in this study, she prioritised her clinical work over the process of documentation. Consequently, extra work remained hidden and the risk of detection, the dangers to the nursing team and the potential consequences often remained undetected.

Summary

The data presented here indicate that district nurses are increasingly viewing their work as a commodity. This process has been secured through coercion and threat which for many nurses has threatened the security they once felt in relation to their work in the community.

The commodification of district nurses work has challenged their professional ideology. For some, this challenge has left them confused about their role, others were sceptical about the new discourse of economics. Yet others relished the change that had occurred as consequence of commodification, equating the new approach to an increase in both status and kudos. At times when these competing and sometimes colliding philosophies intersected intra-professional conflict could ensue.

Local level rationing of district nursing services sometimes occurred through the use of direct exclusion criteria but in the main, the process of rationing was secured through discretionary processes which were observed to be variable among participants.

The discourse of economic value has gone someway to produce a self-reflexive, flexible nursing team. District nurses were sometimes observed to operate at the core of care provision, both providing and organising peripheral workers. At other times the reverse situation was true. This form of flexible working has echoes with a post-modern orientation to the organisation of work and may explain why research has consistently suggested that district nurses' work has always been and still remains, somewhat idiosyncratic and variable.

Chapter 9 - Findings

Introduction

Whilst the previous chapters have discussed the ways in which district nursing services have been increasingly re-organised by internal systems and nurse managers, this chapter deals with yet another system of organisation that is peculiar to district nursing. Thus this chapter will deal with the direct cultural relations between district nurses and GPs.

Reluctant Inclusion

Being Visible

It was universally suggested by the nurses in this study that they had to make themselves visible to the GPs to whom they were attached. For most of the nurses the experience of being visible was considered a chore and led to a sense of resignation and acceptance that this is just the way it was: -

> *"You have to go to the surgery twice daily, and be seen to be around so that you can do their business" Int Sister – Area 1*

> *"They have to be the boss don't they? So you have to play the game" Interview – Sister Area 4.*

Being visible meant that district nurses had to make their presence obvious to the practice staff on a frequent basis during their working day: -

> *"we left the house and we drove a short distance to the GP practice which was in the centre of town. (Name) began a conversation about their interactions with GPs 'we promise them a visit, once a day, 12 o'clock usually when the morning surgery has finished and there will be someone around ... we look at the book, one of us does, but sometimes they phone us and ask us to phone the surgery, but we have to call in and they say oh it wasn't urgent, but we have to call in 'cos you can't be using people's phones all the time'. Observation – Sister area 4*
>
> *We approached the surgery and (name) walked directly to the book and checked for messages, the reception staff mumbled hello, ... she asked the receptionists 'which doctors are in' and left the room to speak to the doctor, who was not in the room, she returned to the reception area and busied herself with patients' notes and then we sat around for 5-10 minutes until a doctor came into the room. (Name) got up and collected some blood bottles and we left. On the way back to the car she said 'on the surface the surgery is friendly but underneath it is not'. Observation – Sister Area 1.*

Traditionally district nurses generally only contacted the surgery and doctors when there has either been a problem with a patient or a need of something practical, such as a prescription or a referral. Here participants suggested that it was essential that they attended the surgery during the morning surgery hours, when the doctor would definitely be present.

Perhaps the most salient suggestion made by the nurses in this study was that this process made them and their work more visible to doctors. By definition, district nurses' work is most often invisible and difficult to scrutinise (Griffiths 1996). However, it is a feature of modern organisation to make working practices open to scrutiny or surveillance and particularly to establish clearly defined hierarchies which reflect the prevailing power dynamics

(Foucault 1977; Clegg 1990; Henneman 1995). One nurse described her indignation at having to be seen: -

> *"You know the thing that really pisses me off is the way that we have to wait around and hope to catch one of the doctors, you know to get information or that, like an ornament. They have to see you at least once a day, and some twice. But the thing is they don't tell you anything really – it is because you are THEIR NURSE – any information you get you have to get yourself unless it is something important so you stand around for however long just to show willing and to be seen" Interview – Sister Area 3.*

Foucault (1977) argued that power is exercised rather than possessed and here we see a direct manifestation of power. In this situation, the nurse highlighted her own sense of impotence in the process of ornamenting the surgery. Many nurses realised that they had to play this game. It has been suggested that the rules or discursive practices (Foucault 1977) that exist within an establishment do not merely serve the purpose of defining the role of the individual (Sewell and Wilkinson 1992) but rather they signify the structural position of the person within the organisation (Clegg 1990). Here we see a practice which clearly indicates that the nurse was acting a role, with full knowledge of what she was doing. Like some other participants in the study, she was openly aware of her "deference" (Witz 1992) to medical power in this situation but felt compelled to continue the game. The reasons for this action was often described as "keeping them sweet," "selling you self" or "being available to them." It was often suggested that this form of action functioned

as some sort of exercise centred around letting them see that nurses' were actually around and attached to the surgery.

Visible but on the edge of the team

Being visible within the surgery did not equate with team participation. Characteristically, throughout the study, I noted that nurses seldom blended into the practice, an excerpt from my observation notes highlighted this: -

> *"I was reflecting on the many visits I have made to the surgeries with different nurses after today's period of observation with (name). I am struck by the lack of communication that goes on in the surgeries and the very business like approach adopted by the nurses. It seems that the work relationship, whilst on the surface is affable there is hardly ever any personal contact, above general pleasantries or interchanges other than those about work it is very much seems like an outside contractor coming into a firm to do a job " Observation notes June 1998.*

The reality of participants' working relationship with the team was often described as a condition, a routine or a ritual rather than a positive opportunity for inter-professional contact. Repeatedly throughout the study, participants made the comment that relationships were "OK", "fine really" or "not as bad as they are in other areas". It was apparent that every nurse's GP had their faults, but their own medical colleagues were never as bad as the tyrants they had heard about in other areas. This sort of back handed compliment highlights the expectation of nurses that difficulties in their relationships with doctors were to be expected and were almost part of the territory of contemporary district nursing. It was clear that relationships with the GP in particular and the practice team generally were observed to be superficial with

district nurses very much on the edge: -

> *"we have never really been a team, they call us a team but we never really have been. We had this away day thing where we all went to a hotel and were facilitated about each others role, we had a nice time, we all got on and that but at the end of the day it was back to work as usual.*
>
> *SS: What do you mean by usual?*
>
> *DN: You know, same old same old, courtesy but that's it really, we are no better at working with each other than we were before, it was all very nice and that" Observation – Sister Area 1.*

It is interesting to note, that the literature about the existence and functioning of a primary health care team, has a scant research base to support it (Wiles and Robinson 1994; Williams and Sibbold 1999; Jenkins-Clarke 1998; Jarvis 2001). In fact, it is noted that attempts to change the power dynamics in the primary health care team have met with little success (Wiles and Robinson 1994; Poulton and West 1993; Wilson 2000) and the data here concurs with these findings. One nurse describes the team, as if it is something that is happening outside of her: -

> *"They have got a good service, they have different ideas, even as a team they are not really a team, they are not really ever ever, it is this doctor will do that and this doctor will do that .... I don't think they understand what a primary care team meeting is, I think that they look to the practice, which is the building and the people who work in the building, and the people who were employed by the General Practitioners under the fundholding, but that has caused an awful lot of unrest among nurses" Interview – Sister Area 4.*

To some nurses in this study, the primary health care team represented a structure rather than a team in the true sense. It was suggested that the team centred around the doctor, his or her work and the health centre building. This finding is not new, indeed it has been suggested the proprietal rights afforded to GPs, their interest in financial management and gain (Mc Intosh and Dingwall 1978) and the business of primary care, produced a system whereby doctors in general practice view the primary health care team as a group of people to direct and manage, rather than engage with (Wiles and Robinson 1994; Dowell and Neal 2000; Wilson 2000). It is interesting to note that this nurse, like some of her colleagues, implied that the primary health care team comprised of the GPs, the practice nurses, the reception staff and the practice manager. These people represent the core team, from which the business of primary care is organised. By definition (and sometimes by intent) district nurses and health visitors were on the periphery of this practice team due to their external employment status.

It was clear from the data, that even when community nurses were included in primary health care meetings, there still existed a distinction between this and the practice team meetings. It was in this latter arena that the decisions about primary care services and developments were generally made. There appeared, therefore to be a team within a team (field notes June 1998; February 1999). It was apparent that this process constructs district nurses as peripheral to the core team.

This form of organisation represents an imposition of power, characterised by a system of subjection and hierarchical structured management so aptly described by Foucault (1977) and foucauldian scholars (May 1999; Knights and Mc Cabe 2000) as being a feature of post-fordist organisations. That is, a central core of trusted workers operate at the heart of the organisation whilst other, casual or flexible workers are given external and contracted status (Watson 1997). Therefore, the data which suggested that nurses were external to the team find support from this analysis of contemporary work.

The Contrary Experience – Salaried GPs

In contrast to this situation, those nurses working in area 2, the salaried GP practice, had little of this form of subjectification. Their work was more valued and was characterised by a respect rarely encountered elsewhere in the study. One nurse who worked in this environment commented: -

> *"it is very different here, we are all on the same side, you know, working for patients and all that. They don't pay us, the trust does and that makes a big difference" Observation – Sister Area 2.*

The senior sister in this surgery however, was more sceptical about the reasons why this situation differed so much from other areas: -

> *"I think the major change is now, for me and my team particularly is the way that we work with doctors here. This is a salaried GP surgery and the relationship is marvelous between us and the doctors, lots of things are really good. The biggest*

> *thing is I don't have people breathing down my neck all the time, I am left to do my job as I see best, within a certain frameworks and policies and what have you. I think I've got a good grip on them (the frameworks, policies and the system eg GPs) whether that's me or whether that's the system I really don't know, I think it's a mixture of both probably." Interview – Sister Area 2.*

Here this very senior district nurse suggested that the difference originated from the fact that she is highly politically motivated and that she was abreast of legislative changes and their implications for herself and team. It was clear throughout the period of time that I spent with her and her team, that she used this knowledge to her advantage and argued with credibility and insight when ever her team were directly threatened (field notes 1997, 1998). An excerpt from an observation highlights this:-

> "Name *began a conversation about the team meeting. 'Since the salaried general practitioners thing came into force things have really changed here. I have been able to use that and the new legislation about PCGs. I have insisted that we take turns in being the chair of the meeting and all of us have things to put on the agenda. It is much different now really, we all have a say" Observation – Sister Area 2.*

It has been suggested that this adaptive response to a controlling system is one of "radical engagement" (Giddens 1993, p137) which involves practical contestation of the sources of dangers. In this situation, it was clear that this nurse was using legislation to her advantage and in doing so was resisting the controlling power of her medical colleagues. It was further noted, that when new members came into her team (for example an experienced community staff nurse undertaking the district nursing course) they were often in awe of her political awareness and bold approach to confrontation and change.

Particularly pertinent to this excerpt was the suggestion that it was only the salaried nature of the GPs contract, in conjunction with her strong personality that produced the relatively secure structural position within the primary health care team.

Overt Exclusion

Whilst it could happen that nurses experienced themselves as on the edge of the team, some participants felt a sense of complete exclusion. In some areas of the study, it was observed that the district nurses were actively excluded from the primary health care team and even within a team of district nurses, there could be a situation whereby one nurse could be actively involved in the primary health care team whilst her colleague, who was attached to a different team of doctors, would not be afforded the same limited, opportunities for inter-professional communication. In the previous examples, the nurses' interactions with the GPs and other practice staff seemed formalised, if rigid. In the following excerpt, the district nurse had no formal mechanisms for inter-professional interaction and furthermore, her team were actively excluded from all decision making fora: -

> *"and to this day we are not included in the primary health care meeting cos the questions are, we get told that it is the practice meeting now if you are being told it is the practice meeting erm if it is primary health care District Nurses should be involved and we are told it is only about the building and not the people involved in it. Err but they did not talk about health care issues and the practice nurses and the General Practitioners the err fund manager, practice manager and the senior receptionist but not ourselves and as I say we are still not included we are just discussing it now because erm I just feel that we need to be a bit more pushy and say look we are part of this team." Interview Sister – Area 4*

This situation occurred in at least one surgery in each of the study sites and sometimes it was a common experience. Within the surgery highlighted above, the process of overt exclusion extended further than just exclusion from the formal practice meetings. The following piece of observation which was undertaken during a lunchtime meeting illustrated the schism between the district nursing team and the rest of the primary health care staff: -

> *"we returned to the surgery, which was locked up for dinner and we entered via the back staff entrance. When we arrived at the district nurses room, which was a tiny room containing six desks and a number of filing cabinets, bookcases and a fridge. The room held all of the community based nurses, six members of the district nursing team, a health visitor and a nursery nurse. There were tea and coffee making facilities. The whole place was completely crowded and very noisy. I asked (name) could I go to the toilet, and as I left the room I passed a sitting room which contained many easy chairs, coffee table and was so spacious compared to the nurses room. The room contained two of the practice doctors, the practice nurse and one receptionist who were chatting whilst eating their dinner. I was struck by the contrast between the two physical spaces. I returned to the 'nurses room' where people were trying to eat sandwiches at their paper cluttered desks. I asked (name)*
> *"why don't you sit next door to eat with the rest of the staff?"*
> *Two of the staff nurses giggled, the health visitor raised her eyes to heaven and (name) said,*
> *"because we only have one room purchased, and we are not generally welcome" Observation – Sister Area 4.*

In this particular situation it could be seen that the group of nurses perceived that their peripheral status actually extended to social contact during lunch times. The constant reminders of their status had the desired effect of creating a divide between practice staff and the district nursing team.

Distrust

Some nurses who experienced exclusion from the inner primary health care team, explained it in terms of GP distrust of their official affiliation to their employing Trust. It was suggested that the developments within the practice and the resulting demands that fundholding practices would make in terms of contractual arrangements were best kept from the ears of the district nursing team in case it was reported back to the providing trust: -

> *"but we feel ... we are not included because I think they were worrying about what would go back to the trust and our managers from us and our managers were saying things to us now don't be letting them do this and don't be letting them do that" Interview – Sister Area 4.*

The inference here was that this district nurse could somehow thwart the plans and developments of the practice by leaking information to the trust, and consequently preparing them for the next round of contracting. As colleagues, therefore, in some situations, district nurses were not trustworthy. It is also interesting to note, that this particular surgery lay on the boundary between two competing provider units, therefore the information about contracting and future plans for the surgery was particularly sensitive. In area 1, another sister discovered, by accident, the minutes and a memo from the primary care meeting from which she had been excluded. It was particularly worrying for her as the information contained within it referred directly to her role and her work at the practice: -

> *"you know they are very very good in that way they erm, erm, they stand behind me they are very supportive, they like to be kept informed but they are very supportive, erm, but I have heard rumblings that they want to get the District Nurse to do dressing clinics at the surgery, so erm, but I don't think that that is very fair, nobody has said that to me yet, but I have seen memos flying around and things like that that is not my role" Interview – Sister Area 1.*

The poignancy of this quote lies in the contradictory nature of this nurses' statement. She offered support to the medical staff and the primary health care team even when they were actively seeking to change her job role without her consent.

There is little written in the literature to support this finding. The majority of research conducted on the role of communication has examined the team from the perspective of competing professional identities and the consequential tribalism that exist as a barrier to communication (Wilson 2000). It is interesting to note, that this district nurse went on vehemently to pronounce that she would not wish to be employed by the practice and lose her status as a Trust employee, even though she described the doctors as supportive of her and her relationship with them as good. This nurse had some faith in the support afforded her by the GPs but was sceptical about the motive and pull to include her in the day to day work of the practice. Giddens (1991) argues that those who trust abstract systems (in this case the system of GP control over her work) render themselves powerless to the control it sequestrates. Healthy scepticism is a defence and resistance against the totalising nature of modernist organisations. In the data presented above the nurse's sense of vulnerability was grounded in the reality that they were in fact

effectively purchased by one service (the GPs) and employed by another (the Trust). This factor and the tensions it created often evoked a sense distrust of the GPs among nurses. In essence for many participants this experience was described as being "piggy in the middle" or "serving two masters," as one nurse illustrated: -

> *"DN: we are told that we are their District Nurses we really and truly felt like piggy in the middle and we are really and truly being used like political pawns – you know at this time*
>
> *SS: that feels really hard it is like saying that management on one side pushing one thing and them on the other side pushing another thing –*
>
> *DN: yeah yeah and you also feel loyal because I would not have them say a bad word about our managers and I used to find that I used to have to defend the surgery as well because you would not want to be saying anything bad about them cos you work with these people and you like these people but I like the people in my management team as well you know because nobody is really out to get you but they didn't realise that because of the contracting we felt very vulnerable you know*
>
> *SS; it is like having to balance two different people" Interview – Sister Area 4.*

The concealed or secret decision making process became more evident as the study moved on and particularly when surgeries began moving to Primary Care Groups (observation notes, May 1999). Another nurse indicated that the process of exclusion might have something to do with the changes that could occur in the near future: -

> *"You know they may be taking us over soon, and really we have no idea what is going on in the surgery, only what we hear second hand like, despite the fact that they are going to have to include us when we become part of the PCG." Interview – Sister Area 1.*

The suggestion was that the role and function of the new team would be decided without direct consultation with district nurses. It is also interesting to note, that the nurse member on the PCG board in this area was a practice nurse. This compounded further the sense of insecurity felt by district nurses about their future role.

Who Owns Whom?

Some sociologists concerned with the area of work have painted a pessimistic picture of the labour process where it is represented as an oppressive system beyond the control or understanding of the worker (Braverman 1974). However the nurses in this study were very often aware of this system of control. As a consequence of this many nurses in this study acquiesced to the demand of being visible and doing peripheral work, with full knowledge of what it was they were doing. This official way of responding was endorsed, encouraged and expected by their Trust managers.

Some nurses alluded to the fact that they were "owned by the doctor". It is interesting to note, that in early days of the reorganisation of district nurses, when they were moved from patch to practice allocation, many older participants in this study referred to their GP colleagues as if they owned them. Phrases such as "my GPs" and "our doctors" reflected a sense in which district nurses felt that they were the controllers of the system rather than being controlled by it. This is an interesting point. The reality of this situation was that for the nurses in this study, if they were in fact owned by anybody, it

was by the Trust. The only nurses to be truly owned by the GP were in fact the practice nurses. It was perhaps this "being one step removed" that presented both GPs and district nurses with a problem. The GPs never owned but did in actuality, purchase district nursing services through a third party. In theory then, there should be a buffer between the GP and the nurse and unlike practice nurses, GPs therefore ought not to have had free rein over the work of district nurses. It could be suggested that district nurses provided a threat to structure of primary care as they were not under direct control of the GP where GPs would like them to be.

In practice however, although this once removed status or the potential buffering effect of the Trust could have the possibility to ease some of the problems district nurses experienced in primary care, this potential was seldom, if ever used. The rule of the day was generally that of deference to GPs.

Other nurses suggested that the contemporary work and their relationships with GPs included practical strategy of "playing the game" or "selling yourself". This was a direct consequence of the process of commodification discussed earlier (see chapter 6). Some nurses were required to sell themselves to GPs in order to secure and protect their current and future contract. One nurse remembered having to do this before the previous year's round of contract setting: -

> "*DN: we had a meeting we belonged to the other trust, the community trust, and everybody was going out with their glossy magazines and they were selling themselves cos it was all about purchasing and providers and*

SS: did you have to do that?

DN: no our trust was doing that our managers were doing that for us but we were involved in it because they brought out this nice glossy folder for District Nursing and health visiting and where ever we worked later on we had to go out and show the doctors what we could do and what we were available for and all our protocols and policies and erm in a way we were selling ourselves to say look keep us we are the nurses for you type of thing" Interview – Sister Area 3.

For many this degrading process caused distress and further reinforced district nurses' peripheral, rather than central status in the team.

Group Meetings

It is interesting to note that during the whole period of my field work, I was able to observe six formal meetings in which all the practice staff were gathered together to exchange information and to discuss developments. The following excerpt from field notes details the content of one such meeting: -

"we entered the staff room and the desk was formally organised, so that people could sit round in a circle. There were three GPs present, all of the district nursing team except the auxiliary and the health visitors. The CPN was also present. (name of district nurse) took the lead, 'As I am the chair today, can we start with the agenda?' She distributed the agenda around the participants and the meeting proceeded. All the staff were encouraged to contribute to the various agenda items and there seemed to be a genuine sense openness between all of the people present. One of the doctors talked candidly about the developments at the FHSA and the implications of these for all the practice staff and asked for contributions which he listened to and either challenged or agreed with. The section devoted to patient problems, represented a structured approach to discussing the various participants interaction with the patients, and allowed suggestions from the floor. The meeting went on

for some 50 minutes and ended with a communal lunch were people circulated around the room and spoke to each other in a friendly collegial manner." Observation – Sister Area 2.

What is striking about this piece of observation was the clear sense of collegiality between the members of the primary health care team. The structure and openness with which the meeting was conducted contrasts sharply to the defensive team structure outlined below. Within this health centre the relationship between the staff members was one in which they were all essentially employees. The GPs here, did not have the same business relationship with the wider health care team that was evident in all other areas studied, which may account for the relative equality encountered in the meetings at this health centre. Another district nursing sister based at this clinic highlighted this contrast: -

"it is so different here, you feel like you are really involved in the practice and that goes for everyone. There are meetings every fortnight, everything is discussed and you know what is going on. I couldn't believe it when I was asked for my opinion." Interview – Sister Area 2.

In contrast to this situation, the following piece of observation, which is typical of other meeting I attended, depicts the normal routine organisation of the primary care meeting: -

"The room was large and had a number of comfortable chairs arranged in a square. There were a number of people already arranged in the room. The rest of the meeting proceeded as follows.

Dr 1 "You start - " to the CPN

CPN Talked about 3 patients and said that they "were doing well" going on to describe a little about the criteria for doing well being that they were socialising and getting out and one had recently returned to work and "had recently re-advertised his work." The doctors seemed pleased at this particularly the female GP and the practice nurse announced that they had received one of his fliers for his business. The CPN then announced that he was leaving to undertake another post at a local surgery which was a research project for one year, in which he will look into service utilisation for mental health services. There was a general agreement with DR 1's comment that "You will be missed" all the people agreed.

Dr 1 "You (district nurses name)"

DN Talked about the patient that we had visited that morning and the problems that her partner was having in taking her back from respite care. She said:-

"I have never seen him like this before, he was really down as if he had really begun to accept it now. It looked like it was getting him down. We talked about increasing his respite care but then after the trouble we had getting it in the first place it is probably best that we leave things as they are. "

GP1 "Yes leave them as they are.... we need to give him more support" Looking at the district nurse.

DN "and there is no real improvement in her pressure sore, in fact it is worse than when she went into the hospice, that sinus has got deeper. Mrs ---- is going for an appointment with the consultant and I will tell what happens when I see her next. (To DR 2) I have arranged for us to do a joint visit to Mrs --- on Wednesday, at 9 o'clock and she is expecting us." Dr 2 nodded.

Dr1 "and you -----, " to the Practice Nurse.

PN "Just Mrs----, she came in the other day in a terrible state, she had the most horrendous diarrhoea and was covered in it, (in an aggressive tone addressed at the DN) She needs to have information and you need to make sure that she has more education on her diabetes. Her family have been buying her diabetic chocolate from Boots and she's been eating it and now I have to face the consequences"

DN: "(rather embarressed and looking like she had been placed on the spot) She has had education about it but what can

you do if her family keep buying her the stuff, she just carries on and eats whether you want her to or not..... I'll tell her again about it, but short of following her to the shops there is not a lot I can do"

Dr2 Picking up on the potentially conflict "What can you do with that woman..... what a pain, "

Dr1 "Do you have anything " to PM

Practice Manager *"No nothing"*

GP1 "And you?" to Dr 2

GP2 "No....."

Dr1 "(DN's name)---?"

GP3 "Just this blood that needs doing"

DN "Oh do you want me to do that ?"

GP1 "That's the meeting finished then, see you all next week" (Observation – Sister, Area 1)

This excerpt is important for a number of reasons and highlights many pertinent feature salient to the relationships between doctors and nurses in this study. Firstly, it is interesting to note that the CPN began the meeting, and his dialogue was one in which he talked favourably about the patients with whom he had been working and was able to give the practice team indicators about how successful his work was. It is also important to note that, this was his final meeting with the practice team and he made no attempt to talk about problem clients or patients that were not doing well.

In contrast, the district nurse in this situation talked about a problem patient. The visit we had been to that morning had been difficult and when she spoke she had obvious sadness in her voice. It was clear that she received no

support or acknowledgement for her distress and she left her description of the situation open ended. In this situation she suggested to the doctors that the probable best course of action was to do nothing and it was this situation that the doctor chose to agree with. The dialogue or dynamic here resembles the doctor nurse game (Stein 1967) in that the nurse adopts a strategy of informal covert decision making (Porter 1991). The suggestion she made was not owned by the nurse but rather tentatively proposed for consideration by the GP. It is interesting that the doctor's solution to this problem was to suggest that "we" need to give him more support. In this case, this "we" was understood by all to mean the district nurse.

The way in which the nurse informed the team of the deterioration in the patient's condition was interesting. In this case, the patient's pressure sore had got worse since she had been in hospital and the sinus had got bigger. The nurse informed the doctors and the rest of the team that this had occurred not as a consequence of her intervention and care but as a result of the patient's stay in hospital. She was covering her back, like a good many of her colleagues reported they also did. In reality, she could never know when the doctor may visit the patient, or the patient may call the doctor and as such she needed to ensure that any deterioration had been communicated to avoid possible repercussions.

The final point about this interaction, was the way in which the practice nurse addressed the district nurse. She openly confronted the district nurse and challenged her about a particular patient. In this interaction the district nurse

had to defend herself and clear herself of the accusation made against her of poor care. The outcome of this display of aggression, was that the nurse conceded to visit the patient and reiterate her previous advice. It was suggested by other participants, that practice nurses had allied themselves with GPs rather than with their community nursing colleagues. This further reinforced district nurses' peripheral status. In other group meetings, nurses often reported that they do not enjoy the experience and suggest that the primary health care meeting had more to with do being examined rather than working together: -

> *"They have you in the meetings but it is also like you are on the outside, it is a sort of tokenistic thing really, they have you there but you are not really involved. But to be honest I don't want to be, I just want some more information about patients so I can get that from the notes and the receptionists. I just do my job, they are friendly, I am friendly and that is all there is to it really. We know each other." Interview – Sister Area 1.*

Here this nurse was acutely aware of her status in her team. It is interesting to note, that much of the literature around this subject of nurses' deference to medical organisation suggests that nurses need to challenge rather than accept the way that they interact with doctors (Porter 1991; Mackay 1993, 1995). It some ways this literature can lead to blaming nurses for their structural relations of subordination to doctors (Mackay 1995) and can therefore represent nurses as somewhat passive. Deeper examination reveals that the process of self or professional compromise can result from a position where nurses actively choose (where choice is limited) to sacrifice their own professional and personal status for the sake of, in this case, the collegial relationships of the team (Gilligan 1982). The data here, indicate that

deference was a protective mechanism for district nurses. Thus, through pragmatically accepting the status quo, it has been noted, pessimism and hope may coexist ambivalently (Giddens 1993). The sacrifices district nurses make may be made in the hope that the investment will pay off and a more egalitarian system could result.

Doctor – Nurse Communication

The process of communication between doctors and nurses in primary care was observed to be hit-or-miss. There was seldom any co-ordinated time set aside for the nurse to report her cases or discuss problems with the doctor. Frequently the interactions nurses had with doctors were noted to be haphazard, informal and in the main a one way communication with the doctor passing over instructions as a demand rather than a request: -

> *"We were leaving the surgery and (name) doctor stopped her in her tracks.*
>
> *Doctor: 'I want you to visit Mrs(name) and Mr(name) today as soon as you can.'He spoke to her in a very curt and abrupt manner.*
>
> *Nurse: 'I am very busy today, I have a full list'*
>
> *She replied. She proceeded to show him the list in her diary, which he ignored. He replied: -*
>
> *'They need to be seen today!'*
>
> *She wrote their names down in her diary, smiled and walked away. He ignored her and carried on talking to the receptionist. As we left, she uttered the word 'bastard' under her voice, saying 'It is like that all the time, you just get yourself organised and then they dump on you like that." Observation Sister- Area 1.*

What is important about this quote was the way in which the doctor hands over the patient to this very experienced and senior district nurse as a command rather than a request. Typically these interactions were characterised by a formal power dynamic in which the doctor exerted his authority over the nurse. Her attempts to bargain with him were met with a cold formality representative of a hierarchical, rather than collegial relationship. The effects of this interaction were very often frustration and anger among nurses. Important here was that the doctor seems unconcerned with the nurse's workload and she does not request information about the patients, their condition or the reason for the importance of the visit.

In other surgeries, it was usual that the courtesy of direct communication was by passed as the following excerpt from observation of another district nurse shows: -

> *"we were in the surgery, and (name) had collected the book and noted down the two referrals made by one of the doctors. She proceeded to go to the case note files and find out details, names and addresses of the patients. As she put the book down the GP came into the reception and bypassing her, asked the receptionist where the District Nurse book was. (name) was busy and carried on with her information seeking. She came back into the reception and the doctor returned to his room. She put the book back on the shelf and as she was leaving, the receptionist said: -*
>
> *'Have you checked the book?'*
>
> *She replied: -*
>
> *'You know I have'*
>
> *'No, no he has just put two more referrals for you to visit in there'*

They gave each other a knowing look and (name) took the referrals and repeated the process once more" Observation – Sister area 1

In the milieu of primary health care as a business, this was they way things were for many nurses. In the majority of practices, the communication between doctors and nurses was invariably written, instructional and diagnosis oriented. In an ethnographic study of acute hospital wards (May 1992) it was noted that the way in which information about a patient was given by the doctors, subsequently defined the patient and the material practices performed by the nurse. This process was also observed in the present study where a typical referral might read "Mrs Jones BP" or "Mr Smith – Enema" (field notes 1998). The definition of the patient as a task had important implications as participants exposed to this form of referral were highly unlikely to move further than the task at hand. Here the data indicate that doctors were responsible for defining some of the working practices of district nurses.

In other situations where direct communication occurred between doctors and nurses, there were sometimes surface pleasantries and platitudes, even courtesy but the underlying process remained the same. The doctor gave an instruction, limited information and requests that the visit was done quickly. Porter (1991) classified this form of reaction among nurses, unproblematic subordination, suggesting that it was representative of the original doctor nurse game (Stein 1967). In his ethnographic study of a hospital wards, he found that this way of interacting seemed to be the exception rather than the rule. The only situation in which this form of deference regularly occurred was

when nurses interacted with senior medical colleagues, particularly consultants. This has echoes for the data presented here, in that the relationship between district nurses and GPs was similar to the power and status relationships between nurses and hospital consultants. Unproblematic subordination was likely to occur as a consequence of the added power and status GP's exercise over district nurses.

Perhaps the most pertinent aspect of the process outlined above was the way in which doctors and nurses communicate and data presented earlier in this thesis which discuss and describe the commodification of district nurses' work (see chapter 6). On the one hand, the health and social care divide had created a move towards defining district nurses' work in terms of tasks. Here the data suggest that the contractual relationships in primary care, where nurses have been requested to perform specific services (or tasks) had reinforced the commodity or business value of their work. Thus district nursing care was becoming increasingly fragmented and task specific in order to cope with the increased demand on both their time and resources. Others have reached similar conclusions (Ross 1990; Griffiths 1996; Mc Intosh et al 2000). The following sections highlight some of issues related to this change in service provision.

Compulsory Referrals

An important element and indeed a frustration in the work of district nurses was the perception that they had to take doctors' orders. The referrals that

they received when attending at the GP surgeries seemed to be of priority to district nurses even if they already have a busy and hectic day: -

> *"DN... you have to take what comes on from the GPs*
>
> *SS: "who says?"*
>
> *DN The GPs almost on a daily basis they want them seen and they have got to be seen" Observation – sister area 1.*

And another sister: -

> *"No matter how many patients you have on your caseload you can't say no to them, to the GPs even if you can't take on any more" Observation – sister area 1.*

These data seem to suggest that nurses' collusion in this process appeared to based around the presumption that GPs actually do head up the primary health care team, coupled with concerns about their contracted in status. This may account for the deference in respect to GPs rather than deference to medical knowledge as is suggested in the literature around this aspect of inter-professional relationships (Stein 1967; Porter 1992).

Contextually, the majority of the research undertaken into doctor-nurse communication has been conducted in acute hospital settings (for example, Hughes 1988; Porter 1991; May 1992; Mackay 1993; Svensson 1996) where the relationships between the doctor and the nurse are very different to those observed in the primary care setting. It has been noted that, within acute care services, both the doctor and the nurse are essentially employees of the

hospital (Nash 1996) and as such, the status difference and deference afforded to doctors by nurses is explained in the differential educational preparation of the two groups (Mackay 1993; Witz 1992) which generates an authoritative, dominant discourse and corresponding power relations (May 1991).

The data from this study indicated that in the community setting the situation was different in a number of respects but what was of prime importance was the contractual obligation between GPs and district nurses, which does not feature in the established and often cited existing literature. In essence in the hospital both nurse and doctor are answerable to a higher authority (Nash 1996) whilst in the community the district nurses were observed and felt as though they were a contracted employee of the doctor. It was this reality that contributed to and influenced the occurrence of super-subordinate relationships. It is interesting to juxtapose these findings with the situation in the second study site, where both the doctors and the nurses were salaried. In this situation, the relationships between the practitioners were consistently noted to be better than other areas and more collegial (Fieldnotes 1998; 1999). In other study sites however, the employer or purchaser power gave GPs the authority to decide what kind of services they wanted and how they would use these services, a position previously noted in the literature (Witz 1992). Thus in primary care the GP did not, therefore, need to rely on his or her medical knowledge and status alone as is the case in hospitals (Porter 1991) but also had a greater amount of power in terms of his or her employer status, which he or she could use to secure deference (Keddy et al 1986;

Nash 1996). Where the literature suggests that the doctor nurse game (Stein 1967) and resistance to it centred around the competing philosophies of medicine and nursing (Porter 1991, 1992) the findings presented here suggest that the optimism shown in some studies of resistance to the coercive effects of doctor's power were less likely to feature in the interactions of district nurses and GPs.

This finding echoes an historical study undertaken with nurses who were trained in the 1920's and 30's which found that when nurses were taught and employed by doctors alone their relationship with them was different to that found in hospitals (Keddy et al 1986). There have also been other robust studies which have linked deference and subordination to the employee status of GPs (Witz 1992; Poulton and West 1999). What is startling about these findings in comparison to old, well established literature is that the situation seems to changed little, if at all (Gilmore et al 1976; Mc Intosh and Dingwall 1978). In the study reported here deference was secured and the relationships nurses endured were strongly influenced by the individual doctor's idiosyncratic requirements. An important comparison to the data presented here is that the nurses in Keddy et al's (1986) study, nurses were employed directly by physicians. Their findings have resonance with this study in that district nurses reported that the doctors perception was that "good nursing" was equated with efficient fulfilment of their doctors' orders, rather than independent action or initiative. This dynamic is reflective of subservience rather than collegiality.

Other sociologists have commented that this form of action is co-terminus with wider gendered relationships present in society as a whole (McIntosh and Dingwall 1978; Witz 1992).

For some nurses then the strategy of action was to comply and acquiesce to doctors' orders, fit in and cause as few waves as possible: -

> *"Sometimes, like with the bloods and things they don't like doing it and we don't like doing it and someone has to do it ... that annoys us when we know that they have been visited by a GP and they have left the blood form, well that is a bit naughty really, but I suppose in the whole spectrum that is really a minor aspect" Interview – Sister Area 1.*

Here the issue seemed be not related to the actual task that the doctor was requesting the nurse to do but rather the process of the order and the manner in which it was executed. Other nurses felt that situations occurred because doctors were "sloughing off" (Mc Intosh and Dingwall 1978) their work to nurses. What ever the interpretation of these scenarios, it amounted to duplication of effort in the fact that the doctor had been in the house and could easily have taken the sample, lends support to the idea that the process was more about subservience, that this is my job and that is yours, than about collegial working.

This above situation has echoes with other research findings in which it was suggested that community nurses' direct subordination to doctors seemed to be a worthwhile trade off for district nursing staff in that by doing so district nurses gained more control over their case load (Mc Intosh and Dingwall

1978). In many ways, this is the reverse situation to one element of the traditional "doctor nurse game" (Stein 1967) where it is suggested that doctors sometimes comply with nurses' overt suggestions and recommendations to achieve an easy life. In these situations nurses often complied because they knew that the doctor could make life difficult by giving them inappropriate referrals. In the following excerpt from an interview this nurse reflects the contradiction inherent in this power dynamic: -

> *"I'm working for a set of doctors and the rapport is much better here than in other surgeries. They are never condescending and they want your opinions and treat you like equals. But I would never like to say that I can't do a certain procedure or no I will not do this, I have never refused to do anything, I wouldn't want to upset the doctors" Interview – Sister Area 1.*

What is interesting about this excerpt was that although the superficial relationship between the two groups seemed to be collegial, this nurse clearly understands her position in the hierarchy. It is well documented in the literature that control over the flow of work is the greatest cause of stress and discontent among nurses (Traynor and Wade 1994; Nolan et al 1995: Parry-Jones et al 1998). Participants in this study recorded their discontent around this area of work.

In the following unusual extract from observation, the district nurse showed how frustrated she was with the constant demands made upon her and her lack of control over the flow of her work: -

> *"We were back in the middle of busy afternoon, where (name) was calling to pick up a prescription for a dressing she needed to do that afternoon. She walked into the reception area and the receptionist said that there were two emergency referrals in the book that needed to be seen that day. (name) looked dazed and snatched the book from the shelf. She turned on the receptionist saying*
>
> *'I don't know how I am going to fit these all in today... I saw her yesterday the catheter must be bypassing, (raises her voice and shouts) what am I expected to do about it'*
>
> *The receptionist looked shocked and (name) snatched the book again and noted down the addresses and stormed out of the surgery" Observation – sister area 1.*

This form of action was a rare occurrence and the salient point here was that it was done in the relative safety of the reception area, to the receptionist in the absence of the doctor. Also important here, was that this nurse was a temporary nurse (bank nurse) and was due for retirement. Therefore, the threat of a complaint about her work was less important to her than it would be for the permanent colleagues whom she replaced. She did not belong to the practice and therefore could show her feelings. There was little doubt that the outburst would be recounted to the doctor by the receptionist but the situation avoided direct conflict between the nurse and the doctor. This situation was akin to "shooting the messenger" where the receptionist was perhaps viewed as being beneath the nurse in the pecking order of the surgery and therefore a safe target.

Doing What They Want Us To Do - Emergency Services

In spite of the fact that resistance could sometimes occur, it was the general case that nurses obeyed doctors orders. The following excerpt illustrates how for some GPs the extent of the business relationship with district nursing services could extend to emergency services that can be used when acute and sometimes serious problems occur in the home: -

> *DN: sometimes I think they expect too much from you, they expect you to drop everything at the drop of hat and it is not always easy to do and it is not appropriate to do, erm, but I think it is difficult.*
>
> *SS: so sometime they use you in an emergency or something,*
>
> *DN: oh yeah definitely yeah I think it was about 10 to 5 one night and one of the receptionists phoned up and I answered the phone and they wanted one of us to go out to a woman who had a fall and her husband wanted to phone the ambulance but she wouldn't let him and the doctor could not get out of surgery and they wanted one of us to go out, assess if she needed an ambulance or what, I don't think that that is appropriate I think that they should have gone out or called and ambulance from here cos we can't diagnose you know, and so it is very difficult,*
>
> *SS: so what did you do?*
>
> *DN: I told them that they should phone an ambulance, really and what I did I just decided to go out and phone an ambulance myself cos I wasn't taking any chances really and I went and just phoned, I didn't know if she needed to go or not really, but then at the end of the day I wasn't taking any chances.*
>
> *SS: but you felt that you had to go cos the doctor had asked you?*
>
> *DN: yeah and I thought of the woman as well so it was like I had to for her sake really,(Interview – Staff Nurse area 4)*

Although the situation was difficult, the doctor in this surgery felt that he could delegate responsibility to the district nurses to go out and undertake an assessment of this acute situation. It was clear that this nurse felt that the task was both beyond the scope of her ability and that on occasions, too much was expected of her. Perhaps the most apposite aspect of the findings here, was that it was observed that nurses in many situations could be "task doers" when it suited the doctor and assessors or skilled professionals when that suited GPs more.

When referrals of this nature were passed over they were generally never refused. However, the strategy often used by GPs was important in securing compliance. In the previous excerpt, it is interesting to note that this was a multi GP surgery, and the patient in question lived only a short distance away. The GP could have passed his own patients over to medical colleagues and visited the patient, instead he asked the reception staff, rather than contacting the district nurse himself, to request the visit. In adopting this strategy he essentially avoided the likelihood of refusal through making himself un-contactable. The patient was at risk and therefore the compulsion for the nurse to visit was obvious and compelling.

Like many of her colleagues, in all areas covered in this study, there was a general perception that doctors were increasingly using district nurses as an emergency service. This for many was a considerable change in their role and one for which (as indicated by the staff nurse cited above) they felt inadequately prepared. In other situations, district nurses were called upon to

go out and check bleeding and in one situation to assess someone with chest pain!

This form of work is traditionally the domain of the GP and is, for most nurses in this study outside of what they would define as their role. It essentially shifted their work from treatment and nursing care to diagnosis and associated with this was a perceived level of risk. The consequences of this type of action could be that the nurse may be placed in a situation which is both beyond her skill and experience. Another senior nurse from a different area suggested that this form of work was very stressful as she recalled being called to see a patient who might have been having a hypoglycaemic attack: -

> *"Just the other day I received a call on the radio to say that a patient was maybe having a hypo, I mean a hypo, I was like a mad woman trying to get to the house and see if the person was still alive. As it happens she was alright and the family were all there with her but I didn't know all this. I think now that I shouldn't have gone really but at the time, because of the patient and all that, and the drama of the situation then you have to really. They are buggers what they do to us sometimes and the situations that they put us in." Interview - sister area 3.*

Yet another nurse called this type of scenario the 4.30 syndrome. The sense was often recounted as being "dumped on". On return the nurse would be called to visit, last thing in her working day to see an emergency. When a call was received in this way (as opposed to the book, the normal method of referral) then they were invariably always responded to from a sense of urgency.

There is a suggestion in the literature from primary care settings that nurses can and do undertake some of the work traditionally performed by GPs (Stillwell 1991; Kinnersley et al 2000; Jarvis 2001). This work, by definition, medical work, is usually done by the ill defined species of nurse labelled "nurse practitioner" who has had some specialist or advanced training for the role (Jarvis 2001). However, these studies are limited to nurse's replacing GPs in primary care with specific disease related monitoring eg Asthma care or set procedures such as minor surgical or investigative procedures (Kinnersley et al 2000; Jarvis 2001). However, a common thread through much of this research is the formulation of strict protocols to which the nurse adheres. The participants in this study suggested that this extra work was organised and passed over through informal mechanisms rather than agreed procedures or protocols. These data assent with other research findings which suggest that there is disparity both in the structural characteristics of practices in terms of skill levels and the process of delegation and referral between members of the team (Jenkins-Clarke et al 1998; Jarvis 2001).

Getting a Visit

The previous section highlighted the way in which doctors sometimes expanded the work of district nurses and nurses they occasionally felt coerced and compelled to undertake work which was both risky and dangerous. By contrast, when nurses felt out of their depth with patients and needed a doctor's assistance or intervention then different rules applied and governed their interactions with GPs. It was generally held amongst the nurses in this

study that they should undertake a gate-keeping role for GPs, thereby controlling doctors visits and unnecessary or extra work: -

> *"they are generally fine, in reality when you are attached to a GP and you are their nurse then what happens is that you generally save them a lot of work, we manage people for them and save them having to do a lot of unnecessary visits really with them, we decide for them and then they rubber stamp things really so that we can just go, I mean I think if you are permanently asking everybody about every slight detail then you are not getting their confidence then fair enough but if then, then, then they know I want them to look at something they are always happy to go to somebody and you know skin problems and that or anything" Interview – Staff Nurse Area 4.*

It was clear their judgement criteria seemed to be the less nurses bothered GPs, the more they managed patients without referring to the doctor, the more reliable and trustworthy they were held to be. Therefore, it was frequently observed that requesting a GP to visit would meet with little resistance from GPs, as the filtering process established trust between the nurse and the doctor. Those nurses who "bothered" doctors least, found it easiest to get a visit when it was needed. It was constantly observed that this form of behaviour was so deeply entrenched that all but the newest recruits to district nurses generally took it for granted. The following young staff nurse described her induction to this process: -

> *"SS: So what is hard about it then (facing doctors)?*
>
> *SN: Going in and learning to face them really and presenting a case so that they would not argue with it, sort of making sure that by the time you get to them that you had either worked out what was going wrong and what was needed to be done, have all the facts really in case they try to get out of it some or something.*

SS: So being sure and accurate is important when dealing with GPs?

SN: Yes 'cos they go mad if the call wasn't necessary and so you make sure otherwise you go into the doctor and suggest what needs to be done or say that I haven't got a clue really then they have to go out" Interview – Staff Nurse Area 1.

Another experienced staff nurse indicated that the expectations on her could sometimes cause her significant worry and concern: -

"I think that they are very happy to leave us to our own devices and I thing they are sometimes a little bit unhappy erm when we erm ask them to look at things they we are not happy about, and that can cause conflict really, but you just dig your heels in really and don't bother them too much so that when you need them to go they generally go and do it, if it is something that I am not happy about, I don't get paid not to go home and not to sleep. I have responsibility to my patients and if I have a patient who I am particularly concerned about it and I want them to see it, I will ask them to see it, I won't be beaten down, and that can happen over the handmaiden routine" Interview – Staff Nurse Area 4.

Different nurses had different levels of confidence and consequently took greater or lesser risks with patients. The above excerpt highlights the pressure often felt by nurses to manage the caseload and avoid contacting the doctor, unless it was absolutely essential. This exemplifies the lack of collegiality and trust in the relationship between doctors and nurses and is indicative of the power dynamic between the groups. For the nurses in this study, it meant establishing a delicate balance between managing the patient and asking for help and assistance.

In some situations, nurses found ways to circumvent this process. Varying tactics were employed to overcome the problem of getting a visit. One strategy observed during the study was that nurses needed to be very explicit with GPs about their concerns: -

> *"I've been very lucky really ... I have got on very well with the doctors ... but there have been problems,*
>
> *SS: In what way? Can you give me an example?*
>
> *DN: I sometimes have to demand a visit when someone is not well and they don't like that.*
>
> *SS: How come you have to demand?*
>
> *DN: Cos they will do anything rather than visit but you make sure that they let them know you are concerned ... they would rather we just told them what we did ... you tell them that you have told the patient and the family that they will visit, so then they have to." Interview – Sister Area 3.*

Professional concern alone was sometimes not enough to secure a visit and so a second strategy was used; specifically informing the patient and the family that the GP will visit. In using this strategy, it was harder for the doctor to not meet her demands for a visit as the family would be expecting him or her to call. The notion of a potentially dissatisfied customer, either the patient or the family when added to the equation secured a response. This gives some insight to the effect that consumerism may have had on doctors in the community and how GPs may be being tamed by external forces other than collegiality and teamwork.

Throughout the study it was observed and suggested that GPs assessed and monitored nurses' interventions through their demand for complete and accurate summaries of district nurses' decision making and actions. GPs were often informed about the patient's condition so he could avoid being accused of neglecting his or her patients. The problem for nurses in this situation was that GPs do not deliver the care when requested and therefore are not responsible for it. This potentially places the doctor in a win/win situation whilst the nurse could possibly be in a lose/lose encounter with the doctor. Although the motivation for the strategy employed by doctors was often recounted as being the avoidance of extra work by nurses, the implications and modus operandi once again left nurses in a potentially risky situation.

Sometimes, this strategy, when used by GPs, had a disciplining function secured through a process of confrontation which had the effect of producing conformity to this process of subjugation. Young recruits to district nursing often learned the hard way that their reports to doctors needed to be comprehensive, well structured and thorough: -

> *"SN: occasionally when you have been to speak to a doctor and they have made you feel stupid, then that is a bad day ...that can sort of make you feel a bit shitty really,*
>
> *SS: how do doctors do that then, make you feel stupid?*
>
> *SN: it is usually when they know something about a patient but have not told you and you go in and ask them something and it has already been investigated and that, and you know, they make you look small in front of other doctors and the office staff and that by intimating that you should have known about it, even when they haven't ever told you. Again it is about*

communication and sometimes they expect you to be telepathic really. So that makes you look stupid, even though you couldn't have known. They make it look and sound like it is your fault rather than theirs for not telling you in the first place." Interview – Staff Nurse, Area 4.

In this situation, it was clear that the doctor was actively drilling the nurse into proper action. In these encounters the implicit implication was that the strategy of holding on to information was one way in which doctors could actively secure deference and maintain power over district nurses. As previous sections have highlighted, access to the information essential to patient care was often difficult to secure for district nurses. The onus for knowing this information however, appeared to be placed with the district nurses. These data suggest that the relationship between nurses and doctors was terse and strictly governed. Pragmatically, the doctor had to rely on the quality of the nurses' information if he or she was to be saved a considerable amount of work. In the final analysis, the once removed decisions he or she made in terms of prescribing antibiotics, changing treatments or prescribing other drugs meant that his or her decisions were limited, either to trust the nurses' assessment and prescribe or to act and do the visit and take on the extra work. The following (disturbing) excerpt from observation illustrates this tension : -

"we approached the surgery and (name) met the staff nurse, they both seemed nervous. We entered and the district nurse approached the doctor, a huge big man and suggested that her patient had become sicker (more terminal) and needed a diamorphine pump prescribing. She seemed very sheepish. He told her that she could not have one because the man was OK. We had just left his house and the man was losing consciousness and was in pain. She told him this and he said that he had seen the patient yesterday and he was OK. He

became aggressive in his tone with her. She said 'look I have just seen him and you don't scare me with that attitude, I want a pump' Reluctantly, he snatched the prescription and signed it. As he left the reception area he said 'fucking sister death'. Everyone was quiet and embarrassed – I felt furiously angry." Observation – Sister Area 3.

The most startling point about this piece of interaction was the open disregard and challenge of the nurse's decision and request. Her counter-challenge was difficult and bold and required a considerable amount of resolution. Importantly, she got what she wanted but not without direct conflict and considerable emotional cost to both herself and the staff nurse.

In rare situations it was found that nurses sometimes refused to engage in this form of interaction with doctors: -

"SN: I don't stand for it really, I am always getting into trouble with him (GP) and the trust

SS: What sort of trouble how?

"SN: Well just before I went to see him about something and he wasn't busy, I had checked with the receptionist, he was just sat in the office and I went in and said I need you to prescribe some antibiotics for Mrs (Name) and I she needs them desperately she has got a chest infection, and he said I can't do it now cos I am busy, so I said, well I just asked the receptionist and she said that you were free, so if you can't do the prescription now, I am on my way to her, then you will just have to go out and do a visit then and see her yourself. I walked away, he came running after me with a prescription. I just won't stand any of their messing. But he said to (Sister) that he would prefer it if she did all the communication with him really so that I could be kept out of the way, he is always having a go at sister about me," Interview – Staff Nurse Area 3.

This nurse broke the general rule adopted by many district nurses in which the patient comes first. Had he not have signed the prescription then the patient

may have suffered. However, this nurse was atypical. One noteworthy characteristic of this nurse was that she was a highly political person belonging not to the standard union common to many nurses in this study, but rather a more radical health care organisation. This may account for her somewhat rebellious and atypical response. It is interesting to note, that the consequences of this behaviour for this nurse was that the doctor refused to have any further face to face contact with her and informed her direct line manager of this sanction. This nurse, however, rather than viewing this as a punishment chose to frame it as a blessing!

The problems of getting a visit and seeking assistance were rarely observed in the practice which had salaried GPs (area 2). The ritualised and confrontational behaviour outlined in the previous sections did not occur within this remarkably different location. Instead, it was common place to observe mutual respect and collegiality between nurses and doctors and requests were presented in such a way that professional opinions of the nurse were called upon rather than demanded. The mutuality between the two groups extended further in this study site when compared to other areas. It was commonplace in this particular practice that when the nurse was unsure or uncertain of any area of her practice then she had little reservation about enlisting the help of the GP: -

> *"We arrived back at the surgery, where (name) had just seen a lady in the terminal stages of HIV disease. She was pyrexial and was refusing to take her anti-pyrexial drugs (paracetamol or aspirin). The nurse met the doctor and asked to see her. She outlined the problem and the doctor listened carefully and intently to what she had to say about the patient and her*

condition. Neither could come to a decision about what would be the best course of action about for the patient. They bandied about different suggestions, which they both felt would not work. They discussed their different methods and at the end of the discussion, the doctor said 'lets both go away and think about it and then we will meet at 1pm, discuss what we come up with and then both of us can go and see her together – a united front thing hey' (name) seemed happy with this and she left the surgery. I was struck by how atypical this encounter was" Observation – Sister Area2.

The interactions between the doctors and nurses here seemed to be less governed by the rules outlined above and more by mutual respect and importantly, trust. They highlight further, the distinction between this and other areas of the study.

Complaints

There was a direct sense of threat among many of the nurses in the study that if they failed to respond to the daily demands of the doctor then it would have serious implications for their work, which could lead to complaints: -

"DN: You have to meet them and respond to their referrals as they make them

SS: Because?

DN: If you don't they complain, then you get it" Observation – sister area 3

In this particular situation, getting it could mean a particularly harsh public humiliation in front of receptionists which most usually took the form of a dressing down in front of other practice staff and colleagues. Alternatively, it could mean a formal complaint by the GP to the Trust manager following

which the nurse could be admonished for failure to comply to the doctor's request. All the nurses in the study were aware of how these complaints systems worked. They knew of colleagues confronted in this way and were aware of the consequences of not responding to GPs demands. Annadale (1995) in a qualitative study called this process "being singled out," in which authorities use personal accountability to admonish individual members of staff. The data here are consistent with her findings as the following two excerpts show: -

> *"Last week I just had a terrible time and we just had to get on with the work. The doctor had a go, I had a right telling off – he really went off, shouted at me in the surgery." Observation Staff Nurse – Area 2*

> *"We got to the surgery and (name) had forgotten (deliberately I found out later) to do the emergency enema she was told to do yesterday when I was out with her. The doctor met her at the door and publicly announced that Mrs (name) had been in agony all night and he was debating sending her to hospital. This was said in front of a health visitor and other reception staff and was in clear hearing of the patients sat in the reception area. (name) was quiet and blushed and I felt furious" Observation Sister – Area 1.*

It became clear that in certain situations doctors claimed the authority to discipline district nurses publicly. Inherent in the above quotes was a sense of vulnerability among district nurses. The doctor framed his criticism to cause the nurse to feel guilty, notably that the patient suffered and this was the fault of the nurse.

It is noteworthy that the practical strategy used by the doctor has maximum impact on the nurse. In this situation the nurse was not legally accountable to the doctor. She was, however, accountable for her actions with patients (Dimond 1997; Nash 1996). The doctor openly challenged her for failing both

to follow his instructions as her employer and also admonished her for leaving a patient suffering. This represented a direct threat to her professionalism and responsibility to patients.

For some nurses in this study, this dual threat from doctors (as employers and as overseers of their work) was particularly coercive. In this situation this particular nurse responded by showing her guilt and embarrassment. This has direct links with Foucault's notion of the normalising judgement (Foucault 1977). It is suggested that in a hierarchically organised system, normalising judgements are used to measure gaps in performance and deviations from what is expected of workers. Thus the normal expectation in this situation would be that the work would be done and the nurse would not challenge the doctor's authority by failing to complete the work. As a disciplinary mechanism such judgements about their work were used to castigate nurses if they failed to meet the required demands. It is important to note that the way in which this punishment (it was experienced as punishing by both nurses) was delivered, left nurses feeling helpless to argue, played on their sensibilities and left them fearful of their position in the surgery.

In an ethnographic study of a medical ward it was found that the nurses were aware and fearful of this form of expression of medical power (Mackay 1995). Particularly they were fearful of a public dressing down and the humiliation associated with this form of discipline. The data presented here concur with these findings. The data were littered with references to how lucky the respondents in this study were in comparison with other nurses who had

difficult and sometimes troublesome GPs. The unlucky nurse was the one who was exposed to this type of punishment outlined here.

A consequence of this form of action was that the majority of nurses in this study would seldom refuse to undertake work given directly by the doctor. There is a plethora of literature which describes bullying at work (Adams 1993; Spiers 1995; Cole 1996; Paterson et al 1997a, 1997b). Indeed one commentator defines bullying as: -

> "a sustained form of psychological harassment which tends to come from a manager or senior colleague" (Spiers 1995, p 381).

Of particular importance in the process of adult bullying or extreme coercion, is the notion that in adults, the victims of such abuse do not perceive themselves to be in a situation where they can act to circumvent or even prevent the bullying occurring (Paterson et al 1997a; 1997b). It is important to note that the data presented in this study suggest that some nurses felt that they could not complain about their treatment in primary care, not even to a higher authority; ie Trust managers. In part it was suggested that this occurred because of their precarious contractual status within the practice setting and partly because they were made to feel that all the fault and blame lay with them: -

> *"Well it is really funny here, because we get lots of support from each other but not from our Trust managers. You know they will not support you at all, they are too worried about contracts and losing one and all that crap. So you know that if a complaint gets back to them then they will hit you like a ton of bricks, they*

> *come down really hard, particularly if it comes from a precious GP." Interview – Staff Nurse Area 2.*

It was particularly interesting to note that even though this staff nurse works in the most "collegial" of study sites, she still felt that obedience and the avoidance of complaints to be extremely important in her work. She was aware that she would not be supported by her managers. Consequently, some nurses felt that it was better to get on with it than argue; -

> *"I just carry on as best I can ... nurse my patients and try to fit in with what is going on around me, but it is a threat, not being able to do the work is a threat." Interview – sister area 1*

Infrequently, nurses' overtly refused to take doctors' orders. When this occurred, it was met with severe and penalising consequences from both the doctor and their trust managers: -

> *"In the last surgery I was in one GP phoned up at 4.20 on Friday afternoon, telling the DN to go out and sort an alcoholic woman out! We were put upon by him (the doctor) in the end I told her to tell him to fuck off, she was really abused by him, we all were, she got into terrible trouble about it all though ... she was moved, we were all abused by him, I just out when I could" Interview – Sister Area 3.*

It is clear from this excerpt that these nurses must have been quite desperate to react and respond in such a way their relationships had become so fraught that breaking point was reached. Sewell and Wilkinson (1992) in an observational study of a UK based Japanese firm, found that the certainty of public humiliation invoked a powerful disciplinary force on the workers in the workplace. In their study, it was found that quality assurances mechanisms

(or normalising judgements, Foucault 1977) meant that when a worker failed to perform, they were publicly punished and disciplined. In this situation, this nurse committed a cardinal sin, by retaliating against the doctor in an abusive way, for which she was correspondingly removed from her work place. The import of this managerial or organisational strategy was the effect that this public display of power had on other district nurses. News of this and other similar incidents travelled fast among district nurses and the threat and punishment dealt out in this way, reached the ears of many of these nurses' colleagues with great speed. As Sewell and Wilkinson (1992) argue such coercive threats penetrate: -

> "right to the very core of each members subjectivity which creates a climate in which self management is assured" p284.

In essence, it has been argued in the literature that resistance to this form of power would be unlikely. However, whilst the non-resisting passive response outlined above was the most commonly encountered strategy to this form of organisation there were instances were resistance to this coercion occurred.

Forms of Resistance

Bargaining

In some situations it was noted that nurses were sometimes able to bargain with the doctor who makes the referral, as the following piece of observation shows: -

> *"We were in the surgery, and (name) picked up the book and noted that there were three referrals, two for blood and one for a wound check. As she was checking the book the GP came into the room. She turned to him and said*
>
> *'I am really busy today Dr (name) if I do the dressing, can I leave the bloods until the morning?'*
>
> *He looked directly at her and after a pause said'*
>
> *'I suppose so, but they do need doing sooner rather than later' Observation – sister area 2*

What was important about this excerpt was the language that the nurse used. Essentially the nurse provided the GP with a situation in which she had prioritised her work and came up with a solution for action which was likely to be acceptable. Once again, this was indicative of the power relationships between the two groups. In essence, nurses had to justify and explain their decisions whilst doctors seldom, if ever, had to.

Regrouping

One strategy of resistance was to gather team support. For some teams, the space that they occupied as team members afforded them privacy from the rest of the primary health care team. It represented a forum in which they could discuss their problems and workload away from the "prying eyes" of the practice staff and doctors, which was sometimes experienced with great intensity: -

> *"we were very lucky, ... although we are based in a GP practice we were linked with 4 other practices so there was a wider (nursing) team, erm, so we did have a lot of support and we used to have a whole lot of nurses outings, a lot lunches out at times (laughs) so we did, we could sort of express it, erm stress, I know there things in the trust like staff counselling but I mean whether any of the others used it I don't know, I tended to find that if I could talk to colleagues and say, that was enough for me" Interview – Sister Area 3.*

This sister implied that the stress experienced by her colleagues was sometimes so acute that professional help was considered as an option. It is well documented in nursing literature that exclusion from a working team leads to stress and distress. In particular it has been suggested that burnout (Nolan et al 1995;) results when perceived self efficacy and self esteem is low and particularly when respect, intellectual stimulation and feedback from super-ordinates is lacking (Churniss 1989; Traynor and Wade 1994). These reports support the data presented here.

The data presented in this study, seemed to suggest that the experience of stress was related to the extent to which district nurses sensed their

peripheral and excluded status. Strategies were encountered in the data to deal with the nurses' felt sense of isolation from the team. Informal peer support seemed to be the most commonly encountered reaction to the sense of exclusion from the team. In area one this was easily achieved because although the nurses were attached to a GP surgery they were actually based at a communal site. So in this situation informal support was readily accessible:-

> *"and sometimes you would say to a member of the team, 'are you having a bad day? Come and have a coffee with me' very very supportive of each other but it definitely did come down to a them and us, but they were causing it in the first place really, if they'd been less threatening it would have been the way they used to be (before fundholding) it used to a very happy practice but, err, me and the girls just dread going to work which is sad.*
>
> *SS: That sounds really really hard, like you felt that the only support you could get was from colleagues – and there was a big tension between you and the doctors, it feels like you are saying that you find it difficult to motivate yourself to go to work?*
>
> *DN: Yeah, yeah we all do" Interview – Sister Area 1.*

This nurse described the polarisation of the nursing and medical staff and the strategy of informal support to counteract this.

The data presented by participants in the study reported here suggested that the stress experienced from being excluded was felt more by the senior nurses encountered in this study, particularly, as the above nurse indicated if they had had a more collegial relationship with doctors before fundholding. This finding has support in the literature. Nolan et al (1995) suggested from a

survey of 1640 nurses in one health authority (return rate 41%, n= 676) that two factors seemed to be dominant in nurses' understanding of satisfaction and morale; their ability to deliver good quality care and good collegial relationships. These authors also found that an already fraught and stressful situation was perceived as worse when a failure to inform and involve staff co-existed with a perceived lack of control over their workload. This supports the data presented here, where district nurses described a situation in which they felt excluded from the power base in primary care. The strategy of action therefore, tended to be a regrouping among immediate colleagues against their perceived assailants.

In areas two, three and four, the majority of the nursing teams were actually based at the GP health centres in small, self contained teams and therefore did not have access to other colleagues who worked in other health centres. Nurses exposed to this type of organisation frequently reported having lower morale, higher stress levels and found patient related work more difficult to get through: -

> *"DN: Well to tell you the truth I have actually got to rock bottom were, my morale is so low it is like sometimes I am a leper or something, they all avoid me when I come in, I am completely stressed out trying to get through my work and communicate what I need to and they are just not interested in what I have got to say. It is having an effect on the team as well, we just don't feel valued at all. It is not that we don't value our work, it is that they just have no idea what we do.*
>
> *SS: That sounds really hard, not feeling like you are being appreciated, and how difficult it seems to get through your work because of the lack of communication, it causes you stress?*

DN: It is, it is it is exhausting some times just trying to get through the work and not feeling part of the team." Interview – Sister Area 3.

For some nurses this situation was made worse because they felt that they were not supported by their own Trust managers who were more concerned with keeping contracts than with the problems faced by district nurses:-

"SS: So I mean that sound like a really difficult situation to manage, what you are saying is that collectively you sort of support each other but there's a sort of them and us?

DN: Yeah Yeah there is, there is and that is a strain as well, I mean just doing that all the time (watching your back). But the other problem was that management were supportive to a degree but wanted to keep the contract so they were keeping very sweet with the doctors as well, so you didn't feel that you had 100% support off management, which again is very unsettling because you think well which way if it ever come to a head which way would they go. And I don't think that they would side with nurses but at the same time the Trust is a business as well so they want to keep contracts." Interview – Sister Area 3.

Here the inference was that this nurse, like some of her colleagues, felt that she did not really have support of either her managers or the doctor. It therefore made the prospect of challenging the authority of doctors very difficult.

Working the Contract

It has been suggested that the contracted in status of district nurses has had a powerful effect on their perception of work. The following excerpt typifies the

way in which this aspect of their standing in the primary health care team invades the consciousness of district nurses: -

> *"In lots of ways they have become very demanding in what they wanted us to do, when they want it, and I want it now sort of thing ... It's unpleasant, and it was raised with them by us and it is a case of we can get cheaper nurses from (name) area, and we said 'aren't you happy' and they said 'yeah we are very happy but we have to look all the time to see if we can get better, they don't see that it is putting a lot of strain on everyone." Interview Sister – Area 3*

For many nurses this direct, controlling form of subjection was constantly at the back of their minds: -

> *"it is always on the back of your mind ... a couple of years ago our district lost a surgery, I think that it came home then really, we all felt threatened, GPs going over to other services and to other areas for contracts" PO Sister – Area 1*
>
> *"I think that we all feel threatened by contracts, make no mistake if they found something cheaper they'll take it won't they?" Observation – Sister Area 4.*

This form of pressure and threat associated with working to contract occurred even if there were ostensibly good relationships between the doctor and the nurse. In the following excerpt, this young staff nurse, new to the community nursing offers a novice's account and illustrated how the situation and interaction with GPs was very different to the relationship she had with doctors in hospital. Pessimistically, she stressed the notion of the contractual obligation and linked this to an old notion of being a handmaiden: -

SS: How do you work with General Practitioners here in the surgery, some people have said that working with fundholders is sometimes difficult?

SN: I think that legacy is still here from fundholding really, I have noticed it here really, and I think in a lot of ways I think that that is a hang on from the past in many ways you know the hand maiden situation and I think fundholding just exacerbated that really, erm, you have doctors saying we are buying in nursing care and you work for us and all the rest of it, erm, in a way I think the reforms in the health service have gone some way to address that but it is literally just wait and see really... So there is no sort of equality really, there can't be when they are paying you to do essentially what they want. They hold the contract at the end of the day." Interview – staff nurse area 4.

In this candid account of the inequalities that exist in primary care, it is interesting to note that she made little reference to different levels of expertise which it is suggested in the literature accounts for status difference between the working practices of doctors and nurses (Hughes 1988; Porter 1991; May 1992; Mackay 1993; Svensson 1996). Here she instead focuses on the contractual and employee-employer relationship. The following excerpt in contrast to the above highlights how this district nurse was actively "working her contract" and keeping the relationship with the GPs on a firm footing as in the near future they very well may be afforded greater control over her work: -

"... at this practice I am in now, it's a very nice practice they are nice people and I'm keeping it like that, not just me (name of manager) came in and she said she'd noticed it so, erm, with all these changes in the White Paper, self governing primary health care teams and all that, keeping them up to date with what I am doing, making myself seen and letting them know my capabilities" Interview sister – area 3.

This finding is in direct contrast to recent policy documents and commentators which suggest that a more collegiate structure will result from the changes primary care and the move to Primary Care Groups and Trusts (DoH 1996a; DoH 1997; Dowell and Neal 2000; Wilkin et al 2001a; 2001b). Here the suggestion was that some district nurses felt that they had to side with their general practice colleagues in order to secure a future. She was selling herself so that when change occurred, her role in the new organisation would be appreciated.

Breaking Through

One consequence of being organised by GPs was that some nurses believed that good care could only be provided by being integrated into the primary health care team. Therefore, they had to develop mechanisms to break through the barriers to integration. Breaking through the barriers that excluded nurses from the inner team required considerable stealth. For one nurse, the chosen strategy was to keep chipping away at the GPs in order to get her team in the primary health care meeting: -

> *"I spoke to them in January about this, and I said ' can we start the year off the way we mean to go on?' and the way it should be, and err, it got brushed under the carpet, quietly forgot AGAIN and then recently cos one of our colleagues is on the PCG and sent a letter out which they said they must include community nurses in the meetings, and err so, we spoke to the practice nurse saying that we feel left and she bless her went and spoke up for us saying that I think that the community nurse should be involved in our meetings, and the two clerical managers objected to it saying is it necessary, why do we need that all that. Why they should have so much power over the General Practitioners I don't know, cos we are the primary*

> *health care team cos health is ourselves not the clerical managers really and erm, one of the doctors stood up for saying we should be there. Even then we were given an ultimatum just the health visitor and the senior sister, but they have still not said it to us and suggested it, and one of the doctors said 'if it keeps them happy' sort of." Interview – Sister Area 4.*

It is notable in this excerpt that this nurse considered her team to be absolutely integral to the primary health care team, when it was clear that this view was not shared by three of the four doctors and astoundingly the administrative and unqualified support staff, who seemingly had a say in the composition of the team. In spite of her attempts, she had to resort to enlisting the help of other nursing colleagues to secure a position in the meeting. In contrast to the previous section where the practice nurse was seen as being "on the doctor's side" here, this nurse used her colleague to assist her in the process of breaking into the team. Despite her efforts at integration, it seemed that the only reason she was eventually allowed in the team was the fact that another colleague, a PCG member, knew of her situation and sent an official letter!

In contrast to this another nurse described how she tried the above strategy with little luck and so drastic measures were adopted: -

> *"but I'd gone down to see a GP about a patient, and at the end of speaking about that he said to me, I see you were at the meeting on Monday for the primary, you know, the primary care groups and all that set up, so I said, oh yeah, and I said to him, something like, well I'm not half pissed off, I don't know where I got the courage to say it, so he just looked at me and said, why what do you mean? ... and I said, well there is no meetings here what so ever, I said, I've never felt*

> *so isolated in my life, I said, the fact that I'm not in your surgery is part of the problem I'm up in (name) Street, but I said, there is no communication, I'm standing out in that reception area waiting to collar one of you, so he said, I know it's difficult, he said, the health visitors and the practice nurses have the same problem, and I said, well yes but I said, the practice nurses are here all day, every day, the health visitors are here for 2 afternoons a week, well I'm not, and I said, I've got to the stage where I feel so isolated that my morale has just hit rock bottom and he just looked at me, so he said, well what is it you want then? so I said, erm, I wouldn't mind a meeting between the GP's and the district nurses, and he come back at me and said, well if you want a meeting you are going to have sell yourself and do you know what, I don't very often get angry but he really angered me, and I said if you think I'm going to come down here and sell myself to you, I said, you can think again ... you are supposed to be the leader of the primary health care team and if you think I'm going to sell myself to you, you are not on, and he said, I didn't mean it like that, so I said, whatever way you meant it, I said, I'm not having that. I said, well let's get one thing straight, it's not a social event I don't want to come down here and make small talk with you, I said, the starting point is to talk about the patient, I mean, he was shocked, he said, erm, talk about the patients, I said, how about if I bring my cardex down here, my case load, and I talk about the patients with you, and he said, well I'll have to discuss it with the other partners ... A couple of days later, I goes in the practice manager collars me, we are getting that meeting sorted out for you, the secretary come out, we are trying to arrange a date, shake up here, so last Friday I went in again and I saw him and he said, oh I saw the practice manager and she said, we are going to have these meetings, this meeting sorted out for you and I have delegated 1 GP to come to your meeting" Interview – Sister Area 3.*

For some nurses then, it appeared that every inch of concession had to be fought for. The data presented here suggest that in certain study sites, nurses had to be exceedingly forceful and sometimes aggressive to secure even the most basic of access arrangements to the primary healthcare team meetings. It is remarkable that this finding echoes very early research findings which suggested that community nurses were often structurally located outside the

practice configuration (Mc Intosh and Dingwall 1978) and that this is a consequence of the fact that the actual structure of the primary health care team eludes description or evaluation (Jenkins-Clarke et al 1998; Jarvis 2001). Others have found that difficulties have always (and still do) exist with the integration of nurses in general practice (Williams and Sibbold 1999) and that professional self interest, both inter and intra-professionally are barriers to integrated team work (Griffiths and Luker 1994; Goodman 2000). The data presented here lend support to these findings.

Confrontation

Some nurses openly challenged GPs, which conflicts with view of the passive subject often portrayed in the literature (Sewell and Wilkinson 1992) and supports other evidence that much of the literature on resistance in the work place paints an overly deterministic picture which rules out the active subject (Knights and Mc Cabe 2000). Sometimes, nurses in this study presented themselves and resisted medical power and managerial control by confronting the compulsory designation of task related work by portraying themselves as assessors of care rather than simply a doer of tasks: -

> *"sometimes they still want us to do the basic and expect that we do them really and we try to tell them that we are not doing that anymore and make of point of saying when they say 'I would like you to go and do such and such' that we say 'yes well I will go and assess such and such and then I will let you know what I decide', it is sort of like a game really trying to get them to come around to our way of thinking really." Interview – Sister Area 1.*

Here this nurse resisted the direct order to undertake the doctors' prescribed work and she correspondingly took control of the situation. In essence she asserted herself and confronted the power dynamic. Porter(1991) labelled this form of interaction "formal overt decision making" although in his study he suggested that this seldom occurred in nurse's interactions with doctors. These findings support his optimism that when the nursing process (a counter discourse to the medical discourse and the concomitant power relations) was used to support their interactions with medical colleagues then an alteration in the super-subordinate relationship between doctors and nurses could occur. In this way, she forced the doctor to see her as a professional in her own right, not just as an employee, subordinate or handmaiden. Another nurse indicated how she played the game of letting the doctor see how much she was capable of, much in the same way as the previous nurse: -

> *"I don't get many referrals from GP's I get phone calls to say can we go and order a backrest and I say 'no I will go and do an assessment' and the man for the backrest was the man who needs re-housing, I actually made 3 visits there just about, about 4 hours work there and I could have just picked the phone up and ordered a back rest and not even gone to see him and the GP didn't expect me to go and see him, which was initially what I was getting at with him, they don't know what we are capable of ... I actually heard myself say to him, which I don't know how he kept his face straight, I said, you've no idea of the services I can provide (laughs), ... I think I've sort of forced this issue now, so what will come of it I don't really know," Interview – Sister Area 3.*

It is important to note that excerpt highlights how "standing your ground" (DN area 3) could have positive outcomes for both the patient and the nurse and held the potential to alter the relationship between the nurse and the doctor.

As discussed earlier, often the designated job could be done as a task and consequently important care issues could be either passively or actively overlooked or ignored. It is also noteworthy that this particular district nurse had had an overt confrontation with the doctor which allowed her to "force this issue" with him. In taking this stance, she effectively began to make her own conception of her work more visible to him. In both the situations outlined above, these nurses seem to be antagonising the strategy of control (Foucault 1988; May 1999) imposed by the doctor and in doing so they confronted the power imbalance between themselves and doctors. This was a courageous and admirable stand against medical and managerial power. However, as both these nurses worked in isolation at their practices and it was potentially easy for medics to counter balance their attempts at challenge with a range of strategies and tactics (May 1999).

Some nurses avoided open confrontation in favour of a soft metered approach, as one staff nurse suggested: -

> *"I mean it is like you know, when you go and see them you sort of have to let them see that you actually do more than an enema, you know that you assess people and all that so you make it obvious to them, but it is a case of tread carefully, but it can be done. You don't have to just take orders, you can do your own thing once you are out there." Interview – Staff Nurse, Area 4.*

It is important to contrast these findings with the data collected from area 2, in which this process and counter-strategies of resistance played little part. Essentially, the main difference in this area from the other areas was centred

around the fact that each separate discipline (GPs and district nurses) had a clearly defined remit and nurses, as has been noted, were salaried along side the GPs.

Resistance through expertise

Whilst the above data indicate that the relationship and trust between doctors and nurses was essentially tenuous and rule bound, in all areas nurses could resist doctors' decisions by claiming their own expertise. In very many observations, it was clear that nurses' decisions went unchallenged and that doctors were happy to conform to the decisions made about wound care by the district nurses. Prescriptions were left and were seldom questioned, and the nurses' decisions most often went unchallenged. Specifically, district nurse's management of wound care often commanded the reluctant compliance of GPs to nurses' decision making, as one nurse suggests: -

> *"and one GP wanted compression bandaging on a patient's leg ulcer and I said I was not prepared to do it until it had been dopplared and when it was it was arterial and I came back and said, yeah there is no way I am putting compression on this leg, you know, you have not investigated properly and you know, I'm not prepared to do it and be compromised that you are doing dressings and not putting dressings on" Interview – Staff Nurse Area 2.*

In this situation the nurse felt certain and assured of her actions and realised that the doctor's decisions would have compromised her work with the patient because it ran counter to best practice and indeed could have been harmful.

In similar situations nurses had little problem in being direct in overtly refusing to follow the doctor's instructions as they were able to support their actions with solid evidence and protocols. Likewise, other nurses in the study seldom met with resistance from doctors when they initiated treatments for wound care although as one nurse acknowledged, the process of deciding care was not without the possibility of conflict: -

> *"I can honestly say that I have not had any bad experiences with them but yes you do meet some that are – they are not very good at accepting our role now either, they can be quite unhappy with any progression we have made I know that some of them haven't been happy about the nurse prescribing worrying exactly what was going to happen and how if was going to infringe on their budget and not progressive thinking and sometime they still want us to do the basic and expect that we do them really and we try to tell them that we are not doing that anymore" Interview – Sister Area 1.*

Here the suggestion was that the newly expanded and endorsed situation in which district nurses could prescribe from a basic formulary of dressings and medication has met with resistance from some doctors. In many ways, the ability of the nurse to decide not only her own care but the necessary prescribed medication and dressings has gone someway to free district nurses from the power doctors held over them. However, the situation could arise whereby the district nurse would not need to consult the doctor at all during the entire time she nursed the patient. The patient had, in some situations, become entirely managed by the district nurse rather than as was previously the case, where care was endorsed, checked and rubber stamped by the GP. It is interesting to note, that this district nurse highlighted the fact

that the source of resistance to this progression was not about relinquishing power on the part of doctors, but rather the financial implications of district nurses decisions. It is notable that even in area 2 (a usually collegial and supportive environment) the situation of having to justify the cost of dressing material was observed. This was a most atypical type of interaction as the usual state of play in this site was one of respect. One care manager indicated: -

> *"Erm, we are very careful about dressing materials and that sort of thing, now if we can prove that a expensive dressing is going to be the most comfortable, the most effective and that usually means they are the most efficient, but we do a lot of conversations and try and balance that. If we use a good dressing product we don't have to change a dressing every day, if we use a cheap dressing product we have to change it every day and that sort of thing and also I think using our skills effectively" Interview – Sister Area 2.*

This district nurse suggested that in order to achieve the best level of care there seemed to be a system of justifying and proving the effectiveness of her decision making if she chose to use an expensive dressing. It is clear that her logic was sound and evidence based but the process of decision making was highly influenced by economic factors, which she will be called to account for.

Summary

The data presented here have shown the attachment to GP has brought district nurses into a close contractual relationship with GPs. This relationship is hierarchically constructed with GPs at the top of the hierarchy, through which they control the primary health care team. District nurses were often observed to be on the periphery of this team and their involvement in the management and organisation of the working primary health care service was variable. Sometimes district nurses were actively excluded from the machinations of the Primary Health Care Team, at times they were visible but peripheral. At other times, they were reluctantly included into part of the inner working of the primary health care system but were invariably distrusted as members of the team. Rarely were district nurses fully included into active team membership.

The peripheral status of district nurses in the Primary Health Care Team fits with the post-modern organisational principle of superficial involvement of hired or replaceable workers, which was secured through their external contracted status rather than core working standing. Correspondingly, for many district nurses a good deal of their work remained hidden from the GPs.

A great deal of deference to medical authority occurred in the data. This was not only the result of the traditionally observed deference to medical knowledge, which sometimes occurred but rather submission to the threat of being an (albeit indirect) employee of the GP. Where nurses played along

with this system of domination, elaborate communication strategies were employed between the two groups.

District nurses resisted medical power. Whilst some actively sacrificed their own status and played the game with medical colleagues, other nurses sought and successfully broke through the exclusionary mechanisms and secured some standing within the Primary Health Care Team. Others resisted their oppression by claiming nursing expertise either as a professional assessor and prescriber of care (nursing care rather than medical care) or by using the expertise they had over their medical colleagues in areas such as wound care.

Where the literature has described doctor nurse communication as a game (Stein 1967) these data indicate that the relationships endured by district nurses in the Primary Health Care Team did not resemble a playful pastime.

Chapter 10 - Overview of Methods and Discussion

Introduction

The aim of this chapter is to explore the methods and findings presented in this thesis. Part one will examine the theoretical underpinnings of the methods used in the study and evaluate their value in achieving the aims of this inquiry. There will be an examination of the positive and negative aspects of the methodology adopted in this thesis. Part two will review the key findings and present the distinctive contribution this thesis makes to the knowledge of district nurses' work. Part two will also relate this new knowledge to current policy on the organisation of district nurses' work.

Section 1 - Strengths of the Methods

The aims of this study were to examine how the changes in the organisation of primary care were affecting the work of district nurses' and to establish what factors shape district nurses work on a day to day basis. To that end the use of participant observation, informal conversations and polyphonic interviewing have facilitated the presentation of data which gives the reader detailed insight into the working life of four distinct groups of district nurses.

The findings sections of this study have presented data on the changing nature of district nurses' work, the re-organisation and management of their work place, the role of district nurses in the rationing of their services and the

day to day relationships they have with other members of the primary health care team, particularly GP's. Apart from a small number of research papers, these data present new information and knowledge about the work of the district nurses.

In order that the reader may assess the robustness and rigour of the methods employed in this thesis, in line with post-modern thinking, a detailed account was provided of the decision making process involved in this inquiry. To further facilitate the judgement of how trustworthy the data in this study are, long extracts from the detailed data set were purposively included in the text. This was for two reasons. Firstly, the publication of detailed extracts from the data enable the reader of the text to assess whether the story presented in this thesis is a plausible interpretation of the data. It should also allow the reader to think and develop other interpretations of the text and therefore stimulate debate and even further research. Secondly, as the data suggest, district nursing is a changing discipline. The descriptive nature of the observational data has captured elements of participant's work, which may in the near future, disappear from the repertoire of district nurses' work. It therefore adds to the historical body of literature available to the profession at future times.

One unique aspect of this thesis was the employment of the polyphonic interviewing methods. This methodological tool allowed the data to progress naturally to the conclusions presented in this study. This method also produced a sense of diversity and contrariety in the data that would have been

lost had I adopted a more structured (eg grounded theory) approach. One area where this method was most productive was where district nurses juxtaposed their current working practices with the way they used to work. These comparisons were important to participants as a reference point of change and from an analytic point of view, the juxtapositions gave a sense of history to the final text. This important aspect of the data may not have occurred had I taken a more proactive stance in the interview sessions. It is also important from a methodological perspective as it is noted that a classical criticism of ethnography and ethnographic studies is that they are often conceived as being a-historical in their analyses and as such are merely snapshots of the action at a given time (Hammersley 1993; Marcus 1998). Following the polyphonic technique and capturing the insider's perspective, helped to locate contemporary district nursing activity and organisation in a richer framework than would have been possible by reading the established literature in this area. The historical data presented in this study also goes some way to filling a gap in the literature on district nursing practice which has in the past been largely reductionist and quantitative in orientation (Hockey 1966; 1972; Mc Intosh and Richardson 1976; Traynor and Wade 1994).

The combination of interviewing and participant observation in ethnographic texts is accepted and almost expected practice (Hammersley 1993). It is usual however that ethnographers traditionally use their observational data to flesh out their text and thereby add flavour to the story they present (Wolcott 1999). In this thesis, I have treated both observational and interview data in the same way, affording them equal status in the process of analysis. I have

also included both sets of data in the roughly equal proportions in the final text.

From a methodological position, the use of observational and interview data together allowed the examination of consistencies in the data between what respondents do and what they say. An example of the usefulness of this was in the often encountered contradiction between how participants reported their interactions and work with GPs as "good" or "we get on fine" and the way that they behaved when in contact with doctors. That is not to say that there was a deliberate attempt on the part of respondents to be misleading. Rather, as the data in chapter 7 demonstrated, the descriptions of their relationship with GPs was often one of comparison that is, it is not as bad as other nurses' experiences and therefore it was suggested to be good. This is an example of how well ethnographic methods can open up what are described as the obvious and natural occurrences in social action (Slaughter 1989). It also illustrates the suitability of ethnography over other methods of inquiry, for example surveys, which could have taken the "good" or "we get on fine" at face value.

Quantitative research is known for its theory testing potential which aims to establish causal relationships between naturally occurring social phenomena (Denzin and Lincoln 1994). Qualitative research, particularly post-modern research by contrast aims to capture the complexity of the social world and then attempts to describe it (Marcus 1998). The methods employed in this study have facilitated this aim. The use of participant observation and non-

directive interviewing has resulted in a text which demonstrates that the working world of district nurses is indeed complex and filled with competing influences.

However this leads to a general criticism of qualitative methods. It is difficult when the data and findings from qualitative research are rich and varied to link the findings directly to practice (Parahoo 1998) as the data generated in qualitative studies often raise more questions than answers (Denzin and Lincoln 1994). Despite the unpopular nature of qualitative findings with policy makers, some would argue that the raison d'être and the emancipatory potential of qualitative research is in the very generation of these dilemmas which shed doubt on other research findings (Hammersley 1993). Qualitative research in general and this study in particular has reported areas of health care practice that would otherwise remain hidden. For example, there is a dearth of literature which examines district nurses' (or indeed other nurses') role in the rationing of their services. When it is approached, it is most often couched in a more palatable discourse of care management (DoH 1999) team work and work allocation (Mc Intosh et al 2000) or related to the process of assessment (Vernon et al 2000). The data presented in this study make a unique contribution to the knowledge of how district nurses were actively involved in a process of rationing care, which was firmly located within a coercive discourse of economic value. The theme of rationing was entirely generated from the dialogue and actions of participants in this study. In effect these findings suggest that rationing as an active process occurred at a local

level, away from the direct policy making arena. A more structured approached may have failed to discover these findings.

Moving on from the benefits of the chosen methods in this study, it is important to highlight the advantages of being an outsider studying a different culture. As outlined in the methods section, my decision to study district nurses was born out of the fact that it was the area of nursing that I had had least professional contact with or knowledge about. Herein lies a dilemma. Griffiths (1996) a qualified and experienced district nurse, suggested in her own ethnographic study of district nursing that being a district nurse facilitated the process of data collection in her study. She also suggested that research by non district nurses or social scientists could potentially inhibit access to the truth, particularly as district nurses were "suspicious of outsiders" (Griffiths 1996, p225). The methods employed in this study and the emphasis placed on the researcher-participant relationship, meant that the obstacles that Griffiths suggested non-nurses would encounter were in fact surmountable. On many occasions during the study I knew that I was being trusted not only with sensitive information but deep and sometimes raw emotion. I encountered sadness, anger, frustration and despair during my time in the field. This was most often unsolicited. My field notes, interviews and informal conversations were littered with asides, off the record remarks and honest statements which as Griffiths noted, could have painted the district nurse in a negative light (Griffiths 1996). This gave me confidence that I was indeed being trusted by the participants in this study.

However, this raises important ethical issues. It has been noted that all qualitative inquiry is essentially unethical as it is, in essence, a means to an end (Fontana and Frey 1994). That is not to say however, that the researcher can not manage the process within ethical guidelines. Chapter 3 outlines the detailed steps I took to ensure that I conducted the research process in an ethical manner. The chosen methods ensured that I had a relationship with the participants and the study was not what I would term a "hit and run" inquiry where the investigator enters the field briefly and then leaves just as quickly. My presence in the field for long periods of time meant that I knew the participants and I was able to guide my actions accordingly and was therefore able to manage the research process in both an ethical and professional manner.

The benefits of ethnographic research and methods lies in the way in which the methods allow for assumptions and findings to be checked with participants. Throughout the research process I was able to check my hypotheses with the participants of the study as I simultaneously analysed and researched the field of district nursing. This method gives added trustworthiness to the findings (Miles and Huberman 1997). It also ensured that the findings of this study were as grounded in the data as I could possibly achieve.

The express aim in re-forming the data (after an preliminary version of the text was written) was to apply the recommendations made by Foucault (1988) to interpret the data. I have faith in the fact that I have examined the effects of power from the perspective of district nurses and have highlighted the effects of power on them and also their use of power in their interactions with GPs, their own managers and patients. I have explicated the decision making processes involved in the exercise of authority. In doing this, I believe that this thesis has identified district nurses as both the target of control and the mediators of authority. The findings have also shown how power moves in a circular way. This is particularly evident in the forms of resistance used by nurses in opposing the authority. There were also data presented which illustrated that patients, usually portrayed as victims, could also resist power and counter its effects. The use of the discourses of health, illness, managerialism and consumerism encountered during the course of this study have also highlighted the link between knowledge and power which is of concern to post modern commentators. To this end, post-modernism has proven to be a useful explanatory tool in understanding the data that arose during this study.

A post-fordist analysis of the organisation of district nurses has proven to be a useful framework for understanding the flexibility and differences in the structure and working practices of the participants of this study. As a theoretical framework the particular usefulness of this approach was that it helped account for variability in the role of the district nurse (which was evident from the data) when I was, as a naïve researcher expecting the

consistencies in data that seemed so evident in the work of more experienced commentators.

Whilst both these interlinked social theories have been useful in understanding the data, the question must be raised as to how much they influenced the collection and interpretation of the data. This is a problem for all researchers as we are not value neutral and therefore carry opinions with us into an inquiry. As previous sections have highlighted (see chapter 5) I have followed accepted practice but I have ultimately presented a version of events which is uniquely my own. This is both a strength and indeed a weakness of this thesis.

Limitations of the methods

The most often cited criticism against ethnography and qualitative research per se is the positivist critique of the sample size in qualitative research. The trade off in qualitative research is in balancing the richness and depth of the data with the number of participants in the study (Griffiths 1996). Therefore the sample size in qualitative research is, by necessity, small. However, this defensive position essentially plays into the quantitative notion that the only useful samples are those which are highly representative of the wider population under investigation. It rests, in the final analysis, on the positivist idea that discrete populations can be homogeneous (Parahoo 1998).

The post-modern critique of this methodological position is that groups of people in modern society seldom, if ever, have the internal consistency of characteristics suggested by positivist researchers (Guba and Lincoln 1994). There are competing narratives and discursive practices that influence social action (Foucault 1977). Therefore, conflating incommensurate groups of people together for the aim of research is an inherent flaw of the positivist approach (Gbrich 1999). It is the identification of contentious social conditions and subgroups that should be the substance of multi-site ethnography which the process of polyphony endeavours to capture (Marcus 1998). It is this aspect of the methods chosen in the study presented here that gives rise to quality rather than the quantity of the data.

Perhaps the greatest defence against the charge of small sample sizes is that this methodological position denies the contribution that qualitative research can make in the generation of hypotheses (Denzin and Lincoln 1994). Further it denigrates the augmentation of knowledge about the social world that has been made by such disciplines as phenomenology, ethnomethodology, grounded theory and of course anthropological and ethnographic research.

This leads to the next general criticism of qualitative research and ethnography in particular. That is, the claims made by positivist researchers that ethnographic research and the analysis thereof, lacks validity and reliability. In the study presented here, there are no bold claims made that these findings are either valid or reliable in the positivist sense of the words. Rather the claims made from these findings are that they are a truthful

representation and interpretation of the actions of the participants, their thoughts and perceptions of their own working life. In this way trustworthiness is offered as a means of evaluation of the text and considerable efforts have been made in the methods section to ensure the reader can evaluate the trustworthiness of this thesis. However, in the spirit of research humility and the post-modern ethos, this text is presented as being as fallible as any other piece of research be it quantitative or qualitative (Kincheloe and Mclaren 1994). It remains one version of reality however much the findings resonate or not with the wider population of district nurses.

Nevertheless, it is true to state that the truth-value of this text is likely to have been adversely affected by the fact that I was a single-handed researcher working on this project. It has been suggested that the data collection and analysis procedures in qualitative research are enhanced by the presence of a team of researchers who differ in professional backgrounds and personal experiences (Wolcott 1999). Working as a team adds greater depth and richness to the data collection and analysis process (Hammersley 1993; Marcus 1998). Clearly this process was inhibited by the very fact that this thesis will be examined on the basis that it is the sole work of the author.

In order to combat the problem of researcher bias (Hammersley 1993) I employed a number of methods to ensure that I remained alert to different interpretations of the data. Firstly, I followed rather than led the participants in this study by using the principles of polyphonic interviewing. Secondly, I checked my assumptions with participants and secured their interpretation of

the action I was observing and being told about. Thirdly, I compared observational and interview data for consistency and diversity and investigated this with the participants. Fourthly, I encouraged discussion with, rather than interviewing, other groups of district nurses about the findings and the assumptions I had reached. Finally I used academic supervision and peer presentations of the data to keep me alert to other interpretations of the findings.

One potential problem with the study was the suspicion that district nurses had about the nature and methods of the inquiry. I was constantly aware of the damaging and long ranging effects the 1992 Audit Commission Report had had on the culture of district nurses. The problem therefore, is that there may have been some staging of the action I observed during the course of fieldwork (Hammersley 1993; Adler and Adler 1987). To overcome this potential problem I spent long periods of time in the field, secured trust in myself through honesty, openness and reciprocity (Oakley 1981). I also made my own motives for the study clear to the participants. I am convinced that I achieved the aims of naturalistic inquiry of fitting into the field (Hammersley and Atkinson 1996; Wolcott 1999) without becoming overly involved. In so doing, I feel that I successfully managed to keep the inquiry process above board at all times. From a pragmatic stance, I am sure that there was, on occasions, some staging of the action. Yet, I am also convinced that for the majority of my time in the field I got close to the real work of district nurses as it was generally practised.

One criticism of this study that is likely to be made by both quantitative and qualitative researcher is the use of polyphonic interview techniques (Clifford and Marcus 1994; Choularaika 1997). That is, I actively decided to abandon the formal data collection technique of semi-structured or guided interviews, which are traditionally informed by ongoing data analysis (Denzin and Lincoln 1994; Miles and Huberman 1996). It may be argued that adopting this method has weakened the findings presented in this study. It may be true that "saying more by letting others say it" (Marcus 1998, p36) may have had the result that important opinions and ideas were lost in the process of data collection. In spite of this my argument remains that traditional approaches to interviewing can force participants to have an opinion on aspects of their world that have little importance to them. The technique of semi-structured interviewing (however informally they are conducted) has a tendency to lead people down a data trail.

It is a well established criticism that qualitative researchers, just because they value personal experience, often propose that they produce an "immaculate conception" derived from untainted interactions with respondents (Wolcott 1999). This is my critique of qualitative approaches. The researcher will always have an effect on the researched and the research process. The extent to which the inquirer can reduce this potential for bias is to move away from structured ideas, however grounded they appear to be, which could influence the respondent. Instead the process of data collection needs to allow the respondent to lead the research process. The extent to which this is

ever fully achievable is debatable (Gbrich 1999) but polyphony goes some way to securing this (Choularaika 1997).

The consequence of adopting the polyphonic method is that important data may be lost in the inquiry process. This is a valid criticism but it is important to state that true as it may be, the lost data does not invalidate the richness of the data that arises from this method. It is a well established internal critique of the ethnographic methods that traditional modes of inquiry have silenced participants voices by chasing data (Gbrich 1999). Polyphony, whilst not the panacea for this methodological concern, can nevertheless afford the participants a greater opportunity for being heard (Marcus 1998).

A final criticism of this text and ethnographic texts in general is that they provide little more than a snapshot of a culture bound within a particular time frame (Gbrich 1999). However, it has been noted that there are snapshots and snapshots (Griffiths 1996). The depth of the data in this text, its multi-site perspective and the many voices included in the data give a partial snapshot and interpretation of aspects of the culture of district nursing following a period of intense upheaval in their history. It is noted that all research is temporal and therefore revisionist (Sayer 1999). Even in the pure sciences absolute claims to truth are questioned as merely sequential states of knowledge (Gbrich 1999). Thus, as Clifford and Marcus (1984) observe, this ethnographic text, like many others is a snapshot of a group of individuals on a continuum of change which will never be exactly reproduced or represented in the same way. That is not to say that the findings of this thesis do not have

implications for the future of district nursing. It is to the implications these data have for the immediate future that the discussion now turns.

Section 2

Discussion

The data indicate that for many years district nurses have had a long tradition of undertaking work in the community for which they were reportedly over qualified. This state of affairs occurred as a result of a high level of patient and professional expectation on the district nursing service, the coercive effects of patient demand, the lack of co-ordinated social care services and an amorphous and loosely defined role. It is interesting to note that the acting down of district nursing sisters differed from the contemporary system where district nurses undertook roles that may now be described as staff nurses' work from necessity rather than desire. Prior to the skill mixing of district nurses the situation was such that district nurses were largely expected to provide all of the care needed in the home. It was also noted that the continuing training and education of district nurses was haphazard, poorly organised and prior to the introduction of the General Practitioner Contract (DoH 1990) district nurses were largely left to their own devices to update and develop their professional skills. Therefore there has been significant under investment in the educational development of district nurses. This has been noted previously in the literature (Mc Intosh 1996). It is hardly surprising then that successive commentators have found that district nursing services were

highly variable and there was considerable inequity in the provision of district nursing care both within and between geographical areas (Hockey 1966; 1972; Luker and Perkins 1988; Audit Commission1992: 1999;). However, the upshot of these reports into the work of the district nursing team seemed to suggest that the previous mode of organisation was both inefficient and irrational and subject to startling variations in productiveness.

Within an increasingly rationalised health service arena, it was observed that district nursing services were out of synchronicity with the favoured discourse of rationalisation and efficiency existent in the new health service (Klein 1997).

In some ways, the organisation of district nurses' work in the past could be described as more rather than less efficient when compared to the contemporary system of work highlighted in later chapters of this thesis. It could be argued that the data presented in this thesis suggest that district nurses were better able in the recent past to meet the needs of the community for whom they were employed. They were closer to their patients, knew more about them and were able to exert some control over the illness trajectory through skilled observation and continuous contact. These elements were the way in which district nurses knew their patients and paradoxically, these important mechanisms of knowing and working have eluded description in previous nursing research. There is a dearth of research into the way district nurses organised their work in the recent past, the decision making processes

they employed when making care related judgements and the effectiveness of their interventions.

However, it appears from the data presented in chapter 4 that district nurses did have some degree of flexibility and choice over the services they offered patients in the recent past. At other times their hands were tied by the constraints of resources available much like today (Mc Intosh et al 2000). However, simple acts of care performed in the past, such as taking a loaf of bread seem at odds with a technical and skilled job of work. But to the district nurses in this study, these little things could give information about the patient's eating habits, their ability to self care and resulted in the nurse accessing information about the patient that would otherwise remain hidden.

It is noteworthy that recent governmental reports (DoH 1998; 2001) have criticised the level of assessment and quality of services offered to patients in the community, particularly of elderly people (DoH 2001). It seems that the change in district nursing work may have had some part to play in this apparent deficit in the provision of continuing care.

This was an important finding as it seems to be the current organisational post-fordist vogue in the provision of community services to bring professionals into a more flexible contact with their patients (Klein 1997; Edwards and Hale 1999: Mc Intosh et al 2000). The rhetoric of the 1998 White Paper suggests that community services and key players should become closer to the community and patients for whom they care (DoH 1998).

Service providers are charged with developing flexible methods of work to ensure quality care. The data presented in this thesis suggest that the reverse was the tendency in district nursing; inflexibility seemed to be the trend. From the data presented in this study it would appear that district nurses at least had the potential to be flexible in the provision of nursing care in the recent past. Indeed, it is this aspect of their work that received much criticism in the stern criticisms of the apparent flexible approach to the delivery of district nursing care (Audit Commission 1992: 1999). Data from other studies support this assertion that continued and detailed assessments and complicated care packages inhibit the ability of district nurses to devote the requisite time to this increasingly important aspect of care (Ross and Bower 1995; Mc Intosh et al 2000; Vernon et al 2000). Consequently, the reported inefficiency of district nursing services inevitably received considerable management and organisational attention to which the discussion now turns.

The data presented in this study illustrate that there has been a considerable change in the role of the district nurse. This transformation in role represents a move to what post-fordist/post modern authors have termed reskilling, upskilling or flexibility of role (Hurst and Zeitlin 1994; Clegg 1990). Nursing commentators have labelled this process the ditching of dirty and mundane work in favour of taking on more skilled tasks (Ramprogus 1995). Associated with the pull up effect of this new system of organisation has been the move to the business of assessment (Vernon et al 2000) and care management (Mc Intosh et al 2000) which essentially pulls district nurses away from the provision of direct care. This is the pull up effect that modern organisations

exert on employees to change or recreate themselves and their role as a response to the demand of the ever changing external market (Porter 1997). There was considerable data presented in this study to indicate that this was a constant and active process in the working life of the participants in this study.

The data from chapters 5 and 7 indicate, there had been an increasing use of district nurses to undertake work which was previously the domain of medical colleagues or secondary care services. The extra hours and implications that this has for the practice team meant that district nurses have been increasingly given an extended sphere of practice, most often in the form of discrete medical tasks, procedures or, in the case of secondary care, complicated work. What is notable about this finding is the ad hoc basis in which this work has come their way. The findings of this study indicate that district nurses have not been consulted in this process and there are variations in the extent to which they have taken on the extra work. Some nurses had a greater scope of practice than others. It also notable that for some participants this extra work was additional to core work and for others it replaced their more traditional role. However, these data indicate that significant changes have been reported in the form and content of district nurses' work and there has been an increasing move towards functional flexibility within the workplace.

It is noteworthy to compare this with the current state of district nurse training. Specialist practice status is essentially equipping district nurses for a managerial rather than practical role. The data presented in this study

indicate that district nurses in effect need to have excellence in both technical medical/nursing skills and managerial skills. In short they are being pulled to an ever increasing flexible working pattern.

Figure 1 – District Nurses as a peripheral member of the flexible firm (adapted from Atkinson 1984; Marsh 1996)

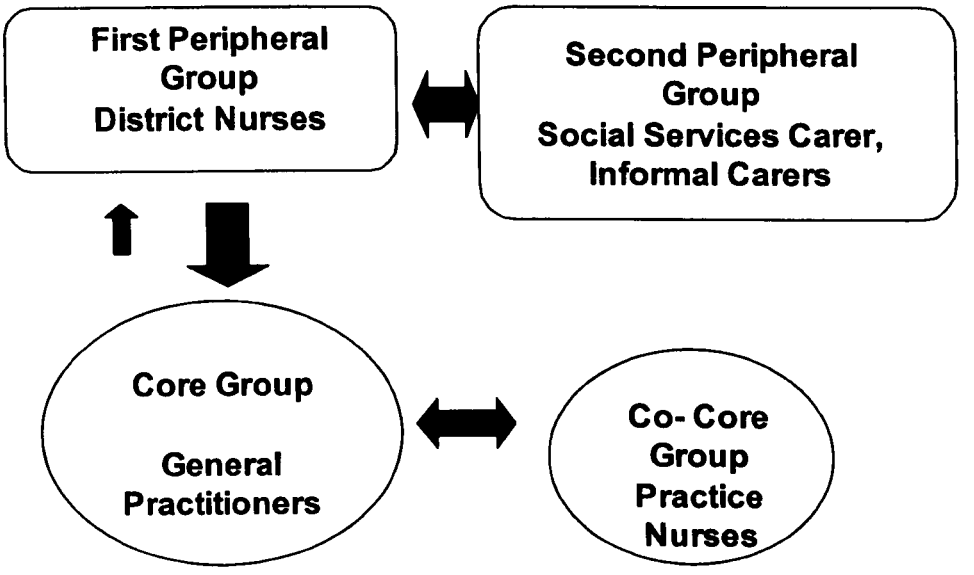


Figure 1 demonstrates the idea that district nurses are part of a flexible and adaptable firm in terms of their structural location to the core grouping. The data from this study indicate that district nurses were very often peripheral to the core team which comprised of the GP and practice nurse. In particular, the data from chapter 7 indicate that the attachment of district nurses to

general practice setting has brought with it a set of relationships which may be explained using a post-fordist organisational model.

For many district nurses in this study, the organisation of primary care was experienced as hierarchical. District nurses were observed to be on the periphery of the core team within primary care. By definition, those workers who operate on the periphery of the team are characterised by both functional and numerical flexibility of role (Clegg 1990). Therefore as a group of peripheral workers, district nurses can be employed and shed as the needs of the practice population demands. The core workers (GPs and practice nurses) by contrast enjoy a relatively stable existence (Porter 1997).

One consequence of peripheral work is that workers are constantly required to both flex up and flex down their skills in the work place. Their functional flexibility requires them to take up new work and modify their role as the demands of the core team and ultimately the consumers of the service dictate. Whilst the data from the study reported here suggested that this process was already occurring in primary care. It is noteworthy that the upskilling process is likely to continue in primary care. There are increasing demands by health care policy makers to increase the services available in primary care by the appointment of General Practitioners with a special interest (DoH 1998). In essence, this will mean that more secondary care services will be provided by GPs who have had extra training. It may be speculated that the upshot of this upskilling of GPs will be that more of their routine work will need to be undertaken by other members of the team. As the data from chapter 7

indicate, this process has already occurred in the designation of tasks and work to district nurses by GPs. It is likely that in the newly formed Primary Care Trusts (DoH 1998) that these changes are set to continue. The probable scenario then is that practice nurses will be given extra work to do in the practice which in turn will mean a shedding of their work to district nurses. The important point here is that there is no evidence at the present time to indicate that this is a more efficient form of organisation than more structured roles. On the contrary, there is increasing evidence to suggest that care provided through flexible teams may have a detrimental effect on both the staff involved and patient satisfaction (Mc Intosh et al 2000; Jarvis 2001). Yet flexibility seems to be the desired managerial goal.

For many nurses flexibility and skill shedding was associated with the real and tangible threat of regrading. It is noteworthy that the removal of the Community Health Care Trusts (who previously negotiated the content of the district nurses contract) and the direct employment of district nurses by Primary Care Trusts will enable the process of changing roles to continue without less chance of challenge. Indeed, as one of the prospectuses for a Primary Care Trust indicated, the grade of district nursing staff would be protected for a set period of time but under the new arrangements there will "invariably be changes in both the role and working practices among community nursing staff" (reference withheld due to confidentiality). It is here that Pollert's (1991) concerns about post-fordist organisation have relevance. It is suggested that the "fetish of flexibility" obscures the real intention of post-fordist organisation which are; job enlargement, effort intensification and cost

controls. In the cult and discourse of flexibility these factors are hidden in the notion of flexible working and team approaches. It remains to be seen, and indeed will be a fruitful research project for the future to observe what effects the new re-organisation of primary care will have on the work of district nurses. The tentative suggestion here is that the changes to district nursing service will serve to increase their productive potential (Foucault 1977) their functional flexibility (Piore and Sabel 1984) and their efficiency within the primary health care team (DoH 1999).

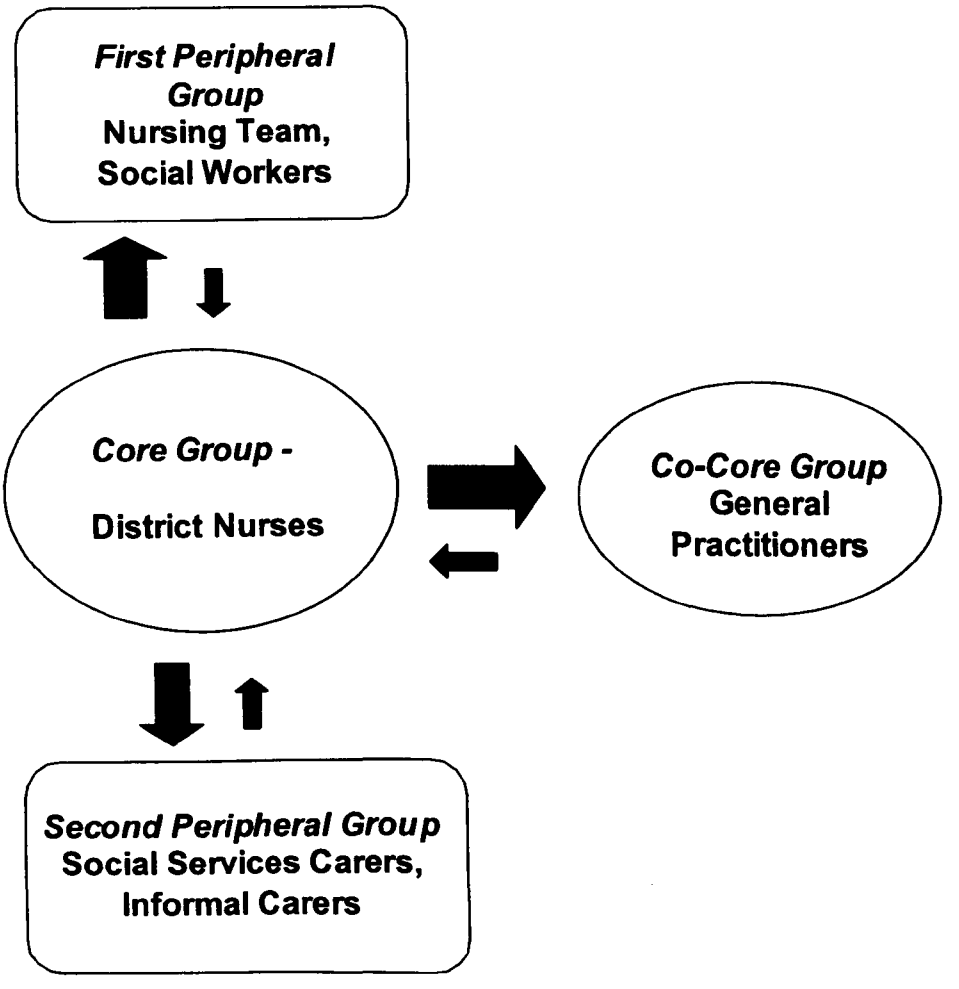
One important aspect of post-fordist organisations is that it is the core group who are trusted and valued in the organisation (Clegg 1990; Porter 1997). Thus, if the post-fordist model fits the primary care situation it would predict that GPs and their practice nurses would have greater status and standing than the more peripheral members of the team, district nurses and social services carers. The data from chapter 7 support this assertion.

Typically, peripheral workers are numerically flexible in as much as their services can be bought in or dispensed with according to the needs of the organisation (Marsh 1996; Watson 1997). It is clear from the data presented in this thesis that district nurses were acutely aware of their peripheral status and the fact that they could easily be dispensed with as the conditions of the market and the primary care organisation dictated. There were active strategies employed by the primary health care organisation to ensure that this dialogue was kept active and participants in this study were constantly made aware of their secondary standing as a contracted and hired service. It

is suggested that whilst the core team enjoy privilege and standing within the organisation, those workers located on the periphery put up with a sense of distrust and disconnection from the inner workings of the core team (Piore and Sabel 1984; Porter 1997). The data from chapter 7 support this literature suggesting that there are active strategies set to maintain district nurses' peripheral status.

There was an anomaly to the representation of peripheral work outlined above. In some situations district nurses operated as a core group (Atkinson 1984; Marsh 1996). Figure 2 highlights this.

Figure 2 – District Nursing as a core group in a flexible firm (adapted from Atkinson 1984; Marsh 1996)



Within this representation, it can be seen that nurses sometimes occupy a core role in the organisation of community nursing and social services. From this position, district nurses operated with functional flexibility and exercise their role as both the assessors and providers of skilled health care services to the community. When they operate in this way, they usually co-opt in the services of their general practitioner colleagues. It is interesting to note, that this action, as a skilled and competent assessor and manager of care was one way in which the district nurses in this study resisted medical domination and carved a niche for themselves.

However, the most usual scenario was that this element of district nurse's work went unnoticed by the General Practitioners. If the nurse was doing this work well, which they often did, then there was little need to involve the doctor for anything other than supplementary medical services. This was a double edged sword for district nurses. On the one hand they enjoyed the autonomy and freedom of managing the care episode for the patient and the co-ordinating aspects associated with it. On the other hand, this element of their work, which requires the combined skills of both providing an expert, technically difficult nursing service and co-ordinating other disciplines remained largely concealed from both medical, paramedical and social service colleagues. This state of affairs was further confounded by the fact that communication between the other members of the team and the district nurses was not usually as effective for district nurses as it was for other members of the team. In many situations, district nurses had to actively solicit the information they required from medical and social work colleagues as well

as those more peripheral to the district nurses such as social services or informal carers.

The data in chapter 7 indicated that district nurses were not practised in discussing their work with patients in public arenas. The usually scenario was that problems alone were discussed. Hence, the irony of this situation was that the more successful district nurses were at managing this element of their work well, the less likely they were to involve other professionals. Therefore, it is likely that this component of their work will remain hidden and their expertise as both managers and providers of community care will remain concealed. In essence their flexibility (the desired element of post-fordist organisation) and versatility, which is unique among all the professionals involved in providing community health care services, seems destined to be overlooked.

It is also important to note, that the suggested status associated with core work essentially eluded the district nurses who took on the core working role. In essence, the data illustrate that mistrust rather than trust was the order of the day. One illustration of this mistrust is highlighted in the intense growth of direct surveillance of district nurses' work recounted throughout the findings sections of this thesis. These changes that occurred in the organisation of district nurses' work were secured through a direct and sometimes highly confrontational approach to organisational management. The findings from chapter 5 suggest that managers sought to make the work of district nurses more visible and tangible by gaining tight control over the way in which district

nurses accounted for their work. This move to structured organisation was associated with both overt and covert observation which produced a sense of fear among the respondents in this study. In the majority of areas managers successfully secured a sense of omnipresence and inspection. In some areas this was secured through direct and open confrontation whilst at other times the inspection process was more covert.

Associated with the process of surveillance was a level of managerial mistrust that is traditionally found in taylorist or fordist styles of organisational management (Taylor 1967; Marsh 1996). In many ways this is a curious mix of management approaches that on the surface seem contradictory with the aims of post-fordist organisation, that is, personal accountability, self surveillance and team working (Burrows and Loader 1994; Piore and Sabel 1984). However, on closer examination the data presented in this study indicate that this form of organisation produced a transformational system of self surveillance among nurses which in turn evoked a system of surveillance of their colleagues' work (Freshwater 2000).

This organisational technique produced an environment and discursive practices in which district nurses were more likely to confront each other about deviations in working practices if they fell out of line with accepted custom and practice. There was a culture of challenge both from management and from colleagues, which secured adherence to the new way of working through fear of exposure and criticism. Where resistance occurred it was experienced as highly risky and fear of detection was intense.

It can be suggested therefore, that peer scrutiny and challenge had a pervasive effect on the decision making and cultural practices of district nurses. This technology of subjection (Foucault 1988) had direct organisational benefits in securing compliance to new working practices (Fox 1995).

Whilst indirect supervision of district nurses was interpreted as threatening in itself, the most common method of securing organisational change among district nursing teams in this study, occurred through the rhetoric and discursive practice of economic value. In order to achieve this, various methods of increasing the visibility of district nurses was undertaken. Overt hostile management tactics were used to challenge and castigate district nurses who could not explicitly defend their care decisions. Tight control over their work was accomplished with the introduction of financial restrictions and economic pressures to provide the service within pre-set budgetary limits. This pressure was also a direct threat to job security and tenure of position. As overt mechanisms of control these organisational practices secured surface compliance and placed district nurses in a situation where they had to change as a consequence of the tight financial control procured over their work (Peters and Waterman 1982).

The data presented in chapter 6 indicate that district nurses were indeed increasingly viewing their work as a commodity. One consequence of the new order of financial value has been that nurses have entered into a more overt form of local level rationing of their services. This shift in the services they

provided was not associated with direct guidelines. Instead of firm directives there were loose guidelines which were variously interpreted by participants. In many ways then, district nurses had become front line practitioners (Jupp 1971) or the public face of rationing (Lipsky 1980; Klein 1997). They were involved in day to day rationing decisions and the discourse of personal responsibility for the provision of nursing services were left with the individual practitioner.

Perhaps the most salient aspect of these findings was that district nurses were very often ill prepared for these types of decisions and certainly, when withdrawing care from long term or even short term patients, the effects of the decisions they made about who could have care were traumatic. Many nurses reported feelings of guilt and shame about leaving needy people in the hands of supplementary but inadequate services. However, despite the emotional impact of rationing participants seldom, if ever, used this discourse of efficiency or cost effectiveness to turn the situation on its head. In essence, district nurses could have used this same discourse to highlight disparities in care, less than effective treatments and poor resources. This coercive strategy could have secured extra resources from managers. However, district nurses continued to manage themselves and their own resources despite experiencing considerable pressure and personal disquiet. The way in which district nurses make these decisions and the strategies they use to implement rationing decisions lends itself well to further examination and research.

The irony of this organisational strategy is that the data illustrated that there were differences in what district nurses offered. It is perhaps these findings that contradict most with the current government policy of equity and consistency (DoH 1998; 2001). Variations in service provision have also been noted previously in the literature (Vernon et al 2000; Mc Intosh et al 2000). If local services are going to be tailored to defined communities and resources are to be found within local practice staff configurations, then variations in service provision are likely to continue. The situation could conceivably arise where one Primary Care Trust could offer a level of service provision that a nearby Trust has not given the same level of priority or importance to. Whilst recent legislation has dictated that assessment of need is to be standardised (Vernon et al 2000; DoH 2001) the question of inequity in resource provision between Trusts, their priorities and levels of service provision seems likely to continue.

Perhaps the most pertinent findings of this thesis are those relating to the structural position of district nurses in the Primary Health Care Team. There is a plethora of literature which espouses the value of a co-ordinated Primary Health Care Team (DHSS 1981b; Jenkins-Clarke et al 1998; Tovey 2000). Yet there is little support that the team as a team, in any conventional sense of the word, actually exists (Williams and Sibbold 1999; Goodman 2000). The findings from chapter 7 of this thesis suggest that district nurses are entering the new era of primary health care reforms with significant baggage and considerable experience of being a peripheral entity rather than a key player in the primary health care team.

The data presented in the final findings chapter, suggest that the recent organisation of primary care has to some extent secured a deference among district nurses to GPs. It has been noted that this deference has always played a part in the dynamic of primary care (Mc Intosh 1985; Griffiths 1996). However, the literature of the past has suggested that compliance arose from differences in educational preparation and the corresponding claims to professional authority. The data presented in this study suggests that much of the contemporary deference to GP's centres around the notion that district nurses was most often a consequence of the employer/employee relationship. This added contractual status evoked much fear and trepidation among participants in this study as they were acutely aware that their medical colleagues were and would be increasingly influential in dictating their future working practices. The post-fordist model gives some insight to this process. It generally accepted that post-fordist organisations rely on the flexible team to achieve effective production (Clegg 1990; Marsh 1996; Porter 1997). The aim of this form of organisation is to ensure that the team are focussed to provide a quality service to consumers. Essential to this notion of team work is effective communication. The data from chapter 7 indicate that there are significant barriers to effective team communication in primary care.

There is a history of suspicion among district nurses and GPs. There was often a rigid and hierarchical structure which previous sections of this discussion has highlighted. The up shot of the hierarchical structure within primary care was that district nurses reported that they seldom had an arena

for inter-professional collegial support and discussion and there were strategies in place which seem destined to inhibit effective communication between the often competing members of the team. Perhaps the most conspicuous of these factors is the perceived threats that exist when, for the first time, district nurses will become the direct employees of GP's.

It is clear from the data then that district nurses are entering the new area primary care organisation with scepticism. They have had, in their recent past experiences in which they have been kept out of the inner machinations of primary care. They have often been subjected to degrading conditions of work, sometimes to the extent of bullying and covert hostility. Although this experience was not universal, the data suggest that the potential for relationships between members of the team to develop in a way that would have dire consequences for the district nursing team was real. A repercussion of this, the data suggests, is that there was considerable evidence to propose that district nurses mistrust the motives and intentions of the GP colleagues, especially relating to their own security within the primary care arena. There is a firmly held belief that the future looks bleak for district nurses when their terms of employment and working conditions are handed over to Primary Care Trusts. There is a commonly held idea that their role will undergo significant change and this filled many participants with fear and anxiety.

Opportunities for Further Research

As is typical of qualitative research, this thesis has generated many questions which would benefit from further exploration and research. There is still relatively little known about the subjective history of district nursing services and how changes in the organisation of primary care have and will continue to affect the work of nurses in the community. An oral history based research method would further our understanding of the changing nature of work in the community and how it affects district nursing.

There is considerable scope for a more detailed examination of the management of district nursing services, particularly in the light of recent reorganisations of primary care. Questions that need to be answered are what is the best method of organising district nurses? Who makes the best managers, district nurses themselves, general managers or indeed the GP? It would be important to consult the district nurses themselves in this process as there is a dearth of information on this aspect of their work.

There are also important questions about the organisation of care within primary care that need to be explored further. There is a lack of knowledge about the divisions of labour and the allocation of work in primary care. Thus, we know little about the efficiency and effectiveness of current skill mix arrangements and their effects on care. We know even less about the effects of skill substitution on work satisfaction levels for all members of the primary health care team. Consequently a study which examines the effects of structured skill mix on both primary health care personnel and their patients is

timely. Given the restructuring in primary care and the likely organisational differences between practices in the delivery of their core business, the time is ripe for a study which examines interpractice variations in the delivery of primary care services and the effects these have on the both staff and patient's perceptions and satisfaction.

There is also very little known about most effective methods of teambuilding, team composition in primary care and methods of securing effective teamwork. Once again, robust studies are needed if the primary health care team is ever going to move beyond the rhetoric of policy documents.

There is also much to be learned about the patient's perspective of district nurses' work. Whilst there have been studies in the past, the constant reorganisation of primary care and the changes in work task among the team, means that a further exploration of the patients' perception of care is needed. This is particularly if patient participation in the delivery and organisation of primary care services is ever to be achieved.

Given some of the findings presented in this thesis, there is a need for further information about the morale and stress levels among district nurses. There is a dire need for research on how district nurses may be most effectively supported during periods of organisational change and restructuring. This is particularly apposite if we are ever going to recruit and retain the level of staff that is needed to maintain an effective district nursing/primary care service.

Conclusion

The data from this study suggest that district nurses are increasingly being managed and organised within a post-fordist system. As a result of this form of organisation, it is suggested that the intense changes that have occurred in the role of district nurses will continue. The pursuit of flexibility means that it is difficult to know what the role of the district nurse will look like, even in the near future. She may be practice based, geographically based or both. It is relatively certain however, that given the pace of change in primary health care that district nurses are likely to face a future which is filled with change and uncertainty.

References

Abel-Smith B (1979) A History of the Nursing Profession London, Heinemann

Adams A (1993) Bullying at work London, Virago

Adler PA & Adler P (1987) Membership roles in field research. Newbury Park CA, Sage

Allen D (1998) Record keeping and routine nursing practice: the view from the wards. Journal of Advanced Nursing26(6) p1223-1230

Altheide DL & Johnson JM (1994) Criteria for assessing interpretive validity in qualitative research. In N Denzin and YS Lincoln (1994) A Handbook of Qualitative Research. London, Sage p 485-500

Amin A (1994) Post-Fordism: Models, Fantasies and Phantoms of Transition. As in A Amin (ed) Post-Fordism: A Reader Oxford, Blackwell

Annadale E (1995) Working on the front line: risk and nursing in the new NHS. The Sociological Review 44(3) p 416-451

Annadale E (1998) The Sociology of Health and Medicine: A critical introduction. Cambridge, Polity Press

Anonymous (1996) Assessing need for district nursing: study findings. Nursing Standard 10 p32

Argyris C (1969) Diagnosing defences against the outsider. In GJ Mc Call & JL Simmons (Eds) Issues in Participant Observation. Reading MA, Addison Wiley p115-127

Armstrong D (1983) The fabrication of the nurse patient relationship. Social Science and Medicine 17, (8) p457-51

Atkin K and Lunt B (1997) Negotiating the Role of the Practice Nursing in General Practice. Journal of Advanced Nursing 24 p498-505

Atkinson J (1984) Flexibility, uncertainty and manpower management Institute of Management Studies, Report 89. Brighton, Falmer Press

Atkinson P (1995) Pearls, Pith and Provocation: Some Perils of Paradigms. Qualitative Health Research 5 (1) P117-124

Atkinson P and Hammersley M (1994) Ethnography and Participant Observation. As in Denzin NK and Lincoln YS (1994) A Handbook of Qualitative Research London, Sage

Audit Commission (1986) Making a Reality of Community Care London, HMSO

Audit Commission (1992) Homeward Bound: A new course for community health The Audit Commission, London HMSO

Audit Commission (1999) First Assessment: A review of district nursing services The Audit Commission, London HMSO

Badger F, Cameron E and Evers H (1989) District Nurses Patients: issues of caseload management. Journal of Advanced Nursing 14 p518-527

Baker G, Bevan JM, Mc Donnell L and Wall B (1987) Community Nursing: Research and Recent Developments London, Croomheld

Baker M & Kirk S (1998) Research and Development for the NHS. Evidence, Evaluation and Effectiveness Oxford; Radcliffe Medical Press

Baly ME (1980) Nursing and Social Change London, William Heinneman

Baly ME (1986) A New Approach to District Nursing London; William Heinemann Medical Books Limited

Beck U (1992) Risk Society London, Sage

Becker R (1983) How I learned what a crock was! Journal of Contemporary Ethnography 22 p 28-35

Benner P & Tanner C (1987) Clinical judgement: how expert nurses use intuition. American Journal of Nursing 87 p23-31

Benson L, Bruce A & Forbes T (2001) From competition to collaboration in the delivery of health care: England and Scotland compared. Journal of Nursing Management 9 p213-220

Bergen A (1991) Nursing caring for the terminally ill in the community: a review of the literature. International journal of Nursing Studies 28 p89-101

Bergen A (1992) Evaluating nursing care of the terminally ill in the community: a case study approach. International Journal of Nursing Studies, 29 p81-94

Bergen A (1994) Case management in the community: identifying a role for nursing. Journal of Clinical Nursing 3 p 251-257

Bergen A (1999) Nursing as caring revisited. In I Norman and S Cowley (Eds) The Changing Nature of Nursing in a Managerial Age. Oxford; Blackwell Science

Bloor M and Mc Intosh J (1990) Surveillance and concealment: a comparison of techniques of client resistance in therapeutic communities and health visiting. As in S Cunningham-Burley and N Mc Keganey (eds) Readings in Medical Sociology. London, Routledge

Blummer H (1969) Symbolic Interactionism Englewood Cliffs NJ, Prentice Hall

Bojke C, Gravelle H & Wilkin D (2000) Is bigger better for primary care groups and trust? British Medical Journal 322 (7286), 599-602

Bowling A (1981a) Delgation in general practice: a study of doctors and nurses. London, Tavistock

Bowling A (1981b) Delegation to nurses in general practice. Journal of the Royal College of General Practitioners 31 p485-490

Bowling A (1985) District Health Authority policy and the 'extended' clinical role of the nurse in primary care. Journal of Advanced Nursing 10 p443-454

Bradshaw A (1995) What are nurses doing to patients? A review of theories of nursing past and present. Journal of Clinical Nursing 4 p81-92

Braverman H (1974) Labor and Monopoly Capital New York; Monthly Review Press

Brocklehurst N and Butterworth T (1996) Establishing good practices in continuing care: a descriptive study of community nursing services for people with HIV infection. Journal of Advanced Nursing 24 –488-497

Bryar R (1994) An examination of the need for new nursing roles in primary care. Journal of Interprofessional Care 8 p73-85

Bryans A and McIntosh J (1996) Decision making in community nursing: An analysis of the stages of decision making as they relate to community nursing assessment practice. Journal of Advanced Nursing 74 p24-30

Burrows R and Loader B (1994) Towards a Post-Fordist Wlefare State London, Routledge

Burgess R (1993) In the field: An introduction to field research London, George Allen and Unwin

Butler J (1999) The ethics of health care rationing. Principles and practices. London; Cassell

Cantor MH (1979) Neighbours and friends: an overlooked resource in the informal resource system Research on Aging 1 p434-463

Carlisle C (1997) Staying On: A Study of the Caregivers of People With HIV Unpublished PhD Thesis, University of Liverpool

Carpenter M (1978) The new managerialism and professionalism in nursing. In M Stacey and M Reid (eds) Health and the division of labour. London; Croomfield

Carstairs V (1966) Home Nursing in Scotland: report of an inquiry into local authority domiciliary services. Scottish Health Services Studies 2, Scottish Home and Health Department; Edinburgh

Cartledge A and Harrison S (1995) Nursing activities of district nursing sisters and practice nurses in selected family health services authority in Northern England Social Science and Health 1 p63-72

Cassell E (1991) The nature of suffering and the goals of medicine New York, Open University Press

Choularaika AJ (1997) The construction of ethnographic text in social scientific discourses. 'Realist' and 'Polyphonic' representations. Language and Discourse 5 p3-22

Churniss C (1989) Burnout in new professionals: a long term follow up study. Journal of Health and Human Resource Administration 12 p11-24

Cioffi J (1997) Heuristics, servants to intuition, in clinical decision making. Journal of Advanced Nursing 20 p203-208

Clegg S (1990) Modern Organisations: Organisation Studies in the Post Modern World London, Sage

Clifford J and Marcus GE (1994) Writing Culture: The Poetics and Politics of Ethnography Berkeley, The University of California Press

Cohen, Sir Henry (1954) Chairman General Practice Within the National Health Service Report to the Committee fo General Health Services Council. (The Cohen Report) London, HMSO

Cohen S and Wills TA (1985) Stress, social support and the buffering hypothesisw. Psychological Bulletin 95, p310-357

Cole A (1996) Fighting the Bully Health Service Journal 11th January p22-23

Cole GA (1998) Management Theory and Practice London; Letts Publishers

Colliere MF (1986) Invisible care and invisible women as health care providers. International Journal of Nursing Studies 23(2) p95-112

Collinson D (1992) Fifty Major Philosphers: A Reference Guide London, Routledge

Coombs EM (1984) A conceptual framework for home nursing. Journal of Advanced Nursing 9 p157-163

Corbin J (1987) Women's perception and management of pregnancy complicated by chronic illness Healthcare for Women Internalional 84 p317-37

Cowley S, Bergen A, Young K and Kavanagh A (2000) A taxonomy of needs assessment. elicited from a multiple case study of community nursing education and practice. Journal of Advanced Nursing 31 p126-134

Coyne IT (1997) Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? Journal of Advanced Nursing 26 p 623-30

de la Cuesta C (1983) The nursing process: from development to implementation. Journal of Advanced Nursing 8 p365-371
Cullum N and Roe B (1995) Leg Ulcers. Nursing Management a research guide. Middlesex, Scutari Press

Culyer A (1994) Supporting research and development in the NHS HMSO; London

Dalley G (1993) The Ideological Foundations of Informal Care. As in A Kitson (ed) (1993) Nursing: Art and Science London, Chapman Hall

Daniel A (1998) Medicine and the State: A failure of trust. In C Waddell and A Peterson (eds) Just Health: Inequality in Illness, Care and Prevention Sydney, Allen and Unwin

Daniel A (1998) Trust and Medical Authority. In A Peterson and C Waddell (eds) Health Matters: A Sociology of Illness, Prevention and Care Buckingham; Open University Press

Davies C (1995) Gender and the Professional Predicament in Nursing Philadelphia, Open University Press

Dawson of Penn, Lord (Chairman) The Future Provision of Medical and Allied Services. Consultative Council on Medical and Allied Services Report (The Dawson Report) London, HMSO

Day P and Klein R (1989) Commission for health improvement invents itself. British Medical journal 322, p1502-1503

Dent S (1995) The New National Health Service: A case of Posmodernism. Organisational Studies 16 p875-896

Denzin NK (1989) Interpretive Interactionism Newbury Park CA, Sage

Denzin NK and Lincoln YS (1994) Handbook of Qualitative Research London, Sage

Department of Health and Social Security (1969) Report of the Working Party on Management Structure in the Local Authority Nursing Services. Chairman Lord Mayston, London, HMSO6

Department of Health and Social Security (1972) Report on the Committee of Nursing. (The Briggs Report) London, HMSO

Department of Health and Social Security (1976) Priorities for health and person social services in England London, HMSO

Department of Health and Social Security (1977) The Way Forward London HMSO

Department of Health and Social Security (1981a) Growing Older London, HMSO

Department of Health and Social Security (1981b) A Handbook of Policies and Priorities for the Health and Personal Social Services in England. London, HMSO

Department of Health and Social Security (1986a) Mix and Match: A review of Nursing Skill London, DHSS

Department of Health and Social Security (1986b) Neighbourhood Nursing: A focus on Care London, HMSO

Department of Health (1988) Community Care: Agenda for Action (The Griffiths Report) London, HMSO

Department of Health (1989) Working for Patients London, HMSO

Department of Health (1990) The NHS and Community Care Act London, HMSO

Department of Health (1992) The Patient's Charter London, HMSO

Department of Health (1994) New World, New Opportunities London, HMSO

Department of Health (1996a) Choice and Opportunity – Primary Care, Delivering the Future London, HMSO

Department of Health (1996b) Primary Care – Delivering the Future London, HMSO

Department of Health (1997) The New NHS: Modern and Dependable London, HMSO

Department of Health (1998) A First Class Service: Quality in the New NHS London, HMSO

Department of Health (1999) Making a Difference. Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare London, HMSO

Department of Health (2001) Primary Care, General Practice and the NHS Plan. Information for GP's, Nurses and Other Health Professionals and Staff Working in Primary Care in England London, HMSO

Derrida J (1976) Of Grammatology Chicago, University of Chicago Press

Descartes R (1968) Discourse on method and meditations Hamondsworth, Penguin

Dimond B (1997) Legal Aspects of Care In The Community London, Macmillan

Dowell T & Neal R (2000) Vision and change in primary care: past, present and future. In Tovey P (ed) Contemporary Primary Care: the challenges of change Buckingham, Oxford University Press

Dreyfus HL snf Dreyfus SE (1986) Mind Over Machine. The Power of Human Intuition and Expertese in the Era of the Computer. Oxford, Blackwell Science

Dunnell K and Dobbs J (1982) Nurses working in the community. Office of population Censuses and Surveys. Social Survey division. HMSO London

Edwards M & Hale N (1999) Opportunities in a managerial age. As in I Norman and S Cowley (eds) The Changing Nature of Nursing in a Managerial Age Oxford; Blackwell Science

Egan G (1998) The Skilled Helper London, Sage

Evers H, Badger F and Cameron E (1991) Taking Extra Care. Health Service Journal 4th July, p27-32

Fanon F (1967) The Wretched of the Earth London, Sage

Farrel GA (1997) Aggression in clinical settings: Nurses' views. Journal of Advanced Nursing 25 p501-508

Finch J (1993) "It's great to have someone to talk to: Ethics and Politics of Interviewing Women. In Hammersley M (1993) Social Research: Philosophy, Politics and Practice London, Sage

Fine F (1994) Working the hyphens: Reinventing self and other in qualitative research. In N Denzin and YS Lincoln (1994) A Handbook of Qualitative Research. London, Sage p70-82

Fontana A and Frey JH (1994) Interviewing: The Art of the Science. In N Denzin and YS Lincoln (1994) A Handbook of Qualitative Research. London, Sage p361-376

Forbes A, While A and Dyson L (2001) A multi-method examination of the views of community nurses on the core skills of community staff nurses. NT Research 6 p682-95

Foucault M (1974) The Birth of the Clinic London, Tavistock

Foucault M (1977) Discipline and Punish Hammondsworth, Penguin

Foucault M (1984) The History of Sexuality. Part 1 Hamondsworth; Penguin

Foucault M (1988) 'Technologies of the self ' in LH Martin, H Glitterman and PH Hutton (eds) Technologies of the self London, Tavistock

Fox J (1995) Ethics: an emerging management issue. British Journal of Healthcare Management 1(2) p 93-97

Fox N (1993) Postmodernism, Sociology and Health Buckingham, OUP

Freshwater D (2000) Crosscurrents: against cultural narration in nursing. Journal of Advanced Nursing 32 p481-89

Galvin K, Andrews C, Jackson D, Cheesman S, Fudge T and Ferris R (1999) Investigating and implementing change with the primary health care team. Journal of Advanced Nursing 30 p238 – 247

Gartman D (1997) Post-modernism, or, the cultural logic of post-fordism? The Sociological Quarterly 39, p119-27

Gbrich A (1999) Qualitative Research in Health London, Sage

Geerson E (1991) Supplementary Grounded Theory, in D Maines (ed) Social Organisation and Social Process: Essays in honour of Anslem Strauss New York, Adine de Gruyter

Geertz C (1988) Works and lives: The Anthropologist and Author Stanford, Stanford University Press

Gibbon B (1994) Stroke nursing care and manAement in the community; a survey of district nurses' perceived contribution in one health district in England. Journal of Advanced Nursing 20 p409-476

Gibbs I, Mc Caughan DN and Griffiths M (1991) Skill mixing in nursing: A selective view of the literature Journal of Advanced Nursing 16 p242-249

Giddens A (1990) The Consequences of Modernity Cambridge, Polity Press

Giddens A (1991) Modernity and Self Identity: Self and Society in the Late Modern Age Cambridge, Polity Press

Giddens A (1992) The Transformation of Intimacy Cambridge, Polity Press

Giddens A (1993) Risk and Ontological Security in Cassell P The Giddens Reader Basingstoke, Macmillan

Giddens A (1994) Beyond Left and Right: The future of radical politics Cambridge, Polity Press

Gilmore M, Bruce Nurse and Hunt M (1976) The Work of the Nursing Team in General Practice Edinburgh, The University of Edinburgh Press

Gillie A (1963) Field of Work of the Family Doctor Report of the Committee of the Standing Medical Advisory Committee (The Gillie Report) London HMSO

Gilligan C (1982) In a Different Voice London, Virago

Girvin A (1996) Leadership and Nursing Part 1: History and Politics. Nursing Management 3 p10-12

Glasser B (1978) Theoretical Sensitivity Mill Valley California, Sociological Press

Glasser B and Strauss A (1967) The Discovery of Grounded Theory: Strategies for Qualitative Research Chicago, Aldine

Glitterman A (1991) Handbook of social work practice with vulnerable populations New York; Columbia University Press

Goodman (1998) The Purchasing and Provision of District Nursing in GP Fundholding Settings: A Case Study.. Unpublished PhD Thesis, University of Hertfordshire.

Goodman C (2000) Integrated Nursing Teams: In whose interests Primary Health Care Research and Development 1 p207-215

Goodman C (2001) The use of metaphor in district nursing: maintaining a balance. Journal of Advanced Nursing 33 p106-112

Goodman C, Knight D, Machen I, Hunt B (1998) Emphasizing terminal care as district nursing work: a helpful strategy in a purchasing environment. Journal of Advanced Nursing 28 p491-498

Gordon DN (1988) Tenacious Assumptions in Western Medicine. In M Lock and Gordon District Nurse (Eds) Biomedicine Explained Dorecht, Klawer

Gramsci A (1971) Selections from the Prison Notebooks New York, International Press

Griffiths J (1995) Basic Clinical Procedures. As in Kenrick M and Luker KA (Eds) Clinical Nursing Practice in the Community London, Blackwell

Griffiths J (1996) An Ethnographic Study of District Nursing Work Unpublished PhD Thesis, University of Liverpool

Griffiths J (1998) Meeting Personal Hygeine Needs in the Community: A district nursing perspective on the health and social care divide. Health and Social Care in the Community 6 p234-240

Griffiths J and Luker KA (1994) Intraprofessional Teamwork in District Nursing: In whose interest? Journal of Advanced Nursing 20 p1038-1045

Griffiths J and Luker KA (1997) A barrier to clinical effectiveness: the etiquette of district nursing. Clinical Effectiveness in Nursing 1 p121-130

Guba EG and Lincoln YS (1994) Competing Paradigms in Qualitative Research. In N Denzin and YS Lincoln (1994) A Handbook of Qualitative Research. London, Sage p105-117

Hallett C (1997) Learning through reflection in the community: the relevance of Schon's theories of coaching to nurse education. International Journal of Nursing Studies 34 p103-110

Hallett CE and Pateman PD (2000) The invisible assessment: the role of the staff nurse in the community setting. Journal of Clinical Nursing 9 p751-762

Hallett CE, Williams A, Butterworth T (1996) The learning career in the community setting: a phenomenological study of a Project 2000 placement. Journal of Advanced Nursing 23 p578-586

Hamilton D (1994) Traditions, Preferences and Postures in Applied Qualitative Research. In N Denzin and YS Lincoln (1994) A Handbook of Qualitative Research. London, Sage p60-69

Hammersley M (1992) What's wrong with Ethnography London, Routledge

Hammersley M (1993) 'The rhetorical turn in ethnography' Social Science Information 32(1) p25-37

Hammersley M and Atkinson P (1996) Ethnography: Principles and Practices London, Routledge

Hancock C (1991) Community Nursing is there a Future? Senior Nurse 11, p18-19

Harre R (1984) Personal Being: A Theory for Individual Psychology Cambridge, Harvard University Press

Hargie O (!993) Communication Studies London, Routledge

Harrison S (1999) Clinical Autonomy and Health Policy: Past and Futures. In M Exworthy and S Halford (eds) Professionals and the New Managerialism in the Public Sector Buckingham, Open University Press

Harrison S and Ahmad WIU (2000) Medical Autonomy and the UK State 1975-2025. Sociology 34 p129-146

Harrison S and Moran M (1999) Resources and Rationing: Managing Supply and Demand in Healthcare. In G Albrecht, R Fitzpatrick and S Scrimshaw (eds) (1999) The Handbook of Social Studies in Health and Medicine London, Macmillan

Harrison S and Wood B (1999) Designing Health Service Organisation in the UK 1968-1998: From Blueprint to Bright Idea and Manipulated Emergence. Public Administration 47 p286-99

Harvard - Davies R (1971) The Organisation of Group Practice The report of the Sub Committee of the Standing Medical Council Advisory Committee of the Central Health Services Council. (The Harvard-Davies Report) London, HMSO

Haste FH and Macdonald LD (1992) The role of the specialist in community nursing: perceptions of specialist and district nurses. International Journal of Nursing Studies 29 p37-47

Haughey AC (1995) Contemporary District Nursing Practice. As in D Sines (ed) (1995) Community Health Care Nursing London, Blackwell Science

Haywood P (2000) The Changing Character of Service Provision. In P Tovey (Ed) Contemporary Primary Care: The Challenges of Change London, Routledge

Heckman SJ (1986) Hermeneutics and the sociology of knowledge Cambridge, Polity Press

Heidegger M (1967) Being in Time Oxford, Blackwell

Henneman EA (1995) Nurse-physician collaboration: a post-structuralist view. Journal of Advanced Nursing 22 p359-363

Hicks D (1976) Primary Health Care: A review by Donald Hicks London, HMSO

Hiscock J and Pearson M (1996) Professional costs and invisible value in the community nursing market. Journal of Interprofessional Care 10 p23-31

Hockey L (1966) Feeling the Pulse London, Queens Institute of District Nursing

Hockey L (1972) Care in the Balance. London, Queens Institute of District Nursing

Hockey L (1974) Use or Abuse London, Queens Institute of District Nursing

Hughes DN (1988) When nurse knows best: some aspects of nurse/doctor interaction in a casualty department. Sociology of Health and Illness 10(1) p1-22

Hugman R (2001) Post-welfare social work? Reconsidering post-modernism, post-fordism and social work education. Social Work Education 20 p320-332

Hunter DN (1995) Rationing Healthcare: The Political Perspective British Medical Journal 51 p876-874

Hunter D (1997) The challenges to healthcare restructuring Nursing Times 93 p67-70

Hurst P and Zeitlin J (1994) Flexible specialisation versus post fordism: theory, evidence and policy implications. Economy and Society 20(1) p1-51

Hyde V (1995) Community Nursing: A unified Discipline? In P Cain, V Hyde and E Howkins (1995) Community Nursing: Dimensions and Dilemmas London, Arnold

Jarvis S (2001) Skill mix in primary care – implications for the future London; Medical Practitioners Committee

Jenkins-Clarke S, Carr-Hill R and Dixon P (1998) Teams and seams: skill mix in primary care. Journal of Advanced Nursing 28 p1120-1126

Johnson M (1997) Nursing and Social Power Ashgate, Aldershot

Johnson M, Long T and White A (2001) Arguments for "British Pluralism" in qualitative health research. Journal of Advanced Nursing 33 p243-249

Jones P (1993) United We Stand – Divided We Fall. Journal of Community Nursing April, p11-13

Jupp V (1971) District Nursing as an example of a front line organisation. Nursing Times Occasional Papers 67 (33) p 129-131

Kant I (1949) Critique of Practical Reason Chicago, University of Chicago Press

Kearney R and Rainwater M (1996) The Continental Philosophy Reader London, Routledge

Keddy B, Jones-Gillis M, Jacobs P, Burton H and Roger M (1986) The doctor nurse relationship: an historical perspective. Journal of Advanced Nursing 11, p745-753

Kendrick K (1995) Nurses and doctors: a problem of partnership. As in K Soothill, L Mackay and C Webb, (eds) Interprofessional Relations in Healthcare London; Arnold

Kenrick M and Luker KA (1995) Clinical Nursing Practice in the Community Oxford, Blackwell Science

Kenrick M and Luker KA (1995) An Exploratioin of the influence of managerial factors on the research utilisation in district nursing practice Journal of Advanced Nursing 23 p697-704

Kilpatrick A (1989) Burnout correlates and validity of research designs in a large panel of studies. Journal of Health and Human Resources Administration 12(1) p24-43

Kincheloe JL and Mc Laren PL (1994) Rethinking Critical Theory and Qualitative Research. In N Denzin and YS Lincoln (1994) A Handbook of Qualitative Research. London, Sage

King L and Appleton LV (1996) Intuition: a critical review of the research and rhetoric. Journal of Advanced Nursing 26, p194-202

Kinnersley P, Anderson A and Parry K (2000) Randomised Controlled Trial for Nurse Practitioner Versus General Practitioner Care for Patients requesting "Same Day" Consultations in Primary Care. British Medical Journal 320 p1043-8

Klein R (1997) The case against. British Medical Journal 314 p506-509

Klein R (2001) Whats happening to Britain's National Health Service? New England Journal of Medicine 45 p305-308

Knights D and Mc Cabe D (2000) Ain't misbehavin? Opportunities for resistance under new forms of quality management Sociology 34 p421-436

Koch T and Harrington A (1998) Reconceptualising Rigour: the case for reflexivity. Journal of Advanced Nursing 28 p882-890

Kratz CR (1976) Some determinants of care of patients with stroke who were nursed in their own homes. Journal of Advanced Nursing 1 p86-91

Kratz CR (1978) Care of the long term sick in the community London; Churchill Livingstone

Kratz C (1982) Community Nursing – Prescription for excellence? Nursing Times April 1982, p676-682

Kristjanson L and Chalmers K (1990) Nurse client interactions in community based practice: creating a common ground. Public Health Nursing 7(4) p215-223

Kunda G (1992) Engineering Culture: control and commitment in a high tech corporation Philadelphia Pd; Temple University Press

Lather P (1991) Getting smart: Feminist research and pedagogy within the postmodern New York, Routledge

Laugharne C (1995) Ethnography: Research Method of Philosophy? Nurse Researcher 3(2) p 45-54

Law R (1997) The quality of district nursing care for dying patients. Nursing Standard 12 p41-44

Leap N (1997) Making sense of horizontal violence in midwifery. British Journal of Nursing 5 p689-696

Le Compte MD and Preissle J (1993) Ethnography and qualitative design in educational research. New York, Academic Press

Le Grand J, May SN, Nulligan J (1998) Learning from the NHS internal market: a review of the evidence London, Kings Fund

Lightfoot J, Baldwin S and Wright K (1992) Nursing by numbers: setting staffing levels for district nurses and health visiting services University of York, Social Policy Research Unit

Lincoln YS and Guba EG (1985) Naturalistic Inquiry Newbury Park, CA, Sage

Lipsky N (1980) Street level bureaucracy: dilemmas of the individual in public services New York; Russell Sage Foundation

LitwarK E (1985) Helping the elderly: The complementary role of the informal networks and formal systems New York; Guilford

Luker K (1995) Research and the configuration of nursing services Winnefred Raphael Memorial Lecture, Royal College of Nursing

Luker KA, Austin L, Caress A and Hallett CE (2000) The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care. Journal of Advanced Nursing 31 p775-782

Luker KA, Austin L, Hogg C, Ferguson N and Smith K (1998) Nurse patient relationships: the context of nurse prescribing. Journal of Advanced Nursing 28 p235-242

Luker KA & Kenrick M (1992) An exploratory study of the sources of influence on the clinical decisions of community nurses. Journal of Advanced Nursing 17 p457-466

Luker KA and Perkins E (1988) Lay carers' views on the District Nursing Service. Midwife, Health Visitor and Community Nurse 24,4 p132-134

Lupton D (1996) Your life in their hands: trust in the medical encounter. Sociology of Health and Illness 18(6) p157-172

Lyotard JF (1984) The Post Modern Condition Manchester, Manchester University Press

Mackay L (1993) Conflicts in care: medicine and nursing. London; Chapman Hall

Mackay L (1995) The patient as pawn. As in K Soothill, L Mackay and C Webb (eds) Interprofessional Relations in Health Care. London; Arnold

Mackenzie AE (1990) Learning from experience in the community: an ethnographic study of district nurse students. Unpublished PhD, University of Surrey

Mackenzie AE (1992) Learning from experience in the community: an ethnographic study of district nurse student. Journal of Advanced Nursing. 17 p682 – 691

Mac Leod M (1993) On knowing the patient: experiences of nurses undertaking care. As in A Radley (ed) Worlds of illness: biographical and cultural perspectives on health and disease. London; Routledge and Keegan Paul.

Macdonald LD, Addington-Hall JM, Hennessy DA and Gould TR (1991) Effects of acute hospital services on district nursing services: implications for quality assurance. International journal of nursing studies 28 p247

Mc Kenna H (1998) The "professional cleansing" of nursing. British Medical Journal 317(7170) p1403-1407

Mc Keown M (1995) The transformation of nurses' work. Journal of Nursing Management 3 p63-73

Mc Intosh J (1976) An observation and time study of the work of domiciliary nurses. Unpublished PhD Theses – University of Aberdeen

Mc Intosh J (1985) District Nursing: a case of political marginality. As in R White (1985) Ed. Political Issues in Nursing: Past, Present and Future Volume 1, Chichester, John Wiley and Sons

Mc Intosh J (1996) The question of knowledge in district nursing. International Journal of Nursing Studies 11 p316-324

Mc Intosh J and Dingwall R (1978) Teamwork in theory and practice. As in R Dingwall and J McIntosh (eds) Readings in the Sociology of Nursing. London; Churchill Livingstone

Mc Intosh J, Moriaty D N, Lugton J and Carney O (2000) Evolutionary change in the use of skills with the district nursing team: a study of two health board areas in Scotland Journal of Advanced Nursing 32 p783-790

Mc Intosh J and Richardson IM (1976) Work study of district nursing staff Scottish Home and Health Department

Mc Mahon RC (1991) Therapeutic Nursing: Theories, Issues and Practices. In R McMahon and A Pearson (eds), Nursing as Therapy. London; Chapman Hall

McMahon R and Pearson A (1992) Nursing as Therapy. London; Chapman Hall

McMurray A (1992) Expertise in community health nursing. Journal of Community Health Nursing 9 p65-75

McPhail G (1997) Management of change: an essential skill for nursing in the 1990's. Journal of Nursing Management 5 p195-198

Maggs-Rapport F (2000) Combining methodological approaches in research: ethnography and interpretive phenomenology Journal of Advanced Nursing 33 p243-249

Manthey M (1991) The practice of primary nursing. Boston; Blackwell Scientific

Marcus GE (1998) Ethnography Through Thick and Thin Princeton New Jersey, Princeton University Press

Marsh I (1996) Making Sense of Society London, Routledge

Marshall VW, Rosenthal CJ and Dacuck K (1987) Older patients' expectations for support. Social Justice Research 1 p405-424

May C (1991) Affective neutrality and involvement in nurse patient relationships: perceptions of appropriate behaviour among nurses in acute medical and surgical wards Journal of Advanced Nursing 16 p552-558

May C (1992) Individual Care? Power and Subjectivity in Therapeutic Relationships Sociology 26 p589-602

May C (1995) "To call it work somehow demeans it" The social construction of talk in the care of the terminally ill patient Journal of Advanced Nursing 552-558

May J (1999) From 'banana time to just in time: power and resistance at work. Sociology 34(4) p767-783

Maynard A and Bloor K (1996) Primary Health Care Reform: The need to reflect before reforming. Health Policy 31 p171-181

Meeds B and Pryor GA (1990) Early home rehabilitation for the elderly patient with hip fracture. The Peterborough hip fracture scheme. Physiotherapy 76(2) p75-77

Meleis A (1985) Theoretical Nursing: Developments and Progress. London; JB Lipincott and Co

Meutzel PA (1988) Therapeutic Nursing. As in A Pearson (ed) Primary nursing: nursing in the Burford and Oxford Nursing Development Units. London; Chapman and Hall

Miles MB and Huberman AM (1997) Qualitative Data Analysis London, Sage

Miller DS and Hackett EM (1980) A new member of the team. Extending the role of the nurse in British Primary Care. The Lancet (August 16th 1980) P358-361

Ministry of Health (1955) Report on the Working Party on the Training of District Nurses London, HMSO

Ministry of Health (1966) Report of the Committee in Senior Nursing Staff Structure The Salmon Report, London HMSO`

Mistiaen P, Duijnhouwer E, Wijkel O, de Bont M and Veeger A (1997) The problems of elderly people at home one week after discharge from and acute care setting. Journal of Advanced Nursing 25 p1233-1240

Morrison K and Cowley S (1999) Idealised Caring: The heart of Nursing. As in I Norman and S Cowley (eds) The Changing Nature of Nursing in a Managerial Age Oxford; Blackwell Science

Morse J (1991) Qualitative nursing research: a free for all?. As in J Morse (ed) Qualitative Nursing Research. A contemporary dialogue. Newbury Park, Sage

Munhall PL (1988) Ethical Considerations in Qualitative Research Western Journal of Nursing Research 10(2) p150-162

Munhall PL (1993) Language and Nursing Research. As in PL Munhall and C Oiler Boyd (Eds) Nursing Research: a qualitative perspective New York, National League for Nursing Research

Murphy E, Dingwall R, Greatbatch D, Parker S and Watson P (1998) Qualitative research in health technology assessment: a review of the literature. London, Health Technology Assessment, NHS R & D HTA Programme vol 2(16)

Nash P (1996) Doctors and nurses once more: an alternative to May. Journal of Medical Ethics 21 p82-83

National Health Service Management Executive (1998) A First Class Service: Quality in the NHS London, HMSO

National Health Service Management Executive (1992) The Nursing Skill Mix in the District Nursing Service. London; HMSO

Nolan M, Nolan J & Grant G (1995) Maintaining nurses' job satisfaction and morale. British Journal of Nursing 4 p1149-1154

Oakley A (1981) Interviewing Women: A Contradiction on Terms. In H Roberts (ed) Doing Feminist Research London, Routledge

Oakley A and Callaway H (1992) Anthropology and Autobiography New York, Routledge

Ong BN (1991) Researching needs in district nursing. Journal of advanced nursing. 16 p638-647

Orr J and Hallett C (1991) The Provision of Community Nursing Experience for Project 2000: an interim report to the English National Board for Nursing, Midwifery and Health Visiting. University of Manchester

Oxford English Dictionary The Concise Oxford English Dictionary London, Longman

Parahoo K (1998) Nursing Research: Principles, Process and Issues London, Macmillan

Parry-Jones B, Grant G, McGrath, Caldock K, Rancharan P and Robinson CA (1998) Stress and job satisfaction among social workers, community nurses and community psychiatric nurses: implications for the care management model. Health and Social Care in the Community 6 p 271-285

Parsons C (1995) The impact of postmodernism on research methodology: implications for nursing. Nursing Inquiry 2 p22-28

Paterson B, Mc Comish A and Aitken I (1997a) Abuse and Bullying Journal of Nursing Management 3 p 8-9

Paterson B, Mc Comish A and Aitken I (1997b) Abuse and Bullying Journal of Nursing Management 4 p21-23

Pederson LL and Leese B (1997) What will a primary care led NHD mean for GP workload? The problem of lack of an evidence base. British Medical Journal 314(7090) p1337-1345

Perry A (1993) A sociologist's view: the handmaidens theory. As in M Jolley and G Brykczynska (eds) Nursing: its hidden agendas. London; Edward Arnold p89-101

Peters T and Waterman RH Jnr (1982) In Search of Excellence. New York; Harper and Row

Piore M and Sabel C (1984) The Second Industrial Divide New York, Basic Books

Polgar S and Thomas SA (1997) Introduction to Research in the Health Services London, Churchill Livingstone

Pollert A (1988) Dismantling flexibility. Capital and Class 34 p42-75

Pollert A (1991) Farewell to flexibility. Oxford; Blackwell

Porter S (1991) A participant observation study of power relations between nurses and doctors in a general hospital. Journal of Advanced Nursing 16 p728-735

Porter S (1992) The poverty of professionalisation: a critical analysis of strategies for the occupational advancement of nursing. Journal of Advanced Nursing 17 p 720-726

Porter S (1997) The Patient and Power: Sociological Perspectives on Holistic Care. Health and Social Care in the CommunityU 5, p17-22

Porter-O Grady T (1993) Patient focussed care service models and nursing: Perils and possibilities. Journal of Nurse Administration 23 p7-8

Potter J and Weatherall M (1987) Discourse and Social Psychology: Beyond Attitudes and Behaviour London, Sage

Poulton BC and West MA (1993) Effective multi-disciplinary teamwork in primary health care. Journal of Advanced Nursing 18 p918

Poulton BC and West MA (1999) The determinants of effectiveness in primary health care teams. Journal of Interprofessional Care 13 p7-18

Punch M (1994) Politics and Ethics in Qualitative Research. In N Denzin and YS Lincoln (1994) A Handbook of Qualitative Research. London, Sage p83-98

Quinney R and Pearson M (1996) Different Worlds Missed Opportunities: primary health care nursing in a north western district Health and Community Research Unit, University of Liverpool

Radwin L (1996) "Knowing the Patient": a review of research on an emerging concept. Journal of Advanced Nursing 23 p 1142-1146

Rafferty AM (1996a) Nursing, Medicine, Quakery and Health Care Reform, 1844-1994. Nursing Research 45 p190-191

Rafferty AM (1996b) The Politics of nursing Knowledge London, Routledge

Ramprogus V (1995) The Destruction of Nursing: Developments in Nursing and Health Care. Aldershot; Avebury

Rapport F and Maggs C (1997) Measuring Care – the case of district nursing Journal of Advanced Nursing 25 p673-680

Reedy BLEC, Metcalfe AV, de Roumaine M and Newell DJ (1976) Nurses and nursing in primary medical care in England. British Medical Journal 2 p1304-1306

Reedy BLEC, Metcalfe AV, de Roumaine M and Newell DJ (1980a) The social and occupational characteristics of attached and employed nurses in General Practice. The Journal of the Royal College of General Practitioners 30 p477-482

Reedy BLEC, Metcalfe AV, de Roumaine M and Newell DJ (1980b) A comparison of the activities and opinions of attached and employed nurses in general practice. Journal of the Royal College of General Practitioners, 30 p 483-489

Rice AK (1958) Productivity and Social Organisation. London; Tavistock

Ritzer G (1996) Modern Sociological Theory London, Mc Graw Hill

Rogers AC (1997) Vulnerability, health and health care. Journal of Advanced Nursing 28 p65-71

Rogers C (1966) On Becoming a Person California, University of California Press

Ross RM (1987) District Nursing. As in J Littlewood (ed) (1987) Recent Advances in Nursing: Community Nursing Singapore, Longman

Ross FM (1990) Key Issues in District Nursing: Paper 2: New Horizons in Community Care: Policy and Perspectives for District Nursing London, District Nurses Association

Ross FM & Mackenzie AE (1996) Nursing in Primary Health Care London, Routledge

Ross FM and Bower P (1995) Standardised Assessment for Elderly People (SAFE): Feasibility Study in District Nursing. Journal of Clinical Nursing 4 p 303-310

Roy C (1970) Adaptation: A Conceptual Framework for Nursing. Nursing Outlook 18 p42-45

Royal College of Nursing (1992) Skill Mix and Reprofiling: a Guide for Members London; RCN

Sabel C (1982) Work and Politics Cambridge, Cambridge University Press

Salvage J (1990) The Theory and Practice of New Nursing. Nursing Times Occasional Papers 86(4) p42-45

Salvage J (1995) Nursing Intimacy: An ethnographic approach to nurse-patient interaction. London; Scutari Press

Salvage J (2000) The culture of culture in National Health Service policy implementation Nursing Inquiry 7 p230-238

Sarafino EP (1994) Health Psychology: Biopsychosocial Interactions. New York; John Wiley and Sons

Sayer A (1999) Method in Social Science: A Realist Approach London, Routledge

Seacombe I and Patch A (1995) recruiting, retaining and rewarding qualified nurses in 1994 Report 272, London, Institute for Employment Studies

Seale C (1992) Community nurses and the care of dying. Social Science and Medicine 34, p375-382

Sewell G and Wilkinson B (1992) "Someone to watch over me:" Surveillance, Discipline and the just in time labour process. Sociology 26 p271-289

Silverman D (1998) Qualitative Research: Theory, Method and Practice London, Sage

Sines D (1995) Community Health Care Nursing London, Blackwell Science

Slaughter R (1989) Cultural Reconstruction in the Post-Modern World. Journal of Curriculum Studies 3 p255-70

Smith J (1984) The problem of criteria for judging interpretive inquiry Educational Evaluation and Policy Analysis 6 p378-91

Speirs C (1995) Strategies for harassment counselling Occupational Health November p381-382

Stein (1967) The Doctor Nurse Game Archives of General Psychiatryu 16 p699-703

Stillwell B (1991) Defining a role for nurse practitioners in British General Practice. In J Wilson-Barnett & S Robinson (eds) Directions in Nursing Research London, Scutari Press

Stocks M (1960) A Hundred Years of District Nursing London, George Allen & Unwin

Strauss A (1987) Qualitative analysis for social scientists New York, Cambridge University Press

Strauss A and Corbin J (1990) Basics of Qualitative Research: Grounded Theory, Procedures and Techniques Newbury Park CA, Sage

de-Swaan A (1990) The Management of Normality London; Routledge

Svensson R (1996) The interplay between doctor and nurses – a negotiated order perspective. Sociology of Health and Illness 18 p379-398

Taylor F (1967) The Principles of Scientific Management New York; Harper

Thorne SE (1991) Methodological Orthodoxy in Qualitative Nursing Research: Analysis of the Issues. Qualitative Health Research 1 p 178- 199

Thorne SE and Robinson C (1988) Healthcare Relationships: The Chronic Illness Perspective. Research in Nursing and Health II p 293-299

Tierney AJ, Worth A and Watson N (2000) Meeting patients' information needs before and after discharge from hospital. Journal of Clinical Nursing 9 p859-860

Timpson J (1996) Towards and understanding of the human resource in the context of change in the NHS: Economic sense versus cultural sensibilities. Journal of Nursing Management 4 p315-324

Todd, Lord (Chairman) (1968) Report on the Royal Commission for Medical Education, 1965-68 (The Todd Report) London, HMSO

Todhunter C and Pearson M (1995) Informal non-kin support for older people: A literature review. Liverpool University; HACCRU

Toms E (1992) Evaluating the quality of patient care in district nursing. Journal of Advanced Nursing 17 p1489-1495

Tovey P (2000) Introduction. In P Tovey (Ed) Contemporary Primary Care: The Challenges of Change London, Routledge

Traynor M and Wade B (1994) The Morale of Nurses Working in the Community: A Study of Three NHS Trust. Year 3. NHS Trust Series Report III. London; Royal College of Nursing

Twigg J (1997) Deconstructing the social bath, help with bathing at home older and disabled people Journal of Social Policy 26 p211-232

Ungerson C (1983) Why do women care? As in J Finch and D Groves (eds) A labour of love: women, work and caring. London; Routledge and Keegan Paul

Ungerson C (1990) The language of Care. As in C Ungerson (ed) Gender and Caring. London; Harvester Wheatsheaf

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) Project 2000: A New Preparation for Practice. London, UKCC

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1991) Report on Proposals for the Future of Community Education and Practice London, UKCC

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) The Code of Professional Conduct London; UKCC

United Kingdom Central Council for Nusing. Midwifery and Health Visiting (1994) The Future of Professional Practice: The Council's Standards for Education and Practice following Registration London, UKCC

Vernon S, Ross F and Gould M (2000) Assessment of Older People, Politics and Practice in Primary Care Journal of Advanced Nursing 31 p282-87

Victor CR and Vetter NJ (1984) District Nurses' and the elderly after hospital discharge. Nursing Times 80 p61

Vidich AJ and Lyman SM (1994) Qualitative methods: Their history in Sociology and Anthropology. As in Denzin NK and Lincoln Y (1994) A Handbook of Qualitative Research London, Sage

Wade BE (1993) The job satisfaction of health visitors, district nurses and practice nurses working in areas served by four trusts: year 1. Journal of Advanced Nursing 18 p992-1004

Watson TJ (1994) In Search of Management: Culture, Chaos and Control in Managerial Work. London; Routledge

Watson J (1995) Post modernism and knowledge development in nursing Nursing Science Quarterly 8 p60-64

Watson TJ (1997) Sociology of Work and Industry. London, Routledge

White R (1985) Political regulators in British Nursing as in R White (ed) (1985) Political Issues in Nursing: Past, Present and Future Chichester, John Wiley and Sons

White E, Riley E, Davies S and Twin S (1993) A detailed study of the relationship between teaching, support, supervision and role modelling in clinical areas within the context of Project 2000 London, English National Board for Nursing, Midwifery and Health Visiting.

Wilkes L, Beale B, Hall E, Rees E, Watts B and Denne C (1988) Community nurses' descriptions of stress when caring in the home. International Journal of Palliative Nursing 4 p14 – 20

Wilkin D, Gillam S and Leese B (eds) (2001a) National Tracker Survey of Primary Care Groups and Trusts: Progress and Challenges 1999/2000. Manchester; National Primary Care Research and Development Centre

Wilkin D, Gillam S and Smith K (2001b) Tackling Organisational change in the new NHS. British Medical Journal 322(7300) p1464-1471

Wiles R and Robinson J (1994) Teamwork in primary care: the views and experiences of nurses, midwives and health visitors. Journal of Advanced Nursing 20 p324-330

Williams A and Sibbold B (1999) Changing roles and identities in primary health care: teams and interprofessional relationships. Journal of Advanced Nursing 129 p737-745

Willmott H (1995) Strength is ignorance, slavery is freedom: managing culture in modern organsiations. Journal of Management Studies 30 p511-512

Wilson AE (2000) The changing nature of primary health care teams and interprofessional relationships. As in P Tovey (ed) Contemporary Primary Care: the challenges of change. Buckingham; Open University Press

Witz A (1992) Professions and Patriarchy. London; Routledge

Wolcott H (1999) Ethnography – A Way of Seeing London, Alta Mira Press

Appendix 1 – Summary of Literature

Name of Author and Journal	Title -	Methods	Findings	Implication/Limitations
1966 Carstairs V X	Carstairs V (1966)Home Nursing in Scotland: report of an inquiry into local authority domiciliary services. Scottish Health Services Studies 2, Scottish Home and Health Department; Edinburgh	Diaries kept by district nurses for two weeks – analysis of activities and interviews with participants	• District nurses enjoyed giving personal or basic care • Just less than half their time is spent in giving patient care • Driving, organising and managing the team and communicating with doctors accounts for a significant amount of time in the working week of the district nurse	• First insight into the inefficiencies of district nursing work • Gives insight into the problems of care associated with community
Hockey L (1966)	Hockey L (1966) Feeling the Pulse. A Survey of District Nurses in Six Areas. London, Queens Institute of District Nursing.	A survey method of district nursing work in 6 areas (2 industrial, 2 retirement and 2 rural). Nurses, Doctors and other community staff were interviewed. Nurses kept a work load diary fro two weeks. Superintendents of district nurses were canvassed (n=149, rr= "good").	• District nurses spent "deplorably little time in actual patient contact" • 60% of time spent with patients and averaged about 12 home visits per day • Superintendents felt that the management system was satisfactory • No desire to improve the working practices of the district nurses • Many GPs claimed it was difficult to contact district nurses • 40% if GPs never or hardly ever met with the district nurse • GPs had no idea of the qualifications and skills of the district nurse • GPs did not know the difference between SEN and District nurse • Many of the district nurses lacked full information of the patient's condition and treatment and did not know what oral therapy they were prescribed	• Gives insight the dynamics of working in the community and the lack of collegiality between district nurses and their GP/Practice based colleagues • Judgemental piece – little account for the process of district nursing – i.e. the travelling, the organisation of the team etc • Highly acknowledge and influential piece of work which set the ball rolling to investigate the process of primary care nursing further
Hockey 1972	Hockey L (1972) Use or abuse. A study of the state enrolled nurse in the local authority nursing services. London, Queens Institute of District Nursing.	Pilot study in four local authorities in all of which SEN. The main study (survey) involved 47 study areas stratified by region and type of area. Final sample composed of SEN (n=528) SRN (n=471) and HV (n=241). Also surveyed chief or principle nursing officer, medical officers of health and General Practitioners. Unstructured interviews were also used to supplement the data.	• Managers were in favour of standardised training for both ENs and DNs. • Some reservation about making the training a licence to practice (like HV or Midwives) • Majority of managers were in favour of district nurse training being a part of the basic nurse education process • Community nurses suggested to be lagging behind the hospital in medical treatment and technology • Total of 56,885 activities analysed, two most frequent activities patient care contact and travelling • 20, 614 patient contacts analysed – (9,952 by SENs and 10 662 by SRNs) • Most patient care done between 8 am and 1 pm. • The only difference between the two patterns of	• The standard and quality of nursing care in the community are not addressed in this large scale study • The study and the findings were rushed in order to supply evidence to the Briggs Report • Does not address the structural components which inhibit best practice in the community particularly continuing education for district nurses • Fails to incorporate the deeper machinations of the district nurses' work

			work is t hat the SRN did more work in the evening than the SEN • SENs did not look after bedfast patients at all • SENs took longer and concentrated on basic care activities such as bed bathing • The role distinction is variable between the teams studied • SENs could easily undertake much of the work done by the SRNs • "The current confusion and anomalies surrounding the employment of enrolled nurses in the local authority nursing services is alarming. Guidelines for the deployment are either not available or outdated" • High standards must be safeguarded	
1976 Kratz CR	Kratz CR (1976) Some determinants of care of patients with stroke who were nursed in their own homes. Journal of Advanced Nursing 1 p86-91 Kratz CR (1978) Care of the long term sick in the community London; Churchill Livingstone	Grounded Theory which examined district nurses (n=34) care of long term patient (n=30). Analysis was systematic and true to grounded theory methodology	• District nurses liked patient who improved rapidly • Liked patient who were grateful • Some valued the old chronics due to the relationship they had with them and the steadiness within their caseload • "Fairness" (legitimate demands on district nursing time and proper use of these by patients • "Managing" patients should be as independent as possible • "People ought to manage and ought to want to manage • Skills were equated with technical tasks	• Shows some of the dynamics of district nursing • Medical discourse and high status work • The socio-political environment is not considered in this work • And the external demands on district nurses' work is not accounted for • Result of symbolic interactionist stance of the author
1974 Gilmore et al	Gilmore M, Bruce N and Hunt M (1974) The work of the nursing team in general practice. University of Edinburgh Press. Edinburgh	An intensive study of nursing teams in three health centres set in the perspective of a broader study of 36 randomly selected practices in England and Scotland 2 separate periods of two weeks each district nurses' and HVs kept timed record of their working activities Followed by 1 period of one month and two months activity of home visits recorded Questionnaires also collected about satisfaction with services they offered Wider teams (36 groups) postal questionnaire forced choice – looking at services and satisfaction levels, details of analysis unclear	• Nurses suggested that through team work with general practitioners they were able to provide a better service • Had a fuller understanding of patient's ailments and problems • Could openly consult with GPs • Could consult without delay • Care was more thorough • Wide variations in the adoption of team working in general practice • Was widely assumed that the team existed just as a result of attachment • No systematic means of working towards common goals, aims or co-ordination of work across the team • Teamwork was in a embryonic state • Laissez faire approach to communication although district nurses and GPs were satisfied with this • District nurses had to catch the doctor before starting domiciliary visits	• Difficult methodology to follow – lots of areas unclear as to why and what was done. • Implications are for the future development of primary care services • Education and training of GPs and district nurses and team efficiency

Reedy et al (1976)	Reedy BLEC, Metcalfe AV, de Roumaine M and Newell DJ (1976) Nurses and nursing in primary medical care in England. British Medical Journal 2 p1304-1306	Pilot study with 152 GP practices in Scotland. 9214 practices in England asked for enumeration of the nurses they employed and their characteristics Telephoned 10% of the non returners RR= 85.3%. Results analysed using inferential and descriptive statistics (chi square).	• Total of 2654 practice nurses employed • HA nurses were attached to the practice • Practices with attached nurses more likely to employ practice nurses • Social professionalisation of practice nurses noted • The numbers of DNs had risen (attached) exponentially whilst the numbers of PNs had risen slowly	• The link between the PN and DN is highlighted in this paper • There seems to have been a role carved out for each even at this early stage • Practice nurses were more practice based • Possible that nurses are empowered in practice because their DN could not do all the practice work
1976 Mc Intosh J X	Mc Intosh J (1974) An observation and time study of the work of domiciliary nurses. PhD Theses – University of Aberdeen	Observation Protocol of district nurses (n=30) over one week period each.	• District nurses find it hard to describe the tasks and work they are involved in • Learning in the community is centred around adaptation of skills previously learned in hospital to the community • Working in the community involves a transitional period and relearning of how to provide care • Power relations between district nurses and GPs in unbalanced – GPs have more authority • District nursing work is difficult for participants to articulate	The work of district nurses have evaded description to date – Small scale study although depth of information gathered looked at tasks (interesting when compared with Hockey's task analysis) Gives important insight to the nurse in the patient's home and the dynamic effect this has Makes little mention of socio-economic circumstances of the patients and the effect that this has on patients demands on the district nursing service
1976 Mc Intosh J X	Mc Intosh J and Richardson IM (1976) Work study of district nursing staff Scottish Home and Health Department	Timed observation of district nurses using a purposely defined observation schedule. Total of 1961 visit were observed, 30 district nurses were took part in the study.	• Marked variation in the time taken to prepare, deliver and complete care episodes among district nurses • Clear association between dependency and duration of visit • Longer duration of visits to the elderly is due to the fact that every nursing procedure is slower with the aged • Practice attached nurses have a significantly higher proportion of shorter visits than nurses attached on geography • Some nurses have a naturally quicker pace than others • Patient related variables can skew the timings – eg bereavement • Supervisory visits explored – but differing views recorded as to the value of these visits • Recorded the pattern of district nursing work and variations from am to pm • Highlighted the influence of travel time and administration on work • Contrasted with Kratz's work that EN's had considerable responsibility but were aware when care needed to be discussed with DNs	Use of time to measure dns work has proved useful and accurate Show the influence of factors such as a bed bath on the work of dns Dispels the myth that district nursing working consists of some technical procedures and social chat – average of 1/3 rd of dns time is spent in obtaining and giving information This knowledge is generally not shared well with other team members District nursing work demands a high level of skill and up to date knowledge Patient's expectation were rising GPs need to learn more about the role of the nurse Need to look at the processes and mechanics of team work in primary care

Jupp V (1971) X	Jupp V District Nursing: an example of front-line organization. Nursing Time August 19th p129-131	Polemical/sociological argument. Adapt sociology of organisation to the case of district nurses	• Devolved power to district nurses as it is difficult to oversee and an control their work • Front line organisation • Three characteristics • Initiative in the hands of district nurses • Each unit performs its work task independent of other similar units • There are barriers to the direct supervision of these units • Therefore show considerable initiative • Task independence • Are hard to supervise and control •	• Important
1978 Mc Intosh J and Dingwall R X	McIntosh J and Dingwall R (1978) Teamwork in theory and practice. As in R Dingwall and J McIntosh (eds) Readings in the Sociology of Nursing. London; Churchill Livingstone	A theoretical discussion of two pieces of research undertaken independently. JMc – district nurses and RD Health visitor. Applied their research findings to the sociology of the professions	• Suggested that district nurses where in a precarious situation in general practice • Doctors had the upper hand in that they were keen for nurses to takes on extra work "sloughing" • Doctors had incentives to make the surgery more efficient • GPs see the PHCT as group of auxiliary workers who they organise and direct • Relatively little sociable interaction • More direct subordination to doctors seems to be a worthwhile cost to pay for greater control over the organisation and management of nursing care • District nurses have low expectations of attachment	• Time to consider the organised hypocrisy that exist in PHC • Either accept the DNs and HVs are going to be subordinate to GPs • Or try to bring about radical change • May need a resolute attempt by DNs to assert themselves • Massive re-education of the public and greater lay involvement in the control of the activities of health related personnel
Reedy BLEC, Metcalfe AV, de Roumaine M and Newell DJ (1980a) X	Reedy BLEC, Metcalfe AV, de Roumaine M and Newell DJ (1980a) The social and occupational characteristics of attached and employed nurses in General Practice. The Journal of the Royal College of General Practitioners 30 p477-482	3 clusters of health authority staff were randomly selected – 72 PNs and 81 DNs were surveyed for the biographical, educational, career and personal details. Data analysed using inferential and descriptive statistics. RR 'high'.	• Attached nurses younger than the PNs • PNs more likely to be married • PNs more likely to be social classes 1 and 2 • PNs had one or more child living at home • More attached nurses DNs were SENs • PN more likely to have had long periods of economic inactivity than DNs (PN=8 years, DN=3.9 years) • PN more likely to have O and A levels and to have been educated in a Medical School rather than a School of Nursing • Differences in continuing education between the groups – DNs more likely to have it! •	• Absence of framework of continuing education for practice nurses • Attachment not effective at producing teamwork – DNs felt outside the practice configuration • GPs prefer to employ older, married nurses as practice based staff • PNs paid less than DNs • PNs not unionised • GPs favoured nurses educated in medical school as opposed to SON

Reedy et al (1980b) X	Reedy BLEC, Metcalfe AV, de Roumaine M and Newell DJ (1980b) A comparison of the activities and opinions of attached and employed nurses in general practice. Journal of the Royal College of General Practitioners, 30 p 483-489	Interviews of random sample of 153 nurses in 113 practices situated in 4 rural and 5 urban Area Health Authorities in England. 81 DNs and 72 PNs. Listed 43 activities developed from the literature, 10 caring activities, 17 intermediate activities and 16 technical activities. Tests of significant difference and descriptive stats used.	• Attached nurses more involved in caring activities than practice nurses • In technical activities the PNs were more active • Less difference between the groups on intermediate activities • Nurses with treatment room facilities did more technical care than those without • 49% of DNs v 20% of PNs chose the community because of direct patient care • 59% of PNs chose their work because of convenience • Significant difference about practice based work for DNs – DNs less likely to agree that teamwork exists than PNs • DNs felt less like a colleague of the GP than PNs • DNs see themselves as autonomous to the doctor whilst PNs see themselves as working for them	• As above • Interesting comparisons made. • Although the treatment room is mentioned, the effect of working in the home is not equated for in the analysis • The interpersonal skills used by the two groups is not considered • The effect of work in the home and the socio-economic conditions of the areas in which they worked is not referred to in the paper • Similarities may be an artefact of the tasks they used in the questionnaire • No validity and reliability of the tool included in the methods
Miller and Backett (1980) X	Miller DS and Backett EM (1980) A new member of the team. Extending the role of the nurse in British Primary Care. The Lancet (August 16th 1980) P358-361	Post questionnaire to a random sample of 690 GP principles (rr=77.3%) questioned about the appropriateness of nurses undertaking, after suitable training (not specified) certain clinical tasks (defined globally rather than specifically)	• 2/3rds of GP in favour of the extended role and were prepared to delegate clinical tasks to DNs • 31% saw no place for the extension of district nurses' roles •	• Method asked about groups of tasks rather than specifics • Show that GPs are reluctant to give over some of their role to DNs • Indicates that any developments in primary will be variably received
Bowling (1981a) X	Bowling (1981a) Delegation in general practice: a study of doctors and nurses. London, Tavistock.	Study using survey and interviews with GP (n=20) and DNs (n=75) in 4 areas in England and Wales. Results content analyses and descriptive and inferential statistics used.	• Doctors practicing delegation were more likely to work in a group practice situation and have influence of team members • They were more likely to be recent graduates • They would generally be involved in providing a wider range of services than non delegating GPs • There would invariably be a high degree of practice organisation (highly structured) • Over half the practices surveyed delegated rarely • Quarter of the practices did not delegate at all	• Results of this study show high variation in the practice of delegation • Suggest further research and policy investigation to establish which practices and activities can be delegated • Suggests that a standard list should be available to avoid confusion • Suggests that team relationships are terse in some areas
Bowling (1981b)	Bowling (1981b) Delegation to nurses in general practice. Journal of the Royal College of General Practitioners 31 p485-490	As above	• Significant number of DNs anti the expansion of their role in GP • 62% of GPs in favour of delegating a wide range of tasks • Up to quarter would not delegate any tasks at all • GPs generally acknowledge that delegation saves them time in their role • 35% felt that delegation would threaten the independence of the doctor • 25% believed that delegation creates more	• As above • This study highlights the fact that there was active resistance to the development of team work in primary care • Also highlights DNs concerns for their role and their lack of consultation in the process • Disparities between areas expressed

X			work • Older doctors regarded teamwork as alien • Nurses felt under-qualified for the expansion in their role	
1982 Dunnell and Dobbs X	Dunnell K and Dobbs J (1982) Nurses working in the community. Office of population Censuses and Surveys. Social Survey division. HMSO London	Survey method of district nurses work – census data	• 35% of work of district nurses' is spent in non clinical role • 74% of trained nurses' time and 89% auxiliary nurses' time is spent with patients over 65 • 26% of time is spent in technical procedures • 25% other nursing care excluding advice and education	• Survey methodology does not examine the rational or the real work of district nursing • What is involved task or more • Gives some impetus to the argument that district nursing services are inefficient
Coombs EM (1984) X	Coombs EM (1984) A conceptual framework for home nursing. JOAN 9 p157-163	Grounded theory using observation of district nurses in their setting, attendance at meetings, interviews with nurses, clients and viewing video material. Discussion groups were also used to validate the emerging theory	• District nursing is characterised by aloneness • Aloneness frequently associated with isolated nursing practice • DNs operating very often in situations in which they were inadequately prepared • No back up • Change the focus of the family from family to sick individual • Limited opportunities to discuss the frustrations of the job • But this counterbalanced with autonomy and freedom from scrutiny	• Makes reference to the isolating effect of district nursing • Points to educational preparation of district nurses being inadequate for the job •
Victor and Vetter (1984) X	Victor CR and Vetter NJ (1984) District Nurses' and the elderly after hospital discharge. Nursing Times 80 p61	A random sample of patients aged 65+ discharged after a minimum of 48hrs in hospital (n=2711). Postal questionnaires covering nine activities for independent life in the community (no offer or reliability of validity made). Patients attitudes to their health status assessed (no reliability and validity offered) RR=71% (83% when adjusted for death). Statistical analysis although details unclear.	• Use of DN services increased x3 after discharge • Disability (eg stroke) associated with highest use of DN services • Geriatric specialist involvement also associated with high rate of referral • Variation in services offered and referral rates noted • Relationship with specialist consultant most important variables	• Use of DN services is set to increase dramatically with the treatment of the long term frail elderly in the community • Further discharge of frail elderly set to swamp the DN service • Variation in services in the community is related to the speciality of the referring doctor, more from geriatricians than from medical doctors
1985 McIntosh X	Mc Intosh J (1985) District Nursing: a case of political marginality. As in R White (1985) Ed. Political Issues in Nursing: Past, Present and Future Volume 1, Chichester, John Wiley and Sons	An historical and policy based analysis of the development of district nursing services.	• Charts the development of district nursing from its earliest roots to the mid 1980's. • Suggests that through a process of policy drift, district nurses have been outside the mainstream nursing caucus • Argues that this is both to the detriment and benefit of district nursing services • Has led to many problems and battles for district nursing leaders • Argues that the services are essential to the development and maintenance of effective care in the home • Argues that district nursing is skilled rather than basic and the community is a difficult area to work	• Very useful references to the historic factors influencing the organisation of district nurses' work • Gives a structured argument based on historical and sociological theory

Bowling (1985) X	Bowling A (1985) District Health Authority policy and the 'extended' clinical role of the nurse in primary care. Journal of Advanced Nursing 10 p443-454	A 'brief' postal questionnaire to each of the 192 director of nursing services (community) (rr=100%) Questions asked What task? What training? What safeguards?	• 9% had no policy despite DoH guidelines • 8% had a verbal policy only • 7% had written policy which made a general statement only • 64% had detailed written policy in which some tasks were listed although the range of tasks varied between areas • 12% said their policy was currently being reviewed • Only 12% indicated the grade of nurse who could undertake the tasks • Few described the training needs of DNs • Only 13% had a structured training needs analysis and suggestions	• Extension of DNs role is a quagmire • DNs are at risk of litigation if the pressure to undertake extra work is not supported by robust training • The nurse can do what ever she/he is trained to do • Indicates the reluctance for a coordinated strategy to the expansion of DN role in primary care • Variation between areas and practices noted
1988 Luker and Perkins X	Luker KA and Perkins E (1988) Lay carers' views on the District Nursing Service. Midwife, Health Visitor and Community Nurse 24,4 p132-134	Detailed but unstructured interviews were collected from 31 carers of elderly people cared for at home	• Found that district nursing services were the most frequently employed service • There were no readily identifiable criteria relating either to the receipt of the district nursing service or frequency of contact • The functional capacity of the of an elderly person is less important in determining access to the district nursing service than social factors – eg living alone • In conclusion – district nurses use their own criteria which operate at a personal level to assess a situation before deciding whether or not to visit	
1989 Badger et al X	Badger F, Cameron E and Evers H (1989) District Nurses Patients: issues of caseload management. Journal of Advanced Nursing 14 p518-527	Multi-method examination using structured interviews with a random sample of patients (n=202) and service providers (n=619). Interviews also conducted to focus on 'interesting cases' (n=24)	• Nearly 20% of district nurse patients who are frail elderly or physically disabled remain current cases for 5 years or more • Three groups of long stay patients were identified • Young disabled, older people dressings and injections, older people seen by auxiliaries for bathing • Team organisation is crucial in relation to caseload mix • Long stayers could easily be discharged • Patients kept on because they were demanding • Or that they may cause a nuisance • DNs used as a shock absorber between GPs and troublesome patients • Traditionally given service therefore difficult to withdraw	• Suggests that district nurses need to re-examine their work with long term patients • Gives useful insight to the pressures faced by district nurses in rationing their services • Recommends further investigations into the caseload and skill mix of DNs

1989 Badger et al X	Badger F, Cameron E and Evers H (1989) District Nursing, the disabled and the elderly: who are the Black patients? Journal of Advanced Nursing 14 p376-82	see above	• Total no of black patients comparatively small • Who were district nurses' black disabled patients? • Black people tend to be disadvantaged compared to white people – less in informed, use the service less, less scope for effective communication • Relationship between Black people and DNs characterised by stereotype and myths • Nurses and disable patients had limited knowledge of each other • Language and communication problems evident in interaction	• Research should be based on the experience of the patient and not the service • Focus on the patient as the expert • Change needed in the organisation of district nurses • Need to be more flexible • GPs act as gatekeepers and therefore don't refer black patients as often as white even in if they have the same problems
1990 Mackenzie	Mackenzie AE (1990) Learning from experience in the community: an ethnographic study of district nurse students. Unpublished PhD, University of Surrey	Ethnography including in depth interviews and observation in two educational institutions inner city and rural. Longitudinal study over 2 years – 80 interviews	• Three major categories arose • Learning to fit to a new environment • Test out their own ideas • Compare the unreality of college with the reality of practice • Difficult for students to try out change • They learn rigid practices and routine • Difficult for the practice nurse teacher to control the practice setting and therefore the learning experience	• Need for further evaluation of the community as a practice setting • There needs to be more emphasis on reflection in district nursing • Points to the rigidness of practice in the community and the inability of district nurse to allow flexibility
1991 Bergen A X	Bergen A (1991) Nursing caring for the terminally ill in the community: a review of the literature. International journal of Nursing Studies 28 p89-101	Literature review of district nursing general and specialist services between 1981-1991 Address the questions • What and how effective are DNs • What and how effective are specialist oncology nurses • What model of nursing works best	• Difficult to make comparisons • Literature suggests • DN is a key player and planner • Carries out necessary care satisfactorily • Is well appreciated • Needs more time • There is unmet need • Some difficulty in obtaining nursing assistance	• Shows that district nurses are an appreciated member of the community service • Services are well liked and received • Need t o evaluate this further •
1991 Macdonald et al X	Macdonald LD, Addington-Hall JM, Hennessy DA and Gould TR (1991) Effects of acute hospital services on district nursing services: implications for quality assurance. International journal of nursing studies 28 p247	Survey of all health authority residents for acute beds with a referral to community health services were registered and followed up for one month at point 1 and then again 1 year later. A random sample of non referred patients were also included in the study. Telephone interviews used. Details of analysis unclear	No difference in referral rate between the two years of the study • There reduction in the number of hospital beds seems to have little effect on referrals to district nurses	• This study does not take into account the fact that there are less hospital beds may mean that district nurses are getting busier and keeping people out of hospital. • Crude measure only really measure no of referrals and their perceptions of care • Further research needed to describe needs and the change in demands of DN work •
1991 Ong X	Ong BN (1991) Researching needs in district nursing. Journal of advanced nursing. 16 p638-647	Multimethod qualitative (ethnographic) approach and quantitative activity/needs analysis with 10 patients and their carers		

1992 Mackenzie X	Mackenzie AE (1992) Learning from experience in the community: an ethnographic study of district nurse student. Journal of advanced nursing. 17 p682 – 691	Ethnography (see Mackenzie 1990) Relies heavily on Schon	Develops the themes from the PhD study • Fitting in • Fitting in with colleagues is an important aspect of the learning – this is associated with accepting traditional practice/routines • Fitting in with patients means having to adapt to work in the patient's home rather than hospital – being non threatening • Trying and testing out new ideas and previous knowledge from other areas of nursing • Learning opportunities variable • Reality of practice differs from the ideal taught in college	• Suggests that there are barriers to students' learning particularly for the process of reflection on their work • Disparity between what students want to do the expectations of the FWT • Community FWT express frustration about not being able to give students a good deal • Paucity of suitable areas for district nurses to work with student and encourage reflection in action (Schon)
1992 Bergen A X	Bergen A (1992) Evaluating nursing care of the terminally ill in the community: a case study approach. International journal of nursing studies, 29 p81-94	Multiple case study design – based on Care of the Dying Standard based on the Donabedian approach – interview schedule and patient interviews. 27 interview conducted patients (n=9) their district nurse (n=9) and a continuing care nurse (n=9)	• District nurses usually meet the expected standards of care for the terminally ill • No problems with time or accessing equipment • Referrals often made too late to provide good/best quality care • Continuing care nurses more instrumental in giving psychological care • Cancer care tested district nurses knowledge/skills but district nurses used other agencies to help • High level of liaison work between the DN and the Cancer Care Nurse	• Care provided by DNs in association with Cancer Care Nurse was meeting most patients needs • Methods of referral need to be improved • Counselling skills of district nurses need to be considered • The standard of care used in the study is incomplete • More case study research is needed • More research into the carer's perspective • Need to research cancer related fatigue
1992 Toms X	Toms E (1992) Evaluating the quality of patient care in district nursing. Journal of Advanced Nursing 17 p1489-1495	A review of the use of Audit in community nursing. No inclusion criteria included therefore the arguments/assertions are largely polemical	• Claims that audit has a positive place in researching community nursing • Greater awareness of staff needs • Community needs can be identified • Staffing patterns can be adjusted • Financial savings made • Audit increases job satisfaction • Leads to greater community involvement and improvements in the quality of care	• Poor support for the assertions offered in this paper • No evidence to suggest that audit or the audit process has any benefits on patient care
1992 Seale C	Seale C (1992) Community nurses and the care of dying. Social Science and Medicine 34, p375-382	Interviews with the person who knew the deceased best during the last 12 months of their life. Nurses providing the care were interviewed. Interviews were subjected to both qualitative and quantitative analysis. All results compared to an earlier study 1969 which used the same methodology	• Original respondents perceptions of the adequacy of the care offered showed little change between 1969-1987 • Respondents were satisfied with the level of help they received • Less frequent visits offered in the 1987 study • Greater emphasis on hands off care in 1987 observed • DNs reported wanting to spend more time with terminal patients in the 1987 study • Nurses were more critical of the services in general than specifically	• Note that the patient satisfaction with the service may be a skewed measure • There are problems with comparisons – when satisfaction is measured what can the patient compare it with • DN need more time to attend to this important aspect of care

X			• DN have to cope with considerable stress • DN services viewed as being overstretched • Lack of time a considerable constraint on best possible care – DNs aware of their inadequacy	
1992 Haste and Macdonald X	Haste FH and Macdonald LD (1992) The role of the specialist in community nursing: perceptions of specialist and district nurses. International journal of nursing studies 29 p37-47	Interviews undertaken with all nurse managers (n=10), specialist nurses (n=12) and district nurses (n=40) in a health authority locality. Variation in techniques – open ended questions for managers and closed format schedules for nurses. Nurse Satisfaction Questionnaire used.	• Disparity in the opinions between DN and specialist nurses as to the function of their role • SN felt that their role entailed education formal and informal • DNs gave this lower priority • DN felt that they needed more education about specialist aspects of the role • DNs would prefer to carry out the specialist tasks themselves • The educational aspect of the specialist role is seriously underdeveloped • Some district nurses resentful of the specialist role • Most resentment centred around the provision of hands on care – there was a lack of clarity around the boundaries of care provision • Communication between district nurses and specialist nurses needed to be improved	• This has implications for the multi-disciplinary team work of DNs • Shows the tensions and alludes to the protectionism of DNs around their work • A robust study – showing professional boundaries of community nursing teams
1992 Mc Murray X	McMurray A (1992) Expertise in community health nursing. Journal of community health nursing 9 p65-75	Participant observation and interviews undertaken with district nurses, school health and child health nurses (n=37).	• expert nurses were judged to have the following characteristics • Increased knowledge, empathy, appropriate communication skills with the team and other professionals, an holistic approach, an ability to see through multiple problems and provide a viable solution, self confidence.	• Suggests that that the model of expertise should be expanded (ref to Benner and Tanner's work) • DN should be taught using more case studies which stimulate inferential and intuitive thinking
1993 Wade X	Wade BE (1993) The job satisfaction of health visitors, district nurses and practice nurses working in areas served by four trust; year 1 Journal of Advanced Nursing 18 p992-1004	A survey of the district nurses (n=140), health visitors (182) and practice nurses (n=212) using the Measure of job satisfaction. Sample came from 4 trusts. Return rate varied between 56 and 73% mean return rate 66%. Data analysed using descriptive and inferential (ANOVA) stats. Some open-ended questions included in questionnaire/survey. Details of the analysis of these not included.	• Practice nurses highly satisfied with their jobs • District nurses "reasonably satisfied" • Health visitors considerably less satisfied • Also noted that there were considerable differences across trust areas which were attributed to historical and geographical factors (not explained) • Findings suggests a sense of alienation nurses • May be related to the speed of change in the community • Conflict between nurses' and managers' agenda	• Shows the beginning effect of change in the profile and working practices on the job satisfaction of community nurses • Show the terse relationship between district nurses and managers
Poulton and West (1993)	Poulton BC and West MA (1993) Effective multidisciplinary teamwork in primary health care Journal of Advanced Nursing 18 p918-925	Reviewed the theories and the nature and development of team work in primary health care and outlined a forthcoming study into the effectiveness of team work in primary health care.	• Assumptions are made that PHCT work well as a team and are more effective in terms of improved quality of service to patients • Health promotion is better tackled in a team approach • Research is needed into what actually constitutes team effectiveness in PHCTs • Research also need to identify performance indicators	• Highlights the notion that the team in PHC is a myth rather than a reality • Team effectiveness is an elusive concept and is difficult to measure • Team outcomes are often doctor led rather than team led and these link into the priorities (often financial) given to doctors by FHSA/central

X			• Seeking to develop a model of team effectiveness	government
1994 Gibbon X	Gibbon B (1994) Stroke nursing care and management in the community; a survey of district nurses' perceived contribution in one health district in England. Journal of advanced nursing 20 p409-476	Semi structured interviews with district nurses (n=28) for 20-30 mins. Mixture of individual interviews (n=14) and focus group (n=12). Interview transcripts analysed using latent content analysis.	• Caring for patients in their own home is valued by district nurses • DNs thought of themselves as a supporter to the carer rather than the main provider of care • Some found rehab work challenging whilst other found it frustrating • Stroke patients were few in number but high in burden • Some nurses were unaware of the patients CVA diagnosis! • Some felt not their job to do rehab work – job of physio, family • Bathing and personal hygiene was thought to be the domain of DNs	• DN interventions result when the carer or carers fail to manage (down stream) • DNs concerned with chronicity rather than rehab • No major role in rehab noted • Auxiliaries do most of the visits • Lack of available time/lack of preparation/beyond role noted • NB similarities with Kratz (1976)
1994 Wiles and Robinson X	Wiles R and Robinson J (1994) Teamwork in primary care: the views and experiences of nurses, midwives and health visitors. Journal of Advanced Nursing 20 p324-330	Random sample of 20 practices were selected from a list of 86 in one FHSA area. Interviewed a practice manager, health visitor, district nurse, midwife and practice nurse in each practice. Most senior nurse chosen for inclusion. Interview constructed from a semi-structured questionnaire, pre-coded. Data analysed by grouping together the responses under 11 main headings	• 6 themes emerged – team identity, leadership, access to gps, philosophies of care, roles and responsibilities, disgreement concerning roles and responsibilities • More than half (54%) of the nurses saw the GP as the leader of the team • DNs felt that gps appeared to account for their not feeling part of the team • DNs felt gps not approachable • DNs felt that many gps did not understand their role – inappropriate referrals • Lack of communication between gps and DNs identified as a problem • DN role felt to be threatened by fundholding DNs have been more able to claim an area of work than PNs or HVs	• Team work in primary care has hit a status quo • DNs seem destined to continue in a team where gps have most status and power • Situation looks bleakest for HVs but is also bad for DNs • They need to define a unique area of work that is theirs and theirs alone • Attempts to change PHCT and produce greater democratic teamwork appear to bring only limited change
1994 Bergen X	Bergen A (1994) Case management in the community: identifying a role for nursing. Journal of clinical nursing 3 p 251-257	122 questionnaires were sent to individual nurse managers in 98 health authorities. Response rate of 68%	• That the advantages of case management were: - • Co-ordination of care package • Individualised care • Cost effectiveness • Promotion of quality care • Advocacy • One stop assessment process favoured • Disadvantages: - • Reduced quality of service • Lack of choice • Low priority given to non case managed clients • Gaps in provision • Confusion	• Care management is extremely variable in the community • Problems with interagency work exist • Further case study work is need to facilitate the organisation and description of case management procedures

1994 Traynor	Traynor M (1994) The views and values of community nurses and their managers: research in progress – one person's pain, another person's vision. Journal of advanced nursing 20 p 101-109	24 structured interviews with trust managers from 3 health authority trusts. Analysed using ETHNOGRAPH computer package. Also self-completed open-ended questions from the Measure of Job Satisfaction questionnaire from 368 community nurses were included in the analysis.	• Nurses described themselves as strongly orientated towards delivering personal care and drew sense and meaning from this • Their frustration was not being able to provide good quality care economic restraints • Nurses felt alienated from their managers • Caring versus finance common theme • Special experience of caring put them on a different dimension to managers • Managers had different priorities from nurses – conflict • Nurses expressed a sense of profound powerlessness in the face of financial forces	• Nurses are colonised by management • Domination and subservient relationships • Further research needed into the specifics of how power is put into practice, as there is little understanding of this. • Relates the work to Foucault and Friere
1994 Griffiths X	Griffiths J and Luker KA (1994) Intraprofessional team work in district nursing: in whose interest? Journal of Advanced Nursing 20 p1036-1045	Ethnographic study in two health authorities in the north west of England. G and H grade district nurses (n=16) took part, caseload managers. Observation and fieldnotes and interviews (in depth) and analysed using grounded theory approach.	• Themes occurred: - • Committing services – don't do anything that a covering colleague wouldn't do • Flat hierarchy exists among similarly qualified district nurses – therefore respect for autonomy and decisions of colleagues • No interference with colleagues work • Collegiality the order of the day • Content of district nurses caseload was not monitored by managers – therefore considerable scope for discrepancies • Rationing of care noted • Setting a precedent was a reason for not committing a service • Rules exist about changing colleagues care plans – etiquette – not the done thing • Presenting a united front • Undermining confidence – not done in earshot of the patient	• Examples given suggest that team work does not occur to any great degree in district nursing team • Shows the relative autonomy and respect for colleagues decisions in primary care • The research does not account for the changing political climate and growth in evidence based practice • Responsibility not addressed in the study
(1995) Luker and Kenrick X	Luker KA and Kenrick M Towards knowledge based practice: an evaluation of a method of dissemination. International journal of nursing studies32 p 59-67	Evaluated the impact of a leg ulcer information pack on reported practice. District nurses in 5 health authorities (n=171) were given a pre-test of which three experimental sites were given a leg ulcer pack (n=146) 25 nurses acted as a control. Post intervention questionnaires were administered t + 6 weeks to the experimental group (n=109) and the control group (n=21). Measure of leg ulcer knowledge was calculated and descriptive and inferential statistics calculated.	• Knowledge scores for the experimental group improved – result statistically significant • Knowledge increased significantly across all measures of the instrument assessment, treatment and general knowledge • Control group did not show any significant change • Research based evidence can affect the knowledge and reported practice of DNs • Particularly when presented material has meaning for DNs • Results of pack depended as much on presentation, marketing etc as the info contained therein	

1995 Ross and Bower X	Ross FM and Bower P (1995) Standardised assessment for elderly people (SAFE) – a feasibility study in district nursing. Journal of Clinical Nursing 4 p303-310	A report on the SAFE assessment measures agreed by the working party of the Royal College of Physicians. A feasibility study of SAFE in district nursing practice. Assessed the time taken to carry out the assessments, acceptability to the patient, carer and district nurse and the training required. 40 patients over 65 interviewed by 2 trained and experienced district nurses. Evaluated the use of BAI, AMT, GDS and PCGMS	• Found that the scales of measurements could be used by district nurses • But suggested that regular use of the instruments must be feasible and take account of practical constraints of time and finance • The instruments must have clinical utility providing information that is both relevant and valid with which DNs can work • The instruments must be acceptable to the patient, carer and DN – and should be used for a therapeutic purpose	
1996 McIntosh X	McIntosh J (1996) The question of knowledge in district nursing. International Journal of Nursing Studies 11 p316-324	A review of the influences on district nursing knowledge. Draws on earlier observation and research.	• Suggests that the formulation of district nursing knowledge is complex • Is artistic and draws on experience of working in peoples home • Education system has failed to prepare nurses for their role in the community • Experiential knowledge related to the work of Schon	• District nursing work and the skills involved are under evaluated in the literature • The skills involved in learning to care in the home are under-estimated • Nursing education system is largely failing district nurses in not working with or facilitating the transition from hospital nursing into the community or the home
1996 Hiscock and Pearson X	Hiscock J and Pearson M (1996) Professional costs and invisible value in the community nursing market. Journal of Interprofessional Care 10 p23-31	Adopted a case study approach working in depth with four general practices and associated community nursing and social services staff. In depth interviews were conducted with 98 staff. Social services managers (n=7) health service managers (n=26) field social workers (n=36) and fieldwork health professionals (district nurses and health visitors) (n=36). Initial data analysed using inductive analysis and then moved onto content analysis.	• Intra-professional organisational issues and concerns within both health and social services have prevented joint working • The introduction of market mechanisms had a major effect on community nurses professional relationships within the health service • DNs described how they had changed their practice – lead to a sense of deskilling for district nurses • Described treating gps with kid gloves • Described bending over backwards to accommodate gps • Described a change in volume and type of demands made by gps • Acted as the trusts day to day shop window in the market economy • Gps power over community nurses had increased • DNs felt a sense of being owned by the GP • No evidence of collegiality or team work • Felt vulnerable and insecure about their future in relation to contracts	• Reflects the effects of the purchaser provider split • Gives insight into the dynamic both intra-professional and inter-professional in primary care • Robust study but does not give an justification for the method of analysis • Lacks observational analysis

			• Felt isolated from other district nurses • Had taken on personal responsibility for their colleagues' and employer's future • The introduction of market mechanisms has strengthened and exposed issues of power in general practice • Significant evidence that district nurses are deskilled and demotivated • Associated with high stress, low morale and vulnerability	
1996 Hallett et al X	Hallett CE, Williams A, Butterworth T (1996) The learning career in the community setting: a phenomenological study of a Project 2000 placement. Journal of Advanced Nursing 23 p578-586	Students from one college of nursing were recruited from the North West of England. 26 subjects recruited, mixture of students and district nursing supervisors (exact breakdown of numbers unclear)	• Students learning in the community understood as a sequence of events • Encountering reality – dissonance between theory and practice • Having a go – gaining competence in practical procedures • Gaining Confidence – great importance attached to the acquisition of competence • Thinking through and understanding – the process of "knowing in action" • Developing ideas – by reflecting on practice • Being independent – independent visiting were students were left to develop their own independent practice • Being assessed – problems between theory (college based) and practical situation • DN assessors reported demonstrating and enabling, building students' confidence, promoting thoughtful practice, monitoring and assessing as important themes	• Small scale study although large in phenomenological terms • Shows internal consistency with the phenomenological method • Experience described well • Shows the complexities of work in the community and the difference to the hospital setting • Has implications for the development of learning in action
1996 Kenrick and Luker X	Kenrick M and Luker KA (1996) An exploration of managerial factors on research utilization in district nursing practice. Journal of Advanced Nursing 23 p697-704	Interviewed 22 middle managers of district nursing services from 5 health districts. Used a structured but conversational style interview schedule. Data analysed using line-by-line content analysis.	• The majority of nurse managers saw themselves as managers and not nurses • In spite of this many of the participants believed that they still maintained strong clinic insights • All managers had had some management training • The more established the trust – the more management training • Managers had a very clearly defined place in a strict hierarchical structure, with direct lines of reporting • Evidence to suggest that the organisational climate is supporting the growth of managerialism at the expense of professional values • It is perhaps necessary for managers of clinical services to have an ownership of clinical work if research utilisation is to be achieved in practice	• Suggests research utilisation is complex and inextricably bound up with the organisational culture of the trusts • A positive organisational culture is needed if evidence based practice is to be achieved • DNs would benefit from knowing that their practices were making a contribution to the delivery of health care in the community

1996 Brocklehurst and Butterworth X	Brocklehurst N and Butterworth T (1996) Establishing good practices in continuing care: a descriptive study of community nursing services for people with HIV infection. Journal of Advanced Nursing 24 – 488-497	Case study analysis of people affected by HIV infection in six health authorities. Triangulated methodology – case study approach, non participant observation, case note analysis, semi-structured interviews, postal questionnaire of district nurses (n=77)	• HIV related patients referred to district nurses only if they had a severe physical problem • A wide range of physical problems were identified, particularly problems with self care, pressure sores, diarrhoea and loss of eyesight • Also many emotional and social problems • Emotional needs of patients were the most time consuming • Nearly half the sample reported visiting HIV infected patients outside normal hours due to time constraints during the day • DNs age, length of time in post and number of HIV positive clients seen were to be predictive of increased self reported stress • Reported more resources were needed • Better communication with other agencies • More education and training • Increased support and supervision	• Shows the complexity of incorporating highly demanding care into the work of DNs • Show the ineffectiveness of discharge procedure, nursing notes, feedback and communication and liaison • Effective care only achieved when the care was co-ordinated • DNs willing to take on and work with this clients group • Worked considerably long hours • Did not want this aspect of work taken over by specialist nurses • Inadequate training identified
1996 Anonymous X	Anonymous (1996) Assessing need for district nursing: study findings. Nursing Standard 10 p32	A study of two groups of district nurses working in contrasting areas of a major city in the West of Scotland. 706 new referrals to district nurses were monitored. 422 people recently discharged from hospital received a questionnaire. In-depth interviews were held with district nurses (n=20) GPs (n=37) and social workers (n=33)	• The nature of the referral was the main way in which DNs assessed need • Little evidence of practice approach to identifying need at either individual or community level discovered • Direct public access to district nurses is restricted • GP acts a gatekeeper to district nursing services • Referrals to DNs inequitable and main referrers have different ideas about what DNs do • Role boundaries between district nurses and other health and social work professionals are the subject of misunderstanding • The provision of nursing care is hampered by the barriers which exist to the identification of need for district nursing • District nurses face problems in meeting identified needs for their care	• Difficult to evaluate and trust as names and methods are unclear although the study seems robust • Shows the problems facing DNs in interprofessional liaison with social workers and gps
1997 Rapport and Maggs X	Rapport F and Maggs C (1997) Measuring Care: the case of district nursing. Journal of Advanced Nursing 25 p673-680	Interviews and participant observation informed by ethnography and interpretative phenomenology – spoken narrative. 43 participants were recruited district nursing team managers, team members, district nursing officers, a fundholding practice manager social workers and social work manager. Numbers not stated	• Dns have a routine – patient need is reflected through patterns and routines • Time is limited – nurses have to make do • This leads to a lowering in standards • Dns are demoralised • Patients feel well cared for • Nurses describe themselves as being overworked, stressed and rushed • Patients trust nurses more than doctors or social workers • Form filling and paperwork duties have risen out of all proportion	• Shows the threat experienced by dns • Shows the dynamics of collaboration or not • Structural limitations on dns working practices highlighted • Suggest that the lack of collaboration and inter-professional collaboration has been the result of dns being excluded from the planning phase of community care

			• Nurses feel unable to take part in continuing education programmes because of pressure of work • Nurses reported low morale due to staff shortages and regrading • Gps were worried that experienced staff were being replaced with less able substitutes • Dns felt that social care provision was not working well • Nurses felt particularly insecure	
1997 Law X	Law R (1997) The quality of district nursing care for dying patients. Nursing Standard 12 p41-44	Focus group methodology was used for a preliminary study. 6 nurses were interviewed and observed giving care to terminal patients. Data were analysed using key events in the district nurses' community terminal care practices were coded and collated.	• Highlighted the difference between terminal care for cancer patients and non cancer patients • Non cancer patients treated differently • Participants found it difficult to classify when patient began to need terminal care • The findings suggest that there is scope for dns to be more effective in providing terminal care • Dns are satisfied with the terminal care they provide • Good terminal care entailed Establishing good relationships, Effective control of pain and symptoms, Involving patients in their own care, Working relationship with gps • Dns felt that care should be kept by them and not passed over to Macmillan nurses • Dns spent a lot more time than they acknowledged in providing psychological care to terminal patients and their families • Although dns felt that they provided high standards of terminal care to all their dying patients they lacked knowledge about drugs and pain control	• More education needed for dns around terminal care • A team approach to terminal care should be encouraged • More resources should be made available to employ support staff to enable the provision of 24 care • Quality of end of life care should not depend on diagnosis
1997 Griffiths JM and Luker KA X	Griffiths JM and Luker KA (1997) A barrier to clinical effectiveness: the etiquette of district nursing. Clinical Effectiveness in Nursing 1 p121-130	Ethnographic study of district nurses work – 13 days of observation and 50 semi structured interviews with 37 f,g and h grade district nurses	• Findings Etiquette between district nursing teams resulted in a lack of challenge • Care only challenged if the patients' condition had deteriorated • Care would only be challenged if the relationship between the covering nurse and regular nurse was good enough • Care was always challenged in a non threatening way • Challenge was always done away from the patient • Challenge would only occur if the nurse was a member of her own team, if the nurse has a suitable personality, if the visiting nurses' knowledge was up to date, the patient's history was known, stress levels of the substituting nurse, perceived seriousness	• A formal set up for clinical peer review would be useful • Managers need to foster a more challenging, questioning culture • Critical review and support of peers important • Care offered by dns is viewed as nurse centred rather than patient centred

1997 Hallett X	Hallett C (1997) Learning through reflection in the community: the relevance of Schon's theories of coaching to nurse education. International Journal of Nursing Studies 34 p103-110	An phenomenological study of project 2000 students (n=12) and their DN supervisors (n=14) were interviewed. Gadamer's circle of understands used to interpret the data.	• Students reported the value of learning by doing – but under supervision • Reflection on practice is important – particularly when supervised by the district nurse • Developing personal theories about care and the care process was evident • Nursing theories were difficult to adapt and relate to the community setting • The learning is absolutely dependent on the activity and input of the district nurse	• Students believed in learning by doing – has implication for the theoretical approach for teaching students • Students had to spend some time practising without knowing what they were doing • There is no neat fit between theory and practice • Confusion is a necessary pre-requisite for learning
1998 Luker et al X	Luker KA, Austin L, Hogg C, Ferguson N and Smith K (1998) Nurse patient relationships: the context of nurse prescribing. Journal of Advanced Nursing 28 p235-242	A convenience sample of patients selected from the caseload of dns, HVs and PNs at each of the demonstration sites. Interviews with patients in the 3-month period prior to implementation of nurse prescribing (n=157) and a second round 8-12 months following implementation (n=148). Interviews were semi structured and were analysed using thematic content analysis. Themes were verified by the team prior to coding and quantification.	• The majority of patients interviewed were in favour of nurses being able to prescribe • Continuity of care with nurses was important • The expertise of nurses in certain areas was also stressed • More than half of the patients sought advice from a nurse in preference to the GP • DN patients were more likely to ask about skin care and would care • Some patients rated the advice given by nurses as more appropriate than that of gps • Patients were able to distinguish between the role of the GP and the role of the nurse • Problems of getting an appointment with the GP was an important feature • The gender of the nurse was important • There was reluctance to contact a GP	• The patients were overwhelmingly in favour of nurse prescribing • Many expressed confidence in the nurses' ability • Nurses were seen as more approachable • More trivial complaints were seen by dns • There is potential for role expansion • The study does not look at the dynamic effect this extra work has had on the caseload and working practices of dns
1998 Wilkes et al X	Wilkes L, Beale B, Hall E, Rees E, Watts B and Denne C (1988) Community nurses' descriptions of stress when caring in the home. International journal of Palliative Nursing 4 p14 – 20	Data were collected from district or community nurses using a questionnaire (n=21) and semi structured interviews (n-7). Analysed using ethnograph.	• Found palliative care in the home characterised by • - Lack of control • - Inadequacy and overload • - Inability to cope • - Lack of knowledge • Major stressors for the nurses were poor family dynamics, the family wanting the nurse to be part of the family unit, workloads and others' expectations • Nurses wanted a good death (peaceful and accepting) • Cures did not fit in with nurses' was of thinking	• Implications for clinical supervision • All nurses reported high degree of stress • Nurses unprepared for palliative or terminal care • Therefore implications for the training and education of nurses • Clinical supervision and support needed • Relatively small sample (only 25% of total population interview or surveyed)
1998 Jenkins-Clarke et al X	Jenkins-Clarke S, Carr-Hill R and Dixon P (1998) Teams and seams: skill mix in primary care. Journal of Advanced Nursing 28 p1120-1126	Multi-method exploration of the skill mixes in 10 GP practices. Data were collected on gp consultations (form and content) Gp workload diaries, nurse (n=77) diaries and workload analysis over a two-week period (DN n=30). Description of the practice, views about teamwork from all participants (n=208) 2000 patient attitude questionnaires	• Four main activities in order of workload for dns were treatments, discussion and paperwork, advice and reassurance and hygiene • Dns spent a third of their time on activities involving treatments and over a quarter on activities involving paperwork • A large proportion of gp consultations could be handled by the existing team or an expanded team	• There is potential for shifting workload practices between members of the PHCT • Dns spend most of their time on treatment • Hygiene needs are a high percentage of dns work • High level of paperwork reported to be related to dns attached status

		analysed (rr not included) Focus group with staff	• 17% of all referrals could have been delegated • Dns tended to feel more a part of the team if they received more referrals from gps	and justification of working practices • The challenge for primary care is getting the balance right • Community nurses should take the challenge
1998 Parry-Jones et al X	Parry-Jones B, Grant G, McGrath M, Caldock K, Ramacharan P and Robinson BA (1998) Stress and job satisfaction among social workers, community nurses and community psychiatric nurses: implications for the care management model. Health and social care in the community 6 p271-285	Postal survey of all frontline staff in Wales with an assessment and care management role. Pre-coded questions about job satisfaction, stress and practice change were the substance of the questionnaire. Open ended questions also included on the most and least enjoyable aspects of care. Results analysed using descriptive and inferential (ANOVA, Pearson product moment, Mann-Whitney and multiple regression analysis). Questionnaire completed by 504 practitioners rr=30.8%. (DN n=65)	• 80% of practitioners reported increases in their perception of stress • The majority of dns reported increased responsibility and workload • All reported that administration had increased • A sense of decreased ability to manage workload was reported by half of the practitioners • 80% felt the morale of their colleagues had decreased • 60% reported decreased satisfaction with their working conditions • 57% felt less valued as employees	• Practitioners are saying that there is simply not the time for detailed assessment and creative care packaging • There is a skills deficit in relation to care planning • Care managers did not have a budget responsibility and therefore responsibility • Has implications for the management and training of district nurses
1998 Griffiths X	Griffiths J (1998) Meeting the personal hygiene needs in the community: a district nursing perspective on the health and social care divide. Health and social care in the community 6 p234-240	Ethnographic study of district nurses work – 13 days of observation and 50 semi structured interviews with 37 f,g and h grade district nurses	• District nurses still referred to general care and bathing as part of their role despite the health and social care divide • Some divisions of opinion about general care in the DN workload • Some use it to cast an expert eye over their patients • Medical bath v social bath • Led to inequity in service provision as decisions were individualistic • Nurses had their own interpretations of the social care arrangements	• The health and social care divide is hopelessly blurred • Gives the idea that there is flexibility in the work of district nurses • Does not look at the social and political/local issues which affect the decision making process • Implications for the future of district nursing services discussed
Goodman 1998 X	Goodman (1998) <u>The Purchasing and Provision of District Nursing in GP Fundholding Settings: A Case Study..</u> Unpublished PhD Thesis, University of Hertfordshire.	A collective case study. Data collected from 12 trusts across England and Wales. Semi structured interviews with trust managers (n=12) GP fundholders (N=12) and dns (n=36). Second phase – observation with two fundholding practices from the 1st phase. Data analysed using content and thematic analysis.	• District nursing services viewed as straight forward – non contentious service. • District nurses' association with direct patient care thought to make district nurses' work self evident • Definitions of what district nursing work was were highly variable • This is partially due to the different demands made on district nurses by the different gp fundholding practices • District nurses were involved in a delicate balance and negotiation to achieve their work • GP purchasing has made explicit the different expectations and contexts in which district nurses work • Content and context of district nurses' work is widely unacknowledged •	• Implications for the future of district nursing work discussed in the context of policy, gender and power • Captures diversity and looks at the reasons why district nursing work varies • Gives useful insights into the contracting process and its effect on the services in the community • More work needed to understand the mechanics of district nursing

1998 Goodman X	Goodman C, Knight D, Machen I, Hunt B (1998) Emphasizing terminal care as district nursing work: a helpful strategy in a purchasing environment. Journal of Advanced Nursing 28 p491-498	A collective case study. Data collected from 12 trusts across England and Wales. Semi structured interviews with trust managers (n=12) GP fundholders (N=12) and dns (n=36). Second phase – observation with two fundholding practices from the 1st phase. Data analysed using content and thematic analysis.	• Terminal care was valued as a visible area of DN work • Amount of terminal care has increased • Terminal care was a source of satisfaction for dns • Dns reported feeling in control of care • Dns shared general principles of practice when it came to the terminally patients – people die at home if they choose, recognition of family care needs, importance of early contact with families • Recognised as an area of care were their expertise was known • Non cancer terminally ill patients treated differently	• Terminal care was a way of informing the purchasing process • However – limited access to discussions and tendency to fluctuating demands for this service had also hindered the process • Emphasising terminal care hid the rest of their work • Emphasising terminal care may restrict dns ability to make demands about other aspects of care • Leaves the burden of blame with dns and fails to articulate the intense pressures facing dns
1999 Galvin et al X	Galvin K, Andrews C, Jackson D, Cheesman S, Fudge T and Ferris R (1999) Investigating and implementing change with the primary health care team. Journal of Advanced Nursing 30 p238 – 247	Action research project to develop the work of the primary health care team. Qualitative and quantitative data (triangulation) were used. Sources of data were team workshops, patient focus groups, individual interviews with gps and managers, reflective diaries and patient survey. Data analysed used thematic content analysis and SPSS.	• Felt that the team were caring and efficient • Concern about continuity of care across the team • Services provided by the team were based on how professional saw need not on how users saw need • Difficulties encountered in developing work across PHCT • Core skills were difficult to identify • Specialist skills were difficult to identify • Gps wanted a flexible nursing practitioner who could work both in the surgery and in the community	• Small scale action research approach • Few changes occurred in working practices over the life of the project • Difficulties in identifying the benefits of the new primary health care model • The model suggested has been used before by others • Implications difficult to adapt to other surgeries and PHCTs
1999 Williams and Sibbald X	Williams A and Sibbald B (1999) Changing role and identities in primary health care: exploring a culture of uncertainty, journal of Advanced Nursing 29 p737 – 745	Anthropological exploring ideas, values and beliefs of primary health care staff. Extensive literature review and interviews (semi-structured) with 15 respondents including professionals allied to primary care. A further group of 3 (composition not given) were interviewed at their place of work. Data analysed using thematic analysis.	• A culture of uncertainty – some excitement expressed about the developments in primary care and some creativity and innovation • However – overwhelming sense of loss and insecurity • Most uncertainty resulted from a change in boundaries • The breaking down of professional boundaries • Working within a risk environment • Uncertainty relating to the operation of new nursing roles • Tension for nurses in the allegiance to the profession on the one hand and to the place of work on the other • Managers had to dismantle the power of nurses and doctors • Nurses aware of the current attack on their professional status • Nurses believe that old hierarchies have been reinforced rather than flattened	• Need to address how uncertainty can inspire rather than threaten innovation in primary care • Policy makers need to be aware that further erosion of professional boundaries may lead to greater uncertainty and low staff morale • Need clear guidelines between professional roles to enable more efficient exploitation of current opportunities • Training needed for nurses undertaking new roles and for affected colleagues

2000 Goodman X	Goodman C (2000) Integrated nursing teams: in whose interests? Primary Health Care Research and Development. 1 p207-215	Case study of district nursing work drawing on qualitative methods. A total of 36 district nurses were interviewed. Phase 2 of the study observed two teams of district nurses over 3 months.	• Dns have assumed more responsibility for day to day management of the nursing team • Self management by primary care nurses has been initiated by gp fundholders • Gps saw nurse managers as inhibiting the development of dns and as an unwanted add on extra cost • Self management was not nurse initiated • Dns resentful of the impact self management was having on clinical work • Dns not given financial control • Previous management system not working for dns • Wide range of management responsibilities adopted by dns from managing sickness, staff appraisals to interprofessional meetings • Contact with managers was sporadic and only occurred when clarification was needed	• Trends in PHCT resemble those of other organisations in which staff are encouraged to be self motivated, self monitoring and self regulating • Self management was illusory and imposed form above
2000 Tierney et al X	Tierney AJ, Worth A and Watson N (2000) Meeting patients' information needs before and after discharge from hospital. Journal of Clinical Nursing 9 p859-860	30 patients interviewed using a semi-structured guide at I, 4 and 8 weeks after their return to home. Some carers also interviewed and 5 focus groups were conducted staff.	• There were practical constraints on the information given by hospital staff to patients • Patients aware of these constraints therefore patients did not report dissatisfaction • Lack of clarity among patients about the respective responsibilities of the hospital and community • Many patients turned for advice to either the gp or the DN • The information gap remains and the referrals to community are undertaken inadequately	
2000 McIntosh X	McIntosh J, Moriarty D, Lugton J and Carney O (2000) Evolutionary change in the use of skills within the district nursing team: a study in two Health Board areas in Scotland. Journal of Advanced Nursing 32 p783-790	Ethnographic study of 76 members of 21-district nursing teams from 2 areas. All grades of staff interviewed pre observation and post observation. Data analysed using recommendations of Hammersley and Atkinson 1995.	• Variation in the delegation of work across the two areas • Some g grade nurses asserted that assessment was their role • Others delegated to F grade colleagues • Others delegated to E grades but on condition that g grade assessment followed within 24 hours. • Across the 2 areas there were some inconsistencies in the responsibilities given to d and e grade staff nurses • Similar scenario for en and auxiliary nurses • Delegation practices were not static but in a state of continuing evolution • The 2 Trusts adopted different approaches to grade mix • Were more staff nurses had been employed – they assumed more of the traditional role of the DN	• Nature of delegation is evolutionary • Degree of flexibility in delegation practice • Workforce planning and workload management are influential factors • Dns have to develop systems to check on the work of less qualified staff • Supervision may be eroded if further dilution of staff occurs thereby affecting standards of care • Staff nurses have a wide variation in knowledge and experience • Clinical skills can be taught to untrained personnel but they lack in judgement and cognitive skills • There is a need for a greater recognition of the centrality of the leadership and supervision role of the G grade sister

2000 Cowley et al X	Cowley S, Bergen A, Young K and Kavanagh A (2000) A taxonomy of needs assessment. Elicited from a multiple case study of community nursing education and practice. Journal of advanced nursing 31 p126-134	Case study involving four cases. Four cases urban, rural and inner city in the North, South East and West of England. Observation of 33 practitioners (newly qualified dns and HVs) over a normal shift which included at least one assessment visit. Semi structured interviews were carried out after the observation period. Practitioners were asked to talk through their decisions in the assessment. Pattern matching and explanation building were used to analyse the data associated with constant comparative method. Within and between case analyses also used.	• Needs assessment theory difficult to fit into practice • The needs assessments were messy, variable attended to across the 4 sites • Practitioners generally recognised the complexity of the assessing need • Problems with the divisions of health and social care needs • Holism not always transmitted into practice • Needs may be hidden by the client • Lack of worth ascribed by managers and commissioners to profiles compiled from needs assessments • Problems experienced by nurses in finding time to undertake needs assessment	• The way in which needs assessment are taught in colleges need to be addressed • Authors seem to call for standardised assessment process • The implications for this are not discussed i.e. what about areas of differing need • What about the assessment of need of different cultures
2000 Luker et al X	Luker KA, Austin L, Caress A Hallet CE (2000) The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care. Journal of Advanced Nursing 31 p775-782	62 members of the district nursing team were interviewed using an adaptation of the critical incident technique to examine factors, which contributed or detracted from high quality care. Transcribed tapes were analysed and coded thematically and inductively using critical happenings and meanings, which influenced quality of care.	• Getting to know the patient important to all participants • Getting to know the patient on their own ground • Importance of emotional labour identified in this form of work • Spending time and continuity of care felt to be important • Early access was important • Awareness context was identified as important in who knows what and the provision of good quality care • Dns do not know on 1st visit what patient and family members know about the diagnosis • Awareness context still act as a moderator on nurse/patient/relative communication • Physical work is a front for engaging in work perceived as more meaningful • Physical work can be seen as a way of getting in • Invisible work valued by nurses but could be omitted if the constraints of work demanded it • Dns use strategies to ensure quality of care in terminal care: - early contact with family, acting in a friendly manner, limiting staff involved, spend extra time over physical care, maintain continuity of care	• The situation described by dns similar to new nursing • The changes in the organisation of DN services mean the ideals of new nursing may be less achievable than they were a decade ago • Getting to know the patient is increasingly divided across nursing and social care teams • Getting to know the patient in their own is a core aspect of dns work • Collaboration with relatives is essential for the enactment of any care plan

2001 Goodman X	Goodman C (2001) The use of metaphor in district nursing: maintaining a balance. Journal of Advanced Nursing 33 p106-112	61 semi structured interviews with district nurses, NHS managers and gps based in 12 Trusts. Observation of 2 teams of dns over 3 month period	• DN used metaphors to describe their work that equated with not rocking the boat, not making waves • Main target of this effects was the gp • Careful balancing act in letting work be known v assessing the disruption it may cause • Described being caught in the middle, a foot in each patch – balancing between the Trust and the Fund holder • Compelled to take on extra services • Inability to control their work • Pattern of work one of compromise	• The need to maintain balance in district nursing was not only a symptom of powerlessness but also expression of the tortuous and skilled nature of district nursing practice itself • There is a sense in which providing patient care becomes something which is achieved against the odds • Need to examine further the competing realities and influences on district nurses' work

Appendix 2

Dear Lead Nurse/Research Coordinator

Please find enclosed a copy of the aim and objectives of my proposed PhD research which I hope will form the basis of our meeting.

You will note that the study aims to investigate the culture of district nursing staff working in you Trust. The nature of this study is such that I am unable at this time to give you a precise time limit for the investigation the nature of qualitative/ethnographic research is such that data collection continues along an undefined time frame. However, during the course of the study, I will keep you updated, if you so require, about my progress during the study.

Prior to our meeting, I would appreciate it if you would examine the proposed research methods for the need for local ethical approval. It is important to make clear that although I will be observing district nurses in the home of patients, I will not be soliciting the views and ideas of either patients or relatives. My study concerns only the work of district nurses and the way in which their work is organised.

My supervisor for this project is Professor Karen Luker, Professor of Community Nursing, University of Liverpool. If you have an queries or further questions you may contact either myself on 0151 –220 3016 or Professor Luker on the above number.

I thank you for your cooperation

Yours,

Shaun Speed BS(Hons) RGN Dip Co Dip Psych.
Part time PhD Student – Department of Nusing, University of Liverpool.

Research Proposal – An Ethnographic Study of District Nurses' Work

Aims of the Study

To investigate how

- How the changes in the organisation of primary care services are affecting the work of district nurses
- Organisational factors influence the work of district nurses

Study Methods

Non participant observation of district nurses' work and indepth interviews.

Recruitment

Recruitment to the study will be voluntary and once permission is given from yourself and or relevant others, participants will be approached through their respective managers and or professional trade union associations.

Staff Commitment

When recruited to the study, it will be expected that participants will allow me to observe their daily routine work. Although this is an inconvenience, I would suggest that this will affect their work in a minimal way. These periods of observation will be followed by a in depth interview which will examine their perceptions of their working life. This is expected to take up to 11/2 hours. This will be the only request for time away from their work that I will make.

Confidentiality

In keeping with qualitative research, all written and taped material will be kept in an anonymised form. All reports will endeavour to disguise salient identifiers about the people recruited to this study. Your trust will be represented as one of two health care Trusts in the North West of England.

Appendix 3

Dear Participant,

Thank-you for considering participating in my PhD study, an Ethnographic Study of District Nurses Work.

Ethnography is a type of study which belongs to the qualitative branch of research. Qualitative research is concerned with finding out what people think and do in everyday life. In this case, my study aims to look at the day to day work of district nursing teams and examine how the changes in the organisation of primary care have affected how you deliver nursing care in the community.

There are two ways in which I intend to collect information. The first is participant observation. This will mean that I will watch you whilst you work during the day with patients, your staff and others. It also means that I will have to take notes about you work and ask questions about the way in which you organise yourself and others. In order that I get it right, it is important that you give me your opinions about you work and I will check my ideas out with you as we go along.

The second way in which I propose to collect information is in the form of an interview which will be tape recorded and transcribed by me. The interview will again focus on how you see you own work in the community and is not in search of the "ideal" of community nurses. For many years now, relatively little has been known about the difficulties and complexities of district nurses' work, this study aims to highlight this.

I will always endeavour to protect you and your teams' identity in any publications I write as a consequence of this study. You will be one individual or one group of nurses taken from the very many in the North West of England. All notes and interviews will never be identifiable other than by a code known only to myself.

At any time during the study, if you agree to participate, you are free to withdraw. I will not ask any questions about this and will respect your decision.

I hoe that this brief letter outlines the purpose of this study. I will of course meet with you and discuss this and any other questions you have prior to the start of the study.

I thank you for your time

Yours

Shaun Speed BA(Hons) RGN Dip Co Dip IGC
Nurse Practitioner/Part Time PhD Student – University of Liverpool

Appendix 4

Field Notes/Observation Data Staff Nurse Area 2 – Site 1 14th May 1999

Context: A very mlc woman in a vulnerable crisis. keep aware.

We walked out of the health centre and as the first patient was just across the road we walked to the sheltered accommodation facility. XXXX pressed the buzzer and we waited, after a while the warden of the establishment came out and opened the door, they greeted each other and XXX went to the lift saying: -

> "will you buzz her and tell her we are on our way up?"

We took the lift and xxxx talked about the patient

> "She is an old lady, who lives on her own and she is a real MISS. She had polio as a child and she has got deformed feet from badly fitting shoes – she used to have a leg ulcer and now it is just as scab that we are putting a dry dressing on"

By this time we had reached the flat and xxxx waited by the door. A frail looking lady answered and xxxx bid her "good morning" walking into her flat past her. She introduced me: -

> "this is Shaun, I told you about him yesterday ... and then "how is your foot"

The woman replied: -

> "It is terribly sore, I have another sore spot on my foot"

XXXX carried on walking ahead of the patient into the living room of the house collecting her equipment as she was passing it on the corner of the room, she continued talking

> "is it on the ball of your foot then rather than where we are dressing it already"

> "Yes, yes it is underneath"

They were now in the living room and xxx was opening her packs and laying them out on the sofa. The woman hobbled past her and began to undress herself, taking her tights off whilst xxx busied herself.

Appendix 5

Dear District Nurse

Thank you for agreeing to be interviewed. The date we have arranged is

---

I would just like to give you some information about the interview process. Firstly the interview will be tape recorded. This is sometimes off putting for people but it is essential for researchers to have accurate information so that I can record you views exactly as you mean them. It will entail us discussing aspects of your work that you feel are important to you and your team. It will also be an opportunity to air you own thoughts on how your work is organised and managed.

During the interview, I would wish to give you as much control over the information you share as possible. If therefore, I ask any questions that are difficult and you feel you do not want to answer, for any reason, please feel free to tell me and I will simply move on.

Following the interview, I will transcribe (write up) the tapes myself and then following a check to ensure that I have captured what you have said correctly, I will erase the tape myself. None of the written material will be identifiable to you through any names (which will be erased). If you wish, I will send you a copy of the transcribed tape which you may either add to or delete from. Once again, I will not question any decision you make about this.

If at any time during the interview you feel upset or distressed, we can stop the interview and decide what you need to do.

I would like to take this opportunity to thank you for your continuing support for my research project.

Yours

Shaun Speed

Appendix 6

Interview extract showing polyphonic technique of following the participant's train of thought.

IV: You just mentioned bad days, what does that mean a bad day? What makes a bad day?

DN: A bad day is erm, not having enough time to spend with patient, I think that's the most stressful thing really.

IV: Not having enough time?

DN: Yeah. Because you know you are wanting to give a certain level of care and if you haven't got the time to give that care then, then you feel crap – if you feel you should have done something that you haven't you might feel really bad at the end of the day, you've just been so pushed that you can't spend time with people, you know get to know a patient, you dash around like a raving lunatic and if you are in and out in 2 minutes then that's not good is it? But they just keep coming and you just keep taking them.

IV: Mmmm, so it's almost like, in terms of taking on patients that you can't say no, they just keep coming, or have I picked that up wrong, sort of like loads of referrals, you said, like you can't say say no – no I'm not having any more?

DN: Yes yes that's it really – I mean there is somebody you can call on to help out, more often than not, but sometimes, quite often, it's just everyone is busy and you can't do that, you know like a referral comes over the radio, 'can you go and see such a body' you've just, you end up fitting it in no matter what sometime I've worked until 7, half past 7 to get things done. When various other people have been off, holidays and sickness and things, then you just do it, you have to do it, but at the end of the day you can't see a patient not looked after. It's like blackmail really.

IV: Blackmail – whose doing the blackmailing?

DN: Probably the trust, yeah, they are not employing enougn people, if they employed enough people to do the jobs that they should you wouldn't have all this pressure.

IV: Can you tell me more about "the pressures"?

Appendix 7

DN Area 1 – Interview 22nd July 1999 – OPEN CODING

IV: you mentioned the word criteria then – criteria then, what do you mean by criteria?

① ⓒ learning to ration note here, that she says explicitly what other have said less candidly see FN. 100, 272, 316 ⓘ PEO, P89

② ⓒ Exclusion criteria.

③ ⓒ Inclusion criteria.

④ ⓒ splitting work.

① DN: I think that you just learn that with experience really we've never really had any total guidelines to follow but you do learn, I mean I know that if I took a patient on, a chronic ill patient that's going to be ② ill for the rest of their lives and could live 10 years I know I can't take that sort of thing patient on. But if, I can take a terminally ill patient that I know is ③ going to die, erm, obviously only medical things have to be taken on the team but we work in conjunction with a lot with social services and ④ nurses we work together, perhaps one does one thing and one doe the other which we would never have done before, we wouldn't have overlapped it would have been our patient, you know, but you just haven't got the time and we certainly haven't got the ⑤ staffing levels because 15 years ago when I started it was exactly the same staffing levels as now, there's no increase in nursing staff..

note: Chronic non life threatening illness ③ compare with Sr. Site 2 area

⑤ ⓒ Staffing levels note would be interesting to check this out with other areas?? some stats (OPCS?)

IV: I remember when I was out with you the other day that you said the even though there's been a massive increase in the practice population there's been no increase in nursing staff – Gosh how do you cope

⑥ Staffing levels.

⑦ Gaining control

⑦ DN: No, no, I mean at XXX surgery ⑥ I think is nearly 8000 patients, nearly 10 000 patients now, whereas when I, 10 years ago there used to be like nearly 4 or 5 000 but we still had 2 district nurses so really the work did have to be changed otherwise you wouldn't be able to cope with the demand. – note not accepting the change

IV: SO like you have had to change then, is that what you are saying? It is the increase in numbers and same amount of staff?

⑧ Retaining skill.

⑧ facing change/ emotional reaction.

DN: when it was first started I though it was very sad the we were loosing that , you know bathing and all that but I now I think, I think it is a good thing because we can use our expertise ond our training on doing tasks that we should be doing now, whereas before a lot of the time we weren't using all our skills.

note notice the ambivalence here, similar to others FN p362, p481 ⓘ 15, 23, 24, 28 But, different from ⓘ 10, 12, 14.

Code: Refers to theme of rationing.

Code: Refers to gaining control/controlling nurses

Code: Dual application of code to both themes

...reating the rules was
...ier to do if you had
personal caseload cos
...ients were easier to
...de from colleagues.

↔

How do you define intuition &
the reasons why they continued to
visit some people and not others
– intuition / experience and the
fact that they really knew the
patient (see knowing the patient)
No way of counteracting the discourse
as no language to describe

Summary of research ...

Flexibility
have they flexed up, down or
just become more malleable?

I guess there are pressures on them
to achieve all of these, to come up
with the new skills, the consequence
of the contract and to keep on
developing.
Most important note is that
the technocrat / skills seem
to be the currency with which
they trade rules that
set one nurse apart from
another, although this can be
"just talk" they can effectively

District nurses regularly assess
However, this ... assess
does not seem standard
among participants. Sometimes
it is highly task oriented and
health dominated eg (1) and
at others includes more!
Is this a good or a bad thing?
Could be argued either way.
Flexibility of approach. But
links could be made with
equity or inequity of service
provision.

Role of the DN
– Sometimes the assessor
and manager of the
care package.
– Does the assessment of need
→ How well?
→ using what criteria?

Setting the agenda!
What is the nursing agenda.
Seems that the agenda is
characterised by breaking the
problems down into a
... number of ... task
...se lead – avoids very often
psychosocial.
"don't ask the questions"
↓
but this is not always the case.
...areas where they care manage
and have good access to the
complementary services then they
do "ask the questions"
however they are fairly dogmatic
about what they offer. Inequity
service provision

The universality of cancer
care. Doesn't matter where you
are from, get all of the services
if you have cancer. This may
be due to the fact that the care
allowances / ... allow and
payment systems are not
present.

Statutory Responsibility
UKCC (1996) it might be
argued that engaging with
patients may be a risky
activity particularly if you
start to uncover difficult
scenarios.

W/C areas – easier to set the
agenda, people are "grateful"
Even if they are not they do not
complain. exception (3) old woman

Flexibility
...out the discourse but
be quite traditional

∴ DN can sometimes
act as assessors, reassessors
of care, without the doctor
ever being involved.

Sometimes the provider
of care
– Highly repetitive, high
volume work.

(NB)

Consultation v intimidation.
Why is the doctor not involved.
Because this is hidden care, and
there are rules which state that
much work of DN "they do it better
the doctor" unless they have
too → competently handle these
difficult patients and only really
tell them for changes in p/x.
eh
Theory ∴ the better they are
at this the less it is seen and
the less they get the credit for this.
See also Dr.-Nurse communication
particularly team meetings
But in all areas they were
often left with difficult
...

exclusion criteria (rationing)
→ no risk of deterioration eg cancer
→ problems with hygiene ALONE
→ unable to feed properly.
→ lack of social support.

Emotional impact of rationing
Getting out was hard (for some)
manpower? particularly
when they were middle class
patients that they liked
and they were on the cusp
& what they would pay for
and the system patient could
deteriorate → guilty feelings
...

Doing it all at once
...e nurses throw all of the
services at pts from the outset
(2) + (3) in this way, they can
"get in", "manage", "get out"
Doing services one at a time
give it slowly (1 and 4)
make the patient realise
... all under pressure
Managing the process of care.
there is problems in making
people what want what
you offer and can give them
∴ This is a good way of
making sure that pts realise
they are burdensome and
they are taking valuable
... of DN → Clever key.

many pts referred to DN service
without formal social assessment
still. (particularly those who had
been recipients of care before)

M/C backgrounds more
demanding / expect more
and are have to pay
(very important in the management
of patients in the home and
taking on "getting rid"
They sometimes threaten
"pt. knows (name) chair of the
health authority) know the system.

31