Discretion, Commitment and Invisible Work:
An exploration of the labour process of community nurses

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Abstract

This study is about community nurses working in a large city in the North of England, who are employed by a NHS Trust. It explores the nature of the nurses' work and details their labour process. The study is ethnographic in nature and the research methods used focus specifically on the work and the worker. The findings of the study show that labour process theory can be used successfully to illuminate and provide understanding of the labour of public sector workers. However, in doing so it has highlighted some theoretical challenges, these centre on the relationship between some workers and the human product of their labour process. The findings from the study suggest that further theoretical work is needed to ensure that labour process theory remains a relevant and useful analytical tool for the study of all workers, in the public sector.

This study will be of interest to nurses, healthcare workers and other public sector workers. It will also be of interest to employers (and managers) within the public sector; particularly those who employ workers who provide care-giving labour. The study will also be of relevance to academics who have an interest in industrial sociology and the analysis of work using labour process theory.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning
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In loving memory of my much missed dad, David E Elliott, who throughout his life always loved and praised the NHS.
Chapter 1

Introduction
1 Introduction

1.1 Background

The National Health Service (NHS) is the world's largest publicly-funded health service (NHS 2013). It serves over 60 million citizens of the UK and employs more than 1.7 million people; it treats one million patients every 36 hours (NHS 2013). Whilst the NHS holds a significant place in the hearts and minds of the people of the UK, in recent years there have been a number of high-profile NHS ‘failings’, so-called (for example, Mid Staffordshire NHS Foundation Trust), which have reminded us all that healthcare workers and their managers are not perfect. In recent years there has been an increased emphasis within the NHS on consistency and standardisation and a management ethos within healthcare and across other parts of the public sector has developed which believes that tighter control, delivers better outcomes. This has resulted in control of workers, including healthcare professions and to a lesser extent a focus on the management of individual practice.

I have had a long-standing interest in how the practice of healthcare is affected by its context and environment, having previously carried out some research, analysing organisational culture at Mid Staffordshire NHS Foundation Trust. I also have a keen interest in large organisations in the Public Sector and the people who work in them; having spent over 25 years working in the public sector myself.

Through this research and my subsequent analysis, I seek to contribute to the study of work and workplaces and highlight a potential gap in the theoretical relevance of labour process theory (LPT), in the analysis of care-giving labour processes within a contemporary healthcare setting in the UK. I also seek to contribute to the better understanding of management control within the contemporary NHS – in particular, the control of workers who are not bounded in their operation by the confines of a physical building.
In this introductory chapter, I will outline briefly why I wanted to undertake this research in the first place and then explain why I believe it will be of interest to others and who those others might be. I will also provide an outline of the subsequent chapters in this thesis, including a summary of what each chapter will cover. I end this chapter with a conclusion and link to the rest of the thesis.

1.2 My Interest

Doctoral research takes time; from considering the initial flashes of research ideas to finally producing a completed thesis is a journey and certainly not a linear one. This has been inevitably true of my research journey and many of the twists and turns of that journey will remain undocumented, in this, the final product – mainly because it would use up too many words. That said, there are elements of my journey that I do need to highlight and the introduction to this research seems the most appropriate and probably the only place to write about them.

Prior to entering academia, I had worked (in what now seems another lifetime) for over two decades as a local government officer. I rose through the ranks and I saw, first-hand, the many changes a large organisation goes through over the passage of time; changes to funding, changes to structures, changes to vision and direction, changes to leadership and most evidently – on a day-to-day basis – changes to processes and the work expected from the organisation’s employees.

During all this time, one element stood fast and that was my own view that as an employee and then eventually as a manager, I was doing a good job and I was making the decisions that needed to be made; for the organisation, for my staff and for the work to be done and ultimately for the organisation to move forward. I thought I was making these decisions based on an objective assessment of the facts, along with my inherent skill and significant amount of experience. My role as a manager was neutral
after all and if I did not do it well, or if I did not make the difficult decisions, somebody else would and they would be paid for it instead of me – so it might as well be me. I held these views upon leaving local government and also during a brief spell of employment within the NHS. My conviction held firm as I began studying for my PhD. Then I came across a book called *Labour and Monopoly Capital: The Degradation of Work in the Twentieth Century* (Braverman 1974). I read it and my whole perspective on the work I had undertaken in the past and my perspective on any future employment changed (I hope) forever. My reading of this book was something of a watershed moment and as a consequence I felt that my doctoral research needed to be shaped by this new and unexpected intervention.

I did not actually know – until I was partway through the book – that Braverman was acknowledged as the “father” of labour process theory (LPT). I finished the book and then continued to read about LPT and how LPT viewed workers, employers and the relationship between these two groups of actors. However, it was Braverman’s (1974) book that continued to feel very relevant to my experiences, as an employee and also as a manager in a public sector organisation; despite the book having been written some 40 years earlier. I continued to read about LPT and how it had developed over the last 40 years. I also read about the areas of work where LPT had been used as an analytical framework and how it had subsequently developed as a theory – initially, in traditional ‘blue-collar’ environments (Delbridge 1998). I then read about studies using LPT to analyse service-based work (including call centres) and I also read some studies where LPT had been applied to work in a healthcare environment – including studies about nurses (Ackroyd & Bolton 1999; Bolton 2004; Bolton & Wibberley 2014).

An interest in work and how it is organised at a micro-level within organisations has been an interest of mine for some time, since I began working for a public sector organisation, many years ago. Perhaps this latent and at the time unacknowledged interest drew me to a career in
information systems management, where I analysed work processes for a living. I also spent a good proportion of my early career, re-engineering business processes, which involved analysing work in detail with a focus on reducing ‘waste’ and ‘cost’ (features that will be discussed later in this thesis, in relation to New Public Management (NPM)). It was only when I began studying again; initially for a MSc and then subsequently for a PhD and also in light of what I had read in Braverman’s (1974) book, that I realised what I had actually been doing for a good proportion of my career was the systematic reduction into smaller and smaller chunks of the labour process of my fellow workers. These moments of ‘revelation’ were sustained over a period of several months; during which time, I read books and journal articles on NPM. A term I was unfamiliar with until entering academia and yet the influence of NPM on public policy and public sector organisations was something that I had unknowingly been affected by for all my working life.

The context of my research was somewhat unusual, in that it was a study of nurses within a community setting, whereas a good proportion of the studies that I had read focusing on nurses’ behaviour, labour process and attitudes to discretion or standardisation (McDonald et al. 2005; McDonald et al. 2006; Hoyle 2014) were undertaken in a hospital, or a GP practice environment. My interest in community-based healthcare was stirred after working in a management role at a NHS Community Trust. The experience prompted me to think about community healthcare settings and the reduced number of studies in that environment, compared with say a hospital setting and also in particular, studies that used LPT as an analytical tool. Therefore, I felt it would be academically productive to carry out research in this area; that is community healthcare – as it is not the ‘go-to’ setting of choice for many research projects analysing healthcare workers and their labour process. I believe that the community is a neglected healthcare environment in terms of research and yet it has received renewed focus recently, through changes to NHS structures and policy, where there is an increased focus on community healthcare settings in the NHS’s Five Year Forward View (NHS England 2014).
My interest in the labour process of a group of nurses in this setting developed from a knowledge that nurses are the largest occupation group in the NHS (Bolton 2004) and as such, seemed to me to be the bedrock of the contemporary NHS. Nurses are also an occupational group with a somewhat ambiguous professional status – in the sense that some authors describe nursing as a profession (Hoyle 2014), whilst others describe nursing as ‘semi-professional’ (Bolton & Muzio 2008).

My research focus and interests were centred on a couple of key areas before I began my study, these were the exercising of discretion by individual nurses and the mechanisms of management control in a dispersed working environment. Firstly, I was interested in how, when and why the nurses exercised discretion in their labour process and what were the limitations of that discretion, particularly within the context of increasingly standardised healthcare in the contemporary NHS. Secondly, I was interested in how management control was maintained in an environment where the point of production (in LPT terms) was spread over a wide geographical area. Community healthcare often means a large and dispersed organisation, which has an obvious relevance to any research study being carried out in that setting; where nurses are not confined to working in a defined, physical building, located in a specific geographical area.

It is my hope that this research will offer fresh academic insights into the community healthcare environment and the nature and control of the labour process of the nurses who work within it.

What also developed as an unexpected theme of the labour process of the nurses in my study and one which emerged during the course of my fieldwork and then as a result of the analysis of the data I produced, was the concept of ‘invisible work’. Work that was part of the nurses’ labour process but was not acknowledged by their employer and sometimes not even by themselves. This is a theme that punctuates the whole of this thesis and yet it was not a concept that I anticipated analysing when I
began my research; but rather, it emerged as my fieldwork and data analysis progressed. This invisible work tended to fall into one of two categories; the first was work that was not explicitly acknowledged but nonetheless needed to be done – else the effectiveness or efficiency of the labour process would be impacted; the second, was work that was not acknowledged, but was nevertheless performed by the nurses in the Team, but it was work that could not be directly attributed to improving the efficiency or effectiveness of the overall labour process. It seemed to me (and therefore as a consequence, is a significant element of this thesis), that on many occasions, this second category of invisible work was undertaken because of some altruistic motivation on the part of the nurses. It is this aspect of the nurses’ work that I suggest is not adequately theorised within LPT and it is this point that forms one of the central contributions of this thesis.

1.3 Contribution

My academic contributions in this thesis can be divided into four areas: analytical, theoretical, methodological and personal. My analytical and theoretical contributions are drawn from chapter six, where I make broader conclusions from my research findings and discuss in more detail the central contributions of this thesis. A key element of my theoretical contribution is the questions that I raise about the motivation of workers to ‘go the extra mile’ and I suggest that this phenomenon is not fully theorised within LPT or explained by the concept of ‘emotional labour’ (Hochschild 2012). I go on to suggest that this behaviour amongst the workers that I observed may be the result of a relationship between the worker and their human product that is not adequately acknowledged within current LPT. I also outline the consequences of this theoretical gap on the potential effectiveness of LPT as a tool in the analysis of the labour processes of workers within the public sector and how this could have wider implications for the conduct of research of this kind in the public sector.
My analytical contribution is the detailed analysis of the labour process of a group of community nurses within the contemporary NHS. My analysis provides academic insight into the work of these nurses, using LPT as an analytical tool and provides detailed analysis of the mechanisms used by their employer to exercise control and includes examples of work extensification and intensification within the nurses’ labour process. My analysis also provides an outline of the nature of the nurses’ labour and the degree to which the nurses in the Team consented and resisted the boundaries placed upon them by their employer.

My methodological contribution is largely contained within chapter three, which provides details of my research methods and approach. I believe that my approach to this ethnographic study of nurses was somewhat novel in so far as, I placed a significant emphasis on my understanding of the perception of the nurse to their work, employer and their patients. This was unfettered by the potentially distracting presence of the patient; as I did not accompany the nurses when they provided direct care to their patients.

My personal contribution within this thesis is the commitment I made to the nurses who participated in my study, that I would describe in some detail the work that they did day-after-day in circumstances that meant that they were continually managing the demands placed upon them by their employer, their patients and on occasions, by themselves. I also committed to showcasing – through my research – the commitment that I believe this group of nurses showed to their patients; a commitment that (at the risk of sounding overly romantic) left a positive impression on me, every time I accompanied them on a shift.
1.4 Interest to Others

This research study (undertaken over the last four years) and which is contained within this thesis, will be of relevance to anyone with an interest in industrial sociology and the analysis of work using LPT. LPT has been used in the analysis of work in manufacturing environments since the early days of this field of study; however, in later years, LPT has also been applied to service-based work. Indeed, Braverman (1974) himself predicted that deskilling would occur in “white collar” occupations and therefore in that sense he pre-empted the need to undertake analysis (informed by LPT) of service-based labour processes. However, the application of LPT to labour processes that are (perceived as) professional – or at least semi-professional – has been less common. This is also the case in relation to healthcare professionals, where the number of studies using LPT as an analytical tool are not numerous. I believe that this research endeavours to address this gap, as a study of the labour process of professionals within the public sector, using LPT as an analytical tool.

Given that this research is about healthcare workers, I believe that it will be of interest to healthcare workers themselves – including those who are (or are seen as) part of a profession. Using LPT to analyse the work of an individual results in an improved understanding of the work, because of the level of scrutiny devoted to analysing individual components of the labour process. Aspects of the work are illuminated in ways that were not obvious to workers – or for that matter, their masters. This has obvious benefits to workers and in the case of this study, healthcare workers, because it can provide understanding of the work they carry out, which they were not consciously aware that they performed. It also provides healthcare workers with a greater understanding of the work that they were fully aware that they carried out. Analysis of the kind contained within this thesis will also be helpful to workers (and in the case of this study, healthcare workers) because it illuminates potential areas of their labour process that are being undervalued, perhaps through work extensification
or work intensification; which may in turn, also be useful for workers in similar occupations and professionals.

This research is also likely to be of interest to any worker who is paid to provide care to other human beings, as at the core of this thesis is the observed behaviour of workers who care for others and the manifestations of that commitment. The theoretical contribution within this thesis is the suggestion that within the environment of production, there sometimes exists a relationship between a worker and the product that they seek to transform. In this thesis, I also suggest that the relationship between a worker and their product is established when the product is human. It seems reasonable then for me to assume that any study that discusses the nature and characteristics of that type of relationship will be interesting to any worker who has experienced or is experiencing such a relationship between themselves and the product of their labour process.

The managers and employers of the types of workers I have studied in this research and those I have subsequently described in this section, should also find this research of interest to them. Firstly, as an account of a labour process that may resemble something like the one undertaken by their workers and yet one that I hope (after reading this thesis) is different in many ways, to the labour process that they thought their workers were performing. This is useful for employers because it helps to debunk sometimes established and engrained ideas about the nature of a worker’s labour process that are inaccurate and based on misunderstanding and organisational folklore. Secondly, I anticipate that this research will support managers and employers to consider the mechanisms of control of workers outlined in this thesis and reflect on how they compare with those of their own workers. It is my hope, that the analysis within this thesis, prompts managers and employers to reflect on their own practice in such a way, as to cause them to consider the potentially exploitative elements of the labour process of their workers and is a catalyst within them for the removal, or at least minimisation of these elements of their workers’ lot.
It is also my hope that all my readers reflect on the labour process of the nurses included in this study and begin (or continue) to appreciate that a worker's labour process is not completely transparent to them or their employer (or manager); nor is it necessarily transparent to the beneficiary of the labour process (or the “product”, in LPT terms) and as such, will always include aspects of “invisible” labour that are important for the overall effectiveness of the labour process. This will continue to have significance in a public sector environment influenced by new public management (a topic discussed in some detail in chapter two), where judgments may be made about the necessity of work, based on a flawed understanding of the labour process – a situation in healthcare that may have unintended and potentially serious consequences (Allen 2015).

What I hope will also be appreciated by my readers is that a labour process will inevitably also include elements of “invisible” labour that are actually important to the worker. As I argue in this thesis, this may be because (sometimes) a relationship develops between a worker and their product and this is (I suggest) something that is possibly unique to labour processes that transform human products; an idea that I will go on to develop within this thesis.

I hope this research is of interest and indeed resonates with nurses and in particular community nurses, as it is because of them and to them that I dedicate this work. When I began my fieldwork, I promised the nurses that graciously agreed to participate in my study that I would show through my research, the nature of their labour and the different pressures and work demands that they managed on each and every one of their shifts. I also promised that I would illuminate the commitment to their patients, that was also evident every time I accompanied them on a shift. I trust I have fulfilled those promises within this thesis and I hope that I have done so, in such a way, that the nurses who participated in my study and their wider colleagues, recognise it as such – in this the final product of my own labour.
It is Burawoy (1982) that argues that it has been left to industrial sociologists to re-establish the subjective nature of labour. In this thesis, I hope I have made a modest contribution in that regard; in relation to a group of community nurses who administered antibiotics to a group of patients, in a particular city; at a particular time.

1.5 Chapter Summary

In this section of my introductory chapter, I will provide a brief summary of the subsequent chapters in this thesis, which will serve as an overview and guide to the rest of my thesis.

1.5.1 Chapter 2

The second chapter of this thesis is a review of the literature relating to this study and is split into two parts. The first part includes an overview of the emergence and characteristics of NPM and its impact on the traditional ethos of the public sector, as well as a brief discussion on the impact of NPM on the professional occupations within the public sector. I look at the characteristics of professionals and in particular, the characteristic of autonomy. I also look at healthcare professionals, specifically nurses and the relationship between nursing and nurses as managers. Within the context of an acknowledged characteristic of NPM reforms, I go on to look at standardisation and standardisation within healthcare, which suggests that there is a single ‘best way’ of dealing with a situation. An approach which can be used to deskill and enable the delegation of work to less qualified workers. At the end of the first part of the chapter, I look at several different manifestations of non-compliance to standardised practice and the motivation of workers when carrying out their non-compliant behaviour.

In the second part of chapter two, I provide an overview of the core elements of LPT, which is the framework I use for my analysis of the data I produced in this research study. As part of this overview, I use the work
of Braverman (1974) as a device to introduce the central concepts of LPT and I then go on to discuss the concepts of labour, the labour process, the division of labour, management control, consent and worker resistance. Along with the elements of mental and physical labour, I also introduce and discuss the concept of ‘emotional labour’ (Hochschild 2012), as an element of the labour process.

1.5.2 Chapter 3

In chapter three, I provide a detailed account of the methods and methodology I used to undertake my research. In this chapter, I discuss my ontological and epistemological position in relation to this research study. I also include the broad aims of my research and explain how my research design was deliberately developed to observe the non-care giving elements of nurses’ work. I discuss my approach to ethnography and go on to explain how this gave me a unique perspective on the work of the nurses in my study, which was unhindered by potential distractions from patients or patients’ families. In the concluding part of the third chapter, I discuss the ethical issues I considered when carrying out my research.

1.5.3 Chapters 4 & 5

In chapters four and five, I discuss my findings and these chapters form the empirical elements of this thesis. The chapters are broadly split between findings that I felt complied with current LPT (chapter four) and those, which I felt left some analytical and theoretical challenges remaining (chapter five).

In chapter four, I outline in some detail the labour process of the nurses in my study. I consider how their effort power is transformed into labour and I examine the relations between the nurses and their employer; in particular I analyse the mechanisms of control used by their employer to control this group of nurses. I explore the nature of the nurses’ work and
the skills they possess in order to do their work. I also discuss elements of compliance, consent and struggle by the nurses and set these behaviours within the context of the nurses’ labour process and relations with their employer and their point of production.

In chapter five, I describe some of the elements of ‘invisible work’ undertaken by the nurses in my study and to whom this work appears invisible. I also discuss how the nurses exercised discretion within their labour process and I debate whether they were able to act autonomously, or whether this was merely a potential environment of professional vulnerability. In the final parts of chapter five, I look at the joy and sorrow that some of the nurses experienced, as they transformed untreated patients into treated ones. I also begin to explore whether these aspects of the nurses’ labour process are adequately explained within LPT. At the end of this chapter, I discuss mobility power and use this concept as an analytical device, to understand the motivation of the nurses in choosing their current employer.

1.5.4 Chapter 6

In chapter six, I draw broader conclusions from my findings and discuss in more detail the central contributions of this thesis; which are, the theoretical questions that I raise about the motivation of workers to “go the extra mile” and how I suggest that this phenomenon is not fully explained within LPT. I also draw out the potential consequence of this theoretical gap on the effectiveness of LPT as an analytical tool and the implications for this type of research more generally.

1.5.5 Chapter 7

In the final chapter of this thesis, I provide a synopsis of each chapter and then I summarise my academic contribution in more detail; this contribution is split into analytical, theoretical, methodological and personal sections and includes a fifth element, which clarifies and confirms
what my thesis is not claiming. I also outline the limitations of this research study and in this final chapter, I suggest some areas for further research, before ending the chapter with a brief conclusion.

1.6 Conclusion

In undertaking this research study, it was not my intention to reveal ‘the truth’ – as if that were even possible – but rather, to reveal multiple, contextually-sensitive ‘truths’, that may be relevant to others (Emerson et al. 2011). I am uncomfortable with drawing conclusions from the findings of this study that could be understood to have implications for all nursing practice. However, I do believe that the value of ethnographic work comes from its thick description (Geertz 1973) and rich insights into human social life and through the production of theoretical concepts and models, which at certain times may help in the understanding of other social situations, that may appear to be similar. As Mays and Pope (1995) suggest:

…to indicate common links or categories shared between the setting observed and others like it. (Mays & Pope 1995:183)

I would not suggest that these models and concepts can, or should lead to generalisations; but rather, that they form part of a theoretical toolkit that can be utilised by others, in a way that may be appropriate for their particular analytical purposes, in a setting that they believe to be sufficiently similar.
Chapter 2

Literature Review
2 Literature Review

2.1 Background

The NHS as an institution was created in 1948 (Grosso & Van Ryzin 2012; Hyde et al. 2016) and subsequently developed into a large, monolithic organisation, initially accountable to Parliament (Exworthy et al. 1999). Until the late 1980s, politicians set the budget for the NHS, but doctors controlled how the money was spent (Exworthy et al. 1999; Dent 2003). The size of the NHS, as well as its complexity, fragmentation and uneven mix of both centralised and decentralised governance, make it difficult to control and manage. Not surprisingly then, there have been a number of significant, structural changes within the NHS, over its history and whilst all these major reorganisations varied in scope, scale and substance, all recent reforms have shared a common theme; the assumption that efficiency and effectiveness can be improved within the NHS (Sennett 2008). Each of these reorganisations sought to release a hitherto, 'untapped' reserve of service improvement, which would lead to increased efficiency and effectiveness and a reduction in overall costs.

It is the impact of these reforms on the practice of nursing, which this research seeks to examine. In so doing, this study looks at nurses within a community setting and seeks to develop an understanding of the nurses' labour process and how it is controlled by their employer; in an environment where improvements in efficiency and reduction in costs are seen as continuous organisational priorities. To understand the labour process of these nurses and the mechanisms by which they are controlled, I used LPT as an analytical tool.
2.2 Literature Review

For this research study, I analysed the day-to-day work experience of community nurses within an NHS Trust in England. From this analysis of the work of community nurses, I developed a detailed understanding of the labour process of the nurses who participated in my study. Using an ethnographic research approach, I was able to establish to what extent professional discretion was exercised by this group of nurses and I also gained an understanding, as to how these discretionary behaviours were justified by the nurses themselves within an environment and organisational context of standardisation and established practice. During my time with these nurses and in my subsequent analysis, I developed an understanding of the mechanisms of management control and what also emerged during my fieldwork (that I had not anticipated), was the presence of elements of invisible work (Allen 2014; Hatton 2016) within their labour process. In analysing these elements, I have sought to understand how the practice of nurses adapts to the demands placed upon them by themselves, their patients, their profession and their employer. Later in this thesis, I suggest how LPT theory may need to develop further, to account for some of the findings in my research.

In this chapter, I review the literature relevant to my study and this is split into two parts. In the first part of the chapter, I provide contextual background relating to the NHS and the growth of managers as an occupational group within the NHS. I also look at the rise of New Public Management (NPM) as an administrative doctrine and outline the impact and implications of NPM for the public sector and in particular the NHS. Within the context of nursing, I look at professions and professions within healthcare and in particular nursing. At the end of the first part of the chapter, I discuss elements of standardisation and discretion, which were the initial focus of my study. In the second part of the chapter, I outline the main elements of LPT and discuss how this is a useful tool for the analysis of the work of the nurses who participated in my study.
2.2.1 What is the recent history of management in the NHS?

During the 1980s, the Griffiths Report (commissioned by the then, Conservative Government), recommended the introduction of general managers, at all levels within the NHS (Hannigan 1998; Lawton & Parker 1999; Bolton 2000; Dent 2003; Bolton 2004). The consensus at the time was that the NHS was inefficient and there needed to be more accountability for expenditure (Kirkpatrick et al. 2011; Hoyle 2014) and also required the urgent input of general management (Pollock 2005).

Management in the NHS

The organisational changes that began in the 1980s heralded the development of management as a function within the NHS (Pollock 2005) and from that point, Bolton (2000; 2004) argues – control of healthcare began to move from medical professionals to managers, whom she believes were focused primarily on financial and service efficiency. A different view of the era following the Griffiths Report is provided by Hewison (1999) who maintains that the original intention at the time of the Griffiths report was to introduce effective management and involve healthcare professionals more directly, but unintentionally, what actually developed was the emergence of another occupational group – general managers. Thus, the seeds were sown for the influential impact of managers and managerialism over the following decades, which have continued right up to the present day. At this point, it is worth noting the distinction made by Hyde et al. (2016) between management, which they define as an occupational group and managerialism, which they define as an ideology and policy agenda.

A government, overseeing a tax-funded healthcare system, like the NHS, will understandably, always strive to ensure it is the most cost effective and efficient that it can be. However, it is the manner and means in which reforms to achieve these aims (over the last 30 years or so) have been manifest in the NHS, which is of relevance to this research. The emphasis
in the NHS on management and the subsequent focus on organisational performance, value-for-money and consumer satisfaction have their roots in a concept known as new public management (NPM) (Pollock 2005; Pollitt et al. 2007), which has dominated central government policy since the 1980s, in part due to neo-liberal ideals about the need to involve a free-market mechanism in the provision of public services (Mather et al. 2007). Commenting on the impact of NPM on the UK healthcare system, Dent (2003) states:

The UK administrations of the 1980s and 1990s were quick to embrace the principle of the quasi-market… (Dent 2003:77)

It is Dent (2003) who also suggests that the focus in the UK during the 1980s and 1990s was to contain costs in general and in particular, gain cost-control of hospitals. In the next section I will provide a brief introduction to NPM and discuss its impact on public service administration, including within the UK.

New Public Management

NPM is a loose term and is shorthand for a collection of similar administrative doctrines, that have dominated the bureaucratic reform agenda in many industrialised countries from the late 1970s and early 1980s (Hood 1991; Wilkinson 1995; Kirkpatrick et al. 2011). A point highlighted by Evetts (2009) who suggests that NPM includes a number of contradictory discourses; for example, quantity and quality, and transactional and transformational. NPM also appears to be somewhat fluid, with individuals appropriating different meanings to the term, (Thomas & Davies 2005); this is a view supported by Pollitt et al. (2007) who state that NPM is like a chameleon – continuously adapting to local surroundings and environmental contexts. According to Pollitt et al. (2007), this adaptability is possible, because NPM does not comprise of a coherent set of fixed ideas and tools. Thus, NPM’s in-built contradictions, permit the necessary flexibility to create reforms that are appropriate for
different, localised environments. This idea that NPM is not a unified package of measures is also supported by Hewison (1999), who suggests that it is a multi-layered entity, representing a broad range of opinions and initiatives and is more akin to a rhetorical ideology, than a cohesive set of principles.

The particular circumstances which gave rise to NPM are much debated within the literature and Hood (1991) suggests that there is no single accepted, interpretation of why NPM ‘caught on’ in the way that it did. However, Hood (1991) suggests that the most ‘promising’ explanation is that the rise of NPM was in response to a set of social conditions, which developed in the industrialised nations, following the Second World War; not least, a unique period of economic growth (Wilkinson 1995), followed by economic decline (in the 1960s), which resulted in an inevitable decline in investment in public services (Hannigan 1998). By the late 1970s, the traditional models of bureaucratic government in most industrialised nations had come under severe criticism for their administrative inflexibility; an environment which Pollitt et al. (2007) suggest, may have enabled NPM to emerge. Policies inspired by NPM challenged the belief that welfare services should always be provided and directed by the state (Carvalho 2012). Around this time, societies in the West also began to demand smaller and more effective government, better public sector organisations and more professional approaches to delivering services (Evetts 2009).

In contrast to the previous debate around the circumstances that gave rise to NPM, there is much consensus within the literature on the specific characteristics of NPM-inspired reforms. The key elements of NPM administrations are outlined by a number of authors (Hood 1991; Pollitt 1995; Wilkinson 1995; Hannigan 1998; Thomas & Davies 2005; Gleeson & Knights 2006; Taylor & Kelly 2006; Pollitt et al. 2007; Evetts 2009) and include, amongst other characteristics; a focus on performance, quality and consistent standards; an emphasis on a ‘private-sector’ style of management and a challenge to the dominance of professional groups. Indeed, it was the prevailing view that public service officials were seen as
self-serving, inefficient and lacked the motivation to ensure the delivery of efficient public services (Mather et al. 2007).

Most NPM-inspired reforms have a number of characteristics employed together, but not necessarily simultaneously (Pollitt 1995). This supports the idea I discussed earlier in this section, that NPM is fluid, flexible and enables the development of reforms that are specific to local conditions.

Many commentators agree that the over-arching theme running across all NPM’s elements is the need to cut costs and/or increase productivity (Hood 1991; Wilkinson 1995; Bolton 2004; Pollitt et al. 2007; Evetts 2009; Moffatt et al. 2014). This element, Moffatt et al. (2014) argue, changes the traditional public sector focus and moves it from one of good stewardship, to one of productivity and performance. A criticism of NPM is the attempt to import private sector ideology into a public sector context, which has been a feature of many NPM-inspired initiatives; Hannigan (1998) states:

> The theoretical bases for the earliest NPM variants, for example, have now been widely discredited, chiefly for having crudely imported private sector business ideologies into an incompatible public sector environment. (Hannigan 1998:3080)

There has also been criticism of NPM within the literature around the inherent contradiction between equity and efficiency (Hood 1991; Pollitt 1995; Wilkinson 1995). This is particularly relevant in relation to healthcare, a point highlighted by Wilkinson (1995):

> The rhetoric of efficiency improvement through ‘consumer free choice’ has been used to justify the ‘internal market’, however, this method of cost-containment is in conflict with the egalitarian principles in which health service provision is based on need and not on ability to generate revenue. (Wilkinson 1995:982)

Another criticism of NPM has been the inadequate evaluation of the effectiveness of NPM-inspired reforms, in relation to apparent increases in productivity; this is an issue explored by Pollitt (1995), who suggests that
the increases in productivity often attributed to these reforms may (just) be the traditional (albeit grudging) response to enforced budget cuts, rather than a direct consequence of organisational change. In other words, productivity improvements attributed to NPM-inspired reforms, may actually have resulted from intensification of work (resulting from budget reductions), rather than an actual reduction in workload through NPM-inspired organisational change. It may therefore be impossible to untangle where increases in productivity have been as a result of NPM, as opposed to a normative response to the threat posed by budget cuts alone. Also, it seems that where sophisticated analyses of public sector productivity have been attempted, it has been almost impossible to connect macroeconomic changes to specific NPM reforms (Pollitt 1995); Gleeson and Knights (2006) believe that whilst the rationale for reform is one of improving efficiency and effectiveness in the public sector; they argue that it places organisations in a continuous state of foreboding crises. In contrast, Wilkinson (1995) suggest, rather uncritically, that it is kindness, honesty and affection that are vital for good and efficient healthcare – traits which are neither valued, nor their opposites restrained in NPM-motivated policies. This is a concern shared by Hood (1991), who believes that NPM assumes a public service culture of honesty and often removes the very devices created to ensure neutrality and integrity within public service. It is Hood (1991) who also warns of the extent to which NPM may erode these traditional and restraining values.

In this section, I have shown how NPM may have emerged and some of the characteristic impacts that NPM-inspired reforms have had on the public sector; in particular, the change in how and who provides public services and the clear emphasis on the need to improve efficiency and effectiveness and also reduce costs. I have also discussed some critiques of NPM. In the next section, I will briefly outline the influence of NPM in the NHS.
2.2.2 How does NPM and managerialism impact on the organisation and delivery of healthcare in the NHS in England?

As I have already shown, over the last few decades the need to improve service delivery, through increased efficiency, effectiveness and accountability has been left largely at the door of NPM-inspired reforms. In the UK, the main method used to control cost in public healthcare in recent years, has been NPM (Wilkinson 1995).

NPM, Managerialism and the NHS

It is the belief of Hannigan (1998) – although he supplies little evidence to support his view – that NPM within the UK has had its greatest impact in the NHS. More recently, Moffatt et al. (2014) suggest that improving performance in healthcare systems is a key imperative in most industrialised countries and recent strategies and reforms suggest that this is also the case within the NHS. In the late 1990s, the NHS deployed an NPM-inspired strategy to improve the quality of healthcare and the patient experience and the strategy remains one example of the impact of NPM on the NHS – subsequent reforms had the characteristic (NPM-inspired) emphasis on performance measurement and management (Grosso & Van Ryzin 2012). It is Traynor’s (2013) belief that within the NHS:

...the Thatcher government saw professional self-serving interest as a, it not the, major problem. (Traynor 2013:16)

Indeed, the advent of NPM-style reforms heralded an era that moved power away from professionals and saw an increase in managerialism within the NHS, which built on the foundations laid down following the Griffiths Report in the 1980s. According to Numerato et al. (2012), managerialism is seen as being a force for change; one that represents an ideology that has shifted public healthcare towards rationalisation and standardisation. The Conservative and Labour governments of the 1980s, 1990s and 2000s saw increased consumerism and managerialism, as a
way to improve efficiency and control within the NHS, according to Bolton (2004):

The redefinition of health care users as consumers, the apparent incorporation of health professionals into management, the introduction of various quality initiatives…appears to support this version of management control success. (Bolton 2004:321)

It is suggested by Numerato et al. (2012) that managerialism signifies a new mind-set that creates an invisible, but omnipresent tool to govern professionals. An example of the influence of NPM-inspired initiatives on the behaviour of clinicians is provided by Hyde et al. (2016):

Meeting targets could have a negative impact on patient care…patients being moved around (to three different wards in one week…). Yet they [the staff] had no choice but to move them; such is the power of targets to influence behaviour. (Hyde et al. 2016:68)

Before I discuss the impact of reforms within the NHS on professional groups, I will first look at the concept of professions and how managerialism is effective within the healthcare sector.

2.2.3 How is managerialism effective amongst a workforce made up of “autonomous” professionals?

The particular kind of occupation constituting a profession was much disputed during the 1950s and 1960s, along with the specific characteristics which differentiated the professions from other (perhaps expert) occupations (Evetts 2013). Initially, sociologists attempted to define characteristics or ‘traits’ that were common amongst all professions; these included, the monopolisation of certain forms of knowledge, the formation of boundaries into the profession using entrance qualifications and training and the ideology that members of the profession served goals that were higher, than their own economic interests (Abbott & Meerabeau 1998). The socially constructed nature of these characteristics is
supported by Dent (2003), who also highlights that the construction of a profession happens in competition with other occupations and professions. However, according to Evetts (2013), the precise definition of what constitutes a profession is seen to be an unfruitful diversion and she argues, that what is more interesting is gaining an understanding of the power and influence of certain occupational groups – for example, law and medicine and also why the discourse of professionalism continues to remain appealing to society in general. Evetts (2013) states:

> To most researchers in the field it no longer seems important to draw a hard and fast line between professions and occupations but, instead, to regard both as similar social forms which share many common characteristics. (Evetts 2013:780)

I tend to agree with Evetts (2013); a debate about what is or is not a professional occupation is to me less interesting, than the influence and power of so-called ‘professionals’ or why the status of ‘professions’ is maintained by society in general. What is also interesting to me is how and why the influence and power of professionals is curtailed, which is a feat some have argued has been one of the achievements of NPM-inspired reforms.

**Professions**

The meaning of professionalism is fluid and previous sociological analysis of the concept has shown a pattern of change over time; in both interpretation and function (Evetts 2013). Traditionally, professions have been associated with a common identity produced (by socialisation) from shared educational backgrounds, training and vocational experience – all reinforced by the development and maintenance of shared values and a common culture and facilitated by membership of the relevant, professional association (Evetts 2013). Indeed, Evetts (2009) suggests that there was a somewhat romantic image of ‘the professional’, which drew from notions of trustworthy and altruistic lawyers, doctors and clergymen of a bygone era.
A profession’s distinct values and obligations are deemed to restrain a practitioner’s competitive tendencies and generate pride in both their work and the profession itself (Evetts 2013). Historically, there has also been a tradition that professionals are not over-burdened with externally imposed rules, but rather are trusted to make decisions based on their education, training and good judgment (Evetts 2013). The appeal of professionalism to occupational groups includes the exclusive ownership of a specialised body of knowledge and the authority both to define and resolve problems in their area of expertise (Evetts 2013). This view is supported by MacDonald (1995) who states:

The successful deployment of its cognitive and normative aspects not only allows the occupation to establish its social status, it also provides the potential for defining social reality in the area in which members of the profession function, and the opportunity to use their technical expertise as the basis for a claim to a universal validity for their public pronouncements.

(MacDonald 1995:8)

Nevertheless, Evetts (2013) suggests that must researchers now regard professions as being those knowledge-based, service occupations, which generally follow a period of tertiary education and include periods of vocational training and vocational experience. According to Evetts (2009), professionalism can be divided into two distinct and ‘ideal’ types – organisational professionalism and occupational professionalism. I will now deal briefly with each of these ideal-types in turn.

Organisational professionalism is one that is increasingly utilised by managers in organisations to maintain control, as it uses rational-legal forms of authority and often manifests in the use of standardised process and practice and procedures (Evetts 2009; Evetts 2013). In relation to occupational professionalism, this ideal-type arises within an occupational group, where authority develops from mutual values and a trust by clients and employers; this kind of professionalism is characterised by autonomy
and the ability to exercise discretionary judgment (Evetts 2009; Evetts 2013).

One of the criticisms aimed at professionals and the development of a profession is that it is essentially self-serving (Mather et al. 2007). This perspective of the professions and professionals is countered somewhat by Evetts (2009) who states:

Professionals are expected and expect themselves to be committed, and morally involved in their work. (Evetts 2009:252)

The notion of gender in relation to the professionals is an issue considered by Bolton and Muzio (2008) who suggest that qualities, traditionally associated with women are not valued within the professions and as a consequence, this tends to determine whether an occupation is aspiring, semi or established as a profession. Within the established professions, men tend to dominate senior positions while ‘women-like work’ is concentrated in front-line and less-profiled areas of practice; for example, women make up over half of all solicitors and yet women hold less than a quarter of all partnership positions. This situation is replicated in teaching where in all forms of teaching men are in the minority and yet they are still more likely to occupy senior positions (Bolton & Muzio 2008).

In their discussion on feminisation within the professions, Bolton and Muzio (2008) consider nursing – along with teaching – to be ‘semi-professional’ and they argue that this is because women have limited access to the resources necessary to advance and then maintain a ‘professional project’ (Larson 1977). They also point out:

…that without the attachment to the rational, objective, goal-centred masculine model of professional projects, teaching will remain a semi-profession and women teachers will remain consigned to the role of the surrogate mother rather than that of the professional educator. (Bolton & Muzio 2008:293)
In support of Bolton and Muzio’s (2008) suggestion that the number of women in an occupational group has an impact on progress of a professional project; Dent (2003) argues that nursing will only ‘professionalise’ fully, by creating its own specialised areas of work. However, Dent (2003) suggests that this has been particularly difficult in nursing, because of the influence of the medical profession, but hints that this may not always be the case. It seems then that these views go some way to explaining why some occupations have failed to professionalise fully and according to Dent (2003) and Bolton and Muzio (2008), reflects the situation within nursing (as well as teaching), where the status of 'professional' has not been fully realised.

In the next section, I will develop the concept of professions further and look at professions from the particular perspective of the public sector.

**Professions and the Public Sector**

Until the 1980s, the role of professionals in the public sector was understood to be that they interpreted and implemented policy and were able to exercise a high degree of discretion (Taylor & Kelly 2006). However, as we have seen earlier in this chapter – since the 1980s – NPM-style reforms in the public sector, have resulted in the introduction of competition and accountability into the environment. This has resulted in the elevation of the status of managers within the public sector and the increasing significance of governance and inspection bodies, all of which have resulted in the surrender of some degree of autonomy by public sector professionals (Taylor & Kelly 2006). In short, as Evetts (2009) suggests, NPM has and continues to work to advance organisational professionalism, at the expense of occupational professionalism; indeed, some may view one of NPM’s successes, as being the ‘taming’ of previously powerful, professional groups. This view is expanded by Evetts (2009) who questions whether NPM is the state’s response to the high financial and fiscal costs of public services, or a response by the state to try to manage and control powerful professional groups.
There can, however, be a propensity to view NPM in too deterministic a way; one which portrays individuals as passive recipients of change and one where NPM colonises public services filled with unfortunate and resistant professionals (Thomas & Davies 2005). There is also a tendency to portray NPM-inspired changes as the cause of an erosion of the autonomy of professionals (Gleeson & Knights 2006). For example, Moffatt et al. (2014) believe that productivity improvement policies can be construed by healthcare professionals as a potential threat to their autonomy and a dishonourable attempt to devalue and commodify their professional contributions; they also argue that this construction is more likely to be perceived in that way by professionals, because the threat is coming from outside the profession. The inevitability of this tension resulting from external sources is predicted by Dent (2003); who states:

> Wherever organised professionals are employed there is a tension between professional principles and practice and managerial concerns with efficiency. (Dent 2003:86)

This tension then with professional groups within the public sector is also perhaps evidence of one of the characteristics of NPM-inspired reforms, which I outlined earlier in this chapter – that is, challenge to the dominance of professional groups.

This challenge to and tension with professional groups seems somewhat inevitable because, as Evetts (2009) points out – the two pillars of effective and efficient management; (i) acceptance of the control of work activities by management and (ii) the potential to standardise work activity – are not generally acknowledged or accepted by public sector professionals. Increasingly, professionals and occupations practising in contemporary organisations within the public sector are faced with a form of professionalism, which is imposed from ‘above’ by employers and managers (Evetts 2013). This new form of professionalism can be appealing to aspiring occupational groups, as a way of improving status and recognition; however, the implications of this new form are very different from the more traditional construct of professionalism (Evetts
2013). This new form of professionalism is characterised by control of work through supervisors and managers, rather than the practitioners themselves and in some forms, managers have used the notion of ‘professionalism’ to invoke self-exploitation (Evetts 2013) and consequential work intensification – the tidy, rather than The Ragged Trousered Philanthropists (Tressell 2005). This ‘new’ form of professionalism seems to fall into the category of organisational professionalism (Evetts 2009) – a term I discussed in the previous section.

Having briefly looked at NPM and its impact on professions within the public sector; in the next section, I will look specifically at healthcare professionals and the impact of NPM on the nature and practice of their work.

**Health Professionals**

Clinical practice has undergone significant change over the last three decades, as doctors and indeed other health professionals, have come under the influence of management control mechanisms, which have impacted on the nature of their professionalism (Moffatt et al. 2014). It is the belief of Numerato et al. (2012) that standardisation of clinical practice is a tool intended to contain costs and increase the labour productivity of professionals, rather than an aspiration to improve healthcare provision. This tension between professionals and the demands of NPM-inspired reforms is discussed by Evetts (2009) who suggests that professionals are expected to meet the needs of their clients to the best of their abilities and yet at the same time remain within tight financial limits; a situation that was not seen as such a priority before NPM.

In relation to the exercising of discretion, a distinction is made between the exercise of weak professional discretion and strong professional discretion by Cheraghi-Sohi and Calnan (2013) who argue that the implementation of the multiple rule structures associated with standardisation under NPM, suggests that weak discretion remains relevant in relation to professionals
i.e. limited discretion within the confines of rules. However, strong discretion is left to other officials, that is the decision-making outside the confined rules and also perhaps crucially, the criteria on which decisions are made. In other words, limited (weak) discretion remains within the profession; but the framework for decision-making is made outside the profession.

According to Moffatt et al. (2014), there is a strong sense amongst health professionals that their responsibilities lie in patient care and that this is at odds with managers, who are only concerned with productivity, efficiency and financial constraint. This seems to be an overly simplistic view of the tensions that inevitably exist between the priorities of health professionals and those of healthcare managers. However, it is a view that appears to be supported by Hoyle (2014) who argues that a key characteristic of a professional is their focus on the client (or patient in the case of health professionals), rather than any economic concerns. A contrasting perspective is provided by Carvalho (2012) in her study of nurses in Portugal, who argues that some health professionals use their status as a tool of control and resistance – deliberately using their possession of professional caring skills and specialist knowledge, to retain control and autonomy over their work in the face of persistent encroachment from management; Carvalho (2012) goes on to outline how other health professionals use a different strategy, one that incorporates management responsibilities as an integral part of the care practice and then use their more influential position to retain control over their own work. This latter approach could be defined as a type of ‘new professionalism’, a concept discussed within a healthcare context by Speed and Gabe (2013); who argue that there is now a shift from the ‘training-and-licence’ model of professional accountability, to one based on competency and performance – a shift that has been coupled with a move away from professional autonomy and self-regulation.

In line with this idea of ‘new professionalism’, a more contemporary view of professionalism within healthcare has been taken by Frith (2013) who
argues that the concepts of professionalism are changing and now include considerations around efficiency and productivity – in other words, NPM-inspired values. This new form of professionalism is characterised by standardisation, bureaucracy and performance management and an acceptance of organisational, managerial and market values (Cheraghi-Sohi & Calnan 2013) and includes examples of convergence between professional and managerial cultures to create new and hybrid identities (Numerato et al. 2012). This idea of hybrid identities that successfully accept and negotiate the often competing demands of both professional and management cultures may have to be tempered by Bolton’s (2005) belief that professional individuals may ‘embrace’ a role (for example, a managerial role), whilst also remaining emotionally detached from it. This type of detachment is theorised by Hochschild (2012) within her concept of emotional labour; where she argues it is a type of labour that requires a worker to induce or suppress their feelings. I will discuss this concept of emotional labour in more detail, later in this chapter. Hybrid managers are discussed and defined by Hyde et al. (2016) as individuals with management responsibility, who also have a clinical element to their role. However, further temperance is provided by Hyde et al. (2016) who observe that within ambulance personnel, managers were keen to preserve their clinical identity and indeed they were anxious to avoid being perceived as “management”. Hyde et al. (2016) also argue that professionalism and a practitioner identity are the most effective forms of resistance (by hybrid managers), to a perceived shift from patient care to the dominance of business rationale within a healthcare setting.

There are examples of roles where professional and managerial values have merged and are performed by a single actor, which Numerato et al. (2012) argue relies on a professional’s acceptance of management responsibility and can involve the part-time or full-time movement of those professionals into managerial positions. This phenomena of ‘professional-turned-manager’ is recognised by Bolton (2005) who suggests that the importance of nurses in management roles has been acknowledged in the NHS since the early 1990s. This nurse-turned-manager is also recognised
by Pollock (2005) who maintains that both nursing and medical professionals have been appointed to senior managerial posts; but adds (rather implausibly and without convincing evidence to support the view) that appointments to senior management positions have only been approved, if individual health professionals demonstrate a willingness to implement techniques based on NPM.

Notwithstanding, as I have outlined, ‘new professionalism’ describes a professional identity which includes, rather than resists managerial priorities of productivity and efficiency (Moffatt et al. 2014). This is developed further by Taylor and Kelly (2006) who suggest that a degree of entrepreneurial endeavour may be required by professionals, in order to develop new ways of coping with change and increased complexity. This view is supported by Moffatt et al. (2014), who argue that a new discourse has emerged around productivity, where healthcare professionals are identified as a potential solution to this issue, as well as being traditionally part of the problem. However, as Moffatt et al. (2014) point out, this can lead to productivity and fiscal responsibility being reformed as part of the duties of the individual professional and inevitably result in the problem of productivity and its imagined solution being laid at the door of professionals, rather than management.

In contrast to the discourse around ‘new professionalism’ and in relation to nursing, Bolton (2005) suggests that nurses are committed to their role and to the image of the altruistic, caring professional and she goes on to argue that motivational factors within the nursing profession include; the caring aspects of their work and a traditional, public service ethos, values which can appear absent from recent NPM-inspired reforms. The view that nurses are altruistic and motivated by a public service ethos and a need to provide good care to their patients is supported by Adams et al. (2000); who demonstrate that patient care is the highest priority for the nurses in their study, despite working in challenging, environmental conditions. A view that nurses are motivated by a powerful, emotional experience of caring is also argued by Traynor (1994). The views of Traynor (1994),
Bolton (2005) and Adams et al. (2000) can seem somewhat romanticised, given that I have already outlined that some health professionals are incorporating responsibilities typically associated with NPM into their professional roles (Numerato et al. 2012; Frith 2013; Cheraghi-Sohi and Calnan 2013; Moffatt et al. 2014).

In light of the discussion so far, it is important to note at this point that a specific profession is not necessarily a unified or consistent group – a point underlined by Orbe and King (2000) in their study of nurses and organisational wrongdoing. This potential differentiation within a professional group is also illustrated by McDonald et al.’s (2009) study of practice nurses, who outline the contrasts in attitudes amongst individual nurses to the development of their role, with reactions being at both extremes of emotion – enthusiasm and anxiety. The lack of a single unified nursing group is also illustrated by McMurray’s (2010) study of a partnership practice, which had (somewhat unusually) advanced nursing practitioners (ANP) as partners, as well as the more traditional general practitioners (GPs). The study highlights the diversity within nursing as a group, but it also examines the tensions that resulted when ANP partners questioned the decisions made by salaried GPs in the practice. The conclusions from the study contrast with the view that managerialism has a negative effect on professionalism; rather, McMurray (2010) argues that whilst this may be true of the more established professions (for example, medicine), it actually holds opportunities for those who wish to develop a market for their expertise; that is, amongst the less established professions, such as nursing. A view that managerialism may not necessarily have a long-term, negative impact on professions is also supported by Gleeson and Knights (2006), who suggest that as some of the more contradictory consequences of performance management come under increasing scrutiny, professional power may actually be restored.

In summary, in this section I have discussed the impact of NPM and associated managerialism on the work of healthcare professionals and outlined contrasting views on the affect that NPM-inspired reforms have
had on healthcare professions. Some authors have suggested that these reforms have impacted negatively on professionals and have been used as a deliberate device to control and manage their work; whilst other authors have suggested that they have been embraced by professionals and incorporated into their professional identity – to the extent that they may even create development opportunities for certain professional groupings. I have also discussed how different views can pervade within the same professional group, confirming that professionals are not necessarily unified or consistent in their perspectives.

In the next section, I will look specifically at the professional characteristic of autonomy, because it is this specific characteristic that has been a battleground in healthcare, since the mid-1980s (Traynor 2013) and one that is specifically threatened by the influence of NPM-reforms in healthcare. I have also singled out this particular characteristic because it is the tolerance, or curtailment of autonomy that interests me in the context of contemporary healthcare, within the NHS. In particular, how autonomy is exercised (or not) within an environment of increased standardisation.

**Professional Autonomy**

The word ‘autonomy’ comes from the Greek word ‘autos’ meaning ‘self’ and ‘nomos’ meaning ‘law’ and is commonly understood to mean ‘independent’ and/or ‘self-regulating’ (Pollard 2003). Autonomy is defined by Tucker and Edmondson (2002) as:

> …the amount of job-related independence, initiative and freedom either permitted or required in daily work activities. (Tucker & Edmondson 2002:99)

Characteristics which are commonly associated with a person who is said to be autonomous include; the ability to determine the range of activity under their control, having the capacity and right to act on decisions made within their range of activity, having these rights acknowledged by others and taking responsibility for the decisions they make (Pollard 2003).
Whether a professional feels that they have autonomy within their role, may depend on the individual and their perspective, rather than the specifics of the role. This view is supported by Pollard (2003) who reports that midwives required to follow policies and guidelines felt that this prevented them from practicing autonomously. Yet in the same study, the midwives who felt that they were autonomous in their practice, were also the ones who felt that they played a significant role in developing new guidelines and yet these same midwives rather paradoxically, also confirmed that they would not follow guidelines that they felt were not clinically appropriate. The findings from Pollard’s (2003) study seem to suggest that practitioners who feel that they are able to practice with autonomy, are also the ones who contribute to the development of guidelines and are also the ones who feel sufficiently autonomous to be able to ignore those guidelines, if they deem them inappropriate to a particular case. This ability and confidence to select a course of action that is appropriate to the situation that an individual worker faces on the ‘frontline’ is at the heart of Lipsky’s (2010) classic thesis, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Service*.

The term ‘street-level bureaucrat’ was originally coined by Lipsky (2010) for individuals who interact on a daily basis with the public and have wide discretion on the allocation of resources in the form of public services. In his thesis on front-line workers of government bureaucracies, Lipsky (2010) offers two descriptions of a street-level bureaucrat – one that he had intended when writing the book and the other, which evolved from other peoples’ reading of his ideas. The former meaning of the term – the interpretation initially intended by Lipsky (2010) – is one that defines a street-level bureaucrat, as an individual in public service employment of a particular kind, practiced under certain conditions and with some discretion, but also with limitations imposed upon them by the structure of the work. The latter meaning of the term equates to all individuals in public services with which the general citizen typically interacts; as Lipsky (2010) points out, this would include, for example, teachers, police officers, social
workers and in relation to this study, could also include nurses (Hoyle 2014).

These definitions, one intentional and the other – the evolutionary product of other peoples’ ideas – are somewhat confusing and so Lipsky (2010) suggests that it may be useful to think of a continuum of work experiences. At one end are jobs which are deeply stressful and at the other, those that provide an appropriate balance between job requirements and successful practice. This does seem a reasonable way of addressing the problem of definition – albeit perhaps simplistic – as it seems possible that an individual’s role may be placed along different parts of the continuum, depending on their different activities and responsibilities; a situation that is likely to have some relevance to nurses and their practice.

In his thesis, Lipsky (2010) argues that a paradox exists within the activities of public bureaucrats; on the one hand their work is heavily scripted to ensure it achieves its intended policy objective and yet on the other hand it requires improvisation and flexibility to meet the needs of individual cases. Lipsky (2010) goes on to suggest that all the reform efforts of the last 30 years or so, could be seen as an attempt to manage this paradoxical reality – that is, how to treat citizens alike and at the same time to be responsive to their unique and individual needs. If Lipsky (2010) is right, the continuing struggle to resolve this paradox has been set against the background of NPM, which when taken together, may result in an increasing tendency for standardisation within the contemporary public sector.

Within the context of street-level bureaucrats, Taylor and Kelly (2006) maintain that some aspects of recent reforms have impacted on the accountability of what they call street-level professionals – a term presumably used to convey ‘street-level’ characteristics (outlined in Lipsky’s work) that are also seen in professionals working in the public sector. Taylor and Kelly (2006) go on to suggest that NPM-style public sector reforms have been implemented in an ‘undiluted’ form at street-
level, to ensure that policies are the most efficacious they can be. This again suggests a public sector environment of increasing standardisation, implemented from the top-down.

In his book, Lipsky (2010) goes on to question future courses of action where budgets have been cut and ‘waste’ has been eliminated (an environment which seems to closely resemble the one in the contemporary public sector in the UK) and suggests that there are three possibilities. The first is to continue with further automation, systemisation and regulation of the daily interactions between front-line workers and citizens; the second is to ‘drift along’ and implement reductions to services and increase standardisation – justified on the basis of cost effectiveness and maintaining control of budgets. The third is to develop and restore the human interactions in public service that involve the use of discretion. For the time being at least – across the public sector in the UK – the third option appears not to be favoured and a mix of Lipsky’s (2010) first and second options seem to be dominant; as a consequence, standardisation is likely to continue and indeed may increase, in a concerted attempt to systemise, regulate, reduce waste and control costs.

**Nursing as a Profession**

In their study of the effects of a new GP contract on nurses, McDonald et al. (2009) highlight the routine, template-driven care processes described by nurses which appears to be at odds with the nurse professionalisation discourse. However, in the same study, McDonald et al. (2009) maintain that rather than undertaking unwanted work from GPs, practice nurses are becoming the first-contact, care provider in the management of chronic diseases in patients within the practice. They highlight however, that the introduction of Health Care Assistants is possibly undermining the claim by nurses that they should be viewed as a separate profession (not an adjunct to medicine) – one that provides a distinct contribution to care. A rather more dogmatic view is argued by Hoyle (2014) who asserts and accepts nursing as a profession.
According to Hewison (1999), the relative power of nursing, in terms of influencing policy has always been inversely proportionate to size – as an occupational group, nurses are the largest in the NHS (Bolton 2004). In assessing nurses’ ability to impact policy, Hewison (1999) suggests that the best approach for nurses could be to become effective ‘street level bureaucrats’ (Lipsky 2010) and influence the delivery of policy at the local level; evidence of this street-level engagement by nurses is supported by Hoyle (2014). However, Hewison (1999) believes that for nurses to increase their influence within the NHS, they must learn to present their case using the contemporary language of managerialism. This view is supported by Allen (2014) who discusses the emergence of organisational professionalism (Evetts 2009) in nursing, through the involvement of nurses in ‘modernisation’ projects and career progression to hybrid clinical-management roles. This fusion of nursing and management will be discussed briefly in the next section.

**Nurses and Management**

In line with the views of Moffat et al. (2014) outlined previously in this chapter, accounts and analysis of the tension between the views and values of management and those of healthcare professionals are numerous. It is the belief of Hyde et al. (2016) that this tension between professional and management values is manifest most concretely within nursing. With particular reference to nurses, management are sometimes seen as being out of touch with the ‘reality’ of the contemporary demands of healthcare and very often a dichotomy is presented – albeit at times simplistic – between the values of caring and the values of finance and business (Traynor 1994; Bolton 2005; Pollock 2005). In his study, Traynor (1994) reports that some nurses felt that traditional values were being replaced by a culture that they were unable to identify with – one which did not have patients as its main focus. This dichotomy is developed further by Traynor (1994) who suggests that some managers want to see nurses become more rational actors, who allow their expertise to be given the
credit that it deserves. However, Traynor (1994) suggests that other managers see nurses as traditionalists who consistently frustrate the legitimate corporate goals of their organisation. This need to learn a new set of values and ways of presenting their work is discussed in a longitudinal study of nurses carried out by Bolton (2000); in it, she suggests that many senior nurses have conflicting views on the increased managerial elements of nursing and she maintains that whilst nurses feel their forays into management may produce opportunities to increase quality of care, they remain cautious about embracing other management values. This tension is highlighted by Hyde et al. (2016) who maintain that even after moving into management roles, the nurses they observed still perceived themselves as belonging to nursing, as an occupational culture and it is Bolton (2005) who strongly argues for an organisational environment, where nurses do not feel that they have to strip themselves of their own professional values in order to become a successful manager.

According to Cooke (2006), the introduction of nurses as managers has at times been stealth-like, where Ward Sisters have been largely re-titled as Ward Managers within the NHS and have adopted many of the responsibilities formally undertaken by middle managers; Cooke (2006) goes on to suggest that in some NHS Trusts, there have been explicit attempts to transfer management tasks to a lower tier – usually ward manager. The justification for the transfer of these management activities was ‘empowerment’ and ‘increased financial accountability’ and yet Cooke (2006) maintains that most ward managers reported that they had little influence over staffing and were not consulted or even informed about significant changes affecting their ward. This picture of a ward manager having a quasi-management role is underlined by Hoyle (2014) who argues that nurses do not see ward managers as true ‘management’ and feel that they are more akin to nursing staff. It seems then, that the devolution of management responsibilities is somewhat inconsistent and uneven – indeed, the ward managers in Cooke’s (2006) study believed that they held the responsibility without the corresponding authority. A more generic perspective on the incorporation of professionals into
management is taken by Evetts (2009) who argues that it is a deliberate strategy to gain control of professionals and typically uses techniques such as performance review and appraisals, continuous improvement and target-setting to achieve this end.

To summarise this section, I have discussed various aspects of nurses, as managers; in the next section, I will move on to look at the forms that the standardisation I have previously discussed, can take in the NHS – given that the particular focus for this study is nurses in a community setting within NHS England.

2.2.4 How is the influence of NPM-inspired standardisation manifest in the everyday activities of healthcare workers?

The evidence of standardised processes and procedures across the public sector (Carey 2009) is a characteristic of NPM-inspired reforms and I highlighted this as a feature of NPM, earlier in this chapter – that is, quality and consistent standards. In this section, I will first look at some of the features of standardisation within healthcare in the UK and then go on to discuss standardisation within healthcare in more detail.

Causes and Semantics

According to Lawton and Parker (1999), the development of clinical protocols has arisen for a number of reasons. Firstly, the management of risk in an increasingly litigious environment. Secondly, the need to increase management control of healthcare practice to improve efficiency and cost effectiveness, which is partially supported by Hewitt-Taylor (2004) who suggests that the introduction of evidence-based practice has in part resulted from a desire for patients to receive treatment on the basis of evidentiary efficacy and not based on the unproven opinion of an individual clinician. Thirdly, to improve the integration of research into practice – a view supported by Berg (1997) who also adds an additional reason for the emergence of standardisation; the need to reduce variation and increase
transferability of skills and knowledge. The development of clinical guidelines seems therefore to be a move – in part at least – to develop practice based on evidence, reduce variation and introduce standardisation for the benefit of patients (Grimshaw & Russell 1993; Parker & Lawton 2000; Rhodes et al. 2006). However, there may also be a further motivation around the control and the need (as I pointed our earlier in this chapter) to establish limitations on the autonomy exercised by professionals (Campbell et al. 2008). This view is shared by Allen (2009), who attributes the growing popularity of care pathways to the emergence of a shift away from trust in the expertise of professionals. Allen (2009) also suggests that the appeal of care pathways may also be because of their ability to:

...assign clinical, management and service user interests around a healthcare quality agenda. (Allen 2009:355)

However, Allen (2009) is unromantic and indeed pragmatic about the process of developing pathways; which she maintains is an emergent and negotiated process and one that inevitably involves degrees of compromise.

In recent years, an increasingly standardised approach to healthcare across the UK has seen the establishment of the National Institute for Clinical Excellence (Hewitt-Taylor 2004), now renamed the National Institute for Health and Care Excellence; a Non-Departmental Public Body, accountable to the Department of Health and Social Care (National Institute for Health and Care Excellence 2018). One of the responsibilities of the National Institute for Health and Care Excellence is the development of national advice and guidance on all aspects of health and social care – including clinical guidelines. The introduction of a guideline or protocol does not necessarily mean that it will be accepted and subsequently adhered to (Lawton & Parker 1999). However, it is Allen’s (2014) view that evidence-based standardisation is becoming normalised within a healthcare context. The types of standardisation used in healthcare are varied; some relate generally to all clinical practice, whilst others are
specific to a particular clinical discipline. Some forms of standardisation are also applicable to non-clinical (as well as clinical) staff; such as, a complaints procedure (Lawton & Parker 1999). Terminology can also be confusing as different words are often used to convey a similar meaning, such as guideline, pathway, protocol, procedure and policy – but they can also be perceived by individuals to have subtly, different meanings. In their study of health professionals, Lawton and Parker (1999) found that medical staff perceived a guideline as allowing more flexibility to the individual clinician; whereas a protocol was perceived to require more rigid adherence. This particular perception of guidelines is supported by McDonald and Harrison (2004), who define them as a type of algorithm, which guides the user to the appropriate course of therapeutic action and can imply optional compliance. It is Allen (2009) who suggests that pathways differ from guidelines, because they detail specific activities to be undertaken by the various clinical occupations involved in patient care. Whereas Dent (2003) is a little more circumspect and suggests that there is no clear consensus on how detailed pathways should be and whether they are instructions, or merely suggested templars. This differentiation in terminology and meaning is also highlighted by Berg (1997), who argues that despite these differences guidelines are often seen as a set of instructions for medical staff that provide specific advice, in particular situations.

Healthcare Environment

The efficacy of various forms of standardisation is likely to be inconsistent within healthcare. The sector’s nature and complex characteristics (Hewitt-Taylor 2004) make it difficult to state in exacting detail, all the potential variables that may impact on that which has been defined as ‘standard’. In her study of the development of clinical guidelines for intensive care, Hewitt-Taylor (2004) points out that as well as guidelines, practitioners are expected to use their clinical judgment to make decisions on the needs of each patient – indeed, they are duty-bound to do so, by virtue of membership of their various professional bodies. A situation that
could be argued undermines the purpose of guidelines in the first place and underlines the inherent and ongoing dynamic between professionals in healthcare and their need to follow standardised practices and guidelines. A study on the use of computerised checklists by Rhodes et al. (2006) found that the standardisation imposed created a habitual structure to patient consultations, which developed into a one-sided form-filling exercise – rather than an interactive consultation. The authors of the study also believe that the standard checklist had the effect of prioritising clinical data input, stifling discussions and marginalising the patient. This is clearly not conducive to high quality patient care and yet Rhodes et al. (2006) point out that from an organisational perspective, the clinicians who took part in their study, "performed" well – relevant tests and checks were carried out, appropriate data was accurately recorded and patients were given relevant information and advice. Interestingly, Lawton and Parker (1999) report that the general perception of doctors and nurses was that standardisation was used to define best practice and unify behaviour, but not necessarily to improve patient care. Indeed, in some cases the doctors in Lawton and Parker’s (1999) study maintained that following a procedure may at times be detrimental to patient care.

**Purpose and Development**

Some clinicians see standardisation as a support, rather than a prescription of practice, but this is likely to differ between and within professions. This view is supported by Lawton and Parker (1999) who report a difference in the acceptance of standardisation between doctors and nurses. Of the two occupational groups, nurses showed a greater willingness to conform to protocols, but this may not be representative of all nurses, in all environments; indeed, as I have suggested earlier in this chapter, a single profession does not necessarily comprise of a unified and consistent group. In their study of the development of local clinical guidelines, McDonald and Harrison (2004) found that, although guidelines are often perceived as constraining clinical practitioners, there is nothing intrinsically corrosive to professional autonomy resulting from the
guidelines themselves – it is the manner in which they are implemented, which is more likely to have an effect on clinical autonomy. Their study also showed that (perhaps contrary to what may have been expected), the development of guidelines demonstrated limited commitment to ‘scientific’ evidence and indeed the preference was for clinicians to base guidelines on individual, case-based understanding of evidence, rather than a rigid deference to the so-called ‘hierarchy of evidence’. A similar situation was also highlighted by Allen (2009) who stated:

In the absence of research evidence on which to base their standards, the team turned to clinical experience to agree the services to be provided…in doing so they were repeatedly confronted by specificity of individual needs, which was clearly in tension with the aspiration to set an organisational standard. (Allen 2009:358)

This may suggest that even in an environment of standardisation – some clinical autonomy remains – albeit manifesting in the cloak of standardised pathways and guidelines.

**Practice Perspectives**

In this discussion on health professionals and in particular nurses, it is easy to develop an overly romantic view of clinicians and momentarily forget that these individuals are subject to the same weaknesses as individuals in other occupations. In her study of nurses, Hoyle (2014) found that nurses were prone to being influenced by their own moral judgement and were willing to make allowances for patients who they felt were ‘deserving’ of their favour. A different perspective on differentiations in nursing care is illustrated by a study of intravenous medication errors by Taxis and Barber (2003) who argue that the absence of effective training and guidelines, contributed to errors in the administration of medication; as nurses passed on bad practice from one to the other, creating an environment where unsafe drug administration became normalised. The authors of this study concluded that the unsafe medication environment
that had developed, required the implementation of more robust standardisation and guidance in order to improve compliance with safer procedures.

**Advantages and Disadvantages**

In his paper on medical protocols, Berg (1997) highlights a number of problems associated with the use of standardised practice protocols. Firstly, he suggests that a protocol creates and maintains a perception that patient management is a series of individual and rational decisions; Berg (1997) argues that this is not an accurate perception of the practice of medicine, as it excludes the social context of any clinical encounter. This view of protocols is supported by Checkland et al. (2007) in their study of the collection of data through computerised templates. They report that to ensure data entered by practitioners is brief and relevant, issues relating to lifestyle changes – such as, stress and attitudes to food – are reduced to a series of numerical, or yes/no answers. This seems to be a device to create quantitative data from a source that is essentially one suited to qualitative data collection. A second concern highlighted by Berg (1997) is that protocols propagate the illusion that there is a single answer to a given question:

>This is the assumption…that there is one optimal intervention to every medical problem. (Berg 1997:1083)

This view assumes that there is a single, optimal rationality. However, in healthcare a multiplicity of rationalities can co-exist and may contribute to valid justifications made by ‘non-compliant’ clinicians (Berg 1997). A third problem suggested by Berg (1997) is the loss of information, due to difficulties arising from the inability to quantify or explicate some pieces of data generated in a clinical interaction; for example, a tone of voice, the significance of a pause. This loss may also reinforce an already widespread view, that only information that can be quantified is ‘scientific’ and therefore of ‘value’ (Berg 1997). This perspective on value is also
supported by Checkland et al. (2007) who maintain that recorded information is usually made up of information that can readily be reduced to a set of clinical codes and thus tends to neglect more qualitative-based information. This supports the point I made earlier in this section; that qualitative data can be ‘transformed’ into qualitative data, because it is easier to record and analyse. In further expanding the implications of this problem, Berg (1997) suggests that professional groups that see themselves as ‘soft’ occupations – like nursing – are pressured to formalise their knowledge base and in so doing perpetuate the belief that increased quantification is more ‘scientific’. This is a view supported by Traynor (2013) who argues that it is essential for nursing to claim that its activities are based on a technical-rational basis and the subsequent emergence of evidence-based practice, has provided the nursing profession with something it had always craved – legitimacy. The fourth problem described by Berg (1997) follows naturally from the aforementioned consequence of the third and that is that protocols can be seen by some, as a legitimate strategy to strengthen (or rescue) professional autonomy. However, Berg (1997) argues that too often the influence of management, rather than the professionals themselves dominants, he states:

...in the case of nursing protocols and standards, considerations which can be traced back to management needs often predominate. (Berg 1997:1086)

In his paper, Berg (1997) neglects to mention any potential impacts (associated with protocols) on actual patients. An issue that is addressed by Checkland et al. (2007) who highlight how patients who do not fit within the clinical guidelines for a specific condition are given treatment conforming to the accepted ‘norm’, which is developed from large-population based trials, rather than treatment based on the needs of the individual.

The use of standardised templates to enable the delegation of work to less qualified staff is also highlighted by Checkland et al. (2007), who argue
that staff with less training are inevitably less able to resist the pressure to follow standard templates. These less qualified staff are not equipped to discuss the details of a particular clinical approach or take account of a patient's particular social or psychological situation; this results in 'review appointments' becoming a data collection exercise rather than a genuine opportunity for the patient and clinician to assess treatment and progress. This delegation of work to less qualified staff (sometimes labelled *skill mix* within the NHS) is reminiscent of predictions made by Braverman (1974) around the division of labour and associated reductions in cost:

...dividing the craft cheapens its individual parts.

(Braverman 1974:80)

It is argued by Braverman (1974) that modern management came into being on the basis of theoretical construct and systematic practice, at a time where labour was being transformed from processes based upon skill, to those based upon science. Here Braverman (1974) appears to have predicted the standardisation of work within the contemporary healthcare system and the increased focus on rational processes, rather than innate skill, based on practice experience.

In his seminal work, *Labour and Monopoly Capital*, Braverman (1974) maintains that labour power is organised according to the needs of the employer, not the employee – because it is in the interests of the employer to cheapen the 'labour commodity' as much as possible. If I accept Braverman’s (1974) argument and then take it a stage further in the context of healthcare, I might conclude that labour power is being organised according to the needs of the employer and not the needs of the patient, or indeed healthcare workers. This discussion on healthcare labour involving less qualified staff is also reminiscent of Braverman’s (1974) suggestion that a few people retain specialist knowledge and training and are freed from ‘simple labour’, whilst others must work on activities that are more mundane and less fulfilling; Braverman (1974) argues that this has the effect of polarising individuals into those whose time is highly valued, from those whose time is valued very cheaply.
In his paper, Berg (1997) also highlights some potential advantages associated with protocols: firstly, Berg (1997) suggests that the development of a protocol, creates a forum for discussion:

Through explicating that which was implicit, through making public that which was private, patterns of practice become open for scrutiny and contestation. (Berg 1997:1086)

This seems a reasonable conclusion to draw, in relation to a benefit associated with standardised protocols; that is, implicit and innate knowledge is “opened up” to critique and scrutiny, which is more likely to prevent ineffective practice from being propagated as the opposite. A second potential advantage of the protocol, according to Berg (1997) is that relying on it for decision-making may lead to individuals developing new skills and knowledge because they are able to work in complex environments that would otherwise not have been possible, due to their inadequate level of experience. However, Berg (1997) warns:

If protocols are implemented because ‘standardisation’ is pursued as a good in itself, or from a perspective which is unduly management-oriented, then competencies will only be taken away from health care workers. (Berg 1997:1087)

Here, Berg (1997) warns against pursuing standardisation for ‘standardisations-sake’ alone, as this will have the opposite effect; that is, competency and skill will be removed, rather than enhanced. A further potential advantage of standardised templates seems to be that they aid in the improved transfer of information between health professionals (Checkland et al. 2007), which links to both of Berg’s (1997) highlighted advantages. However, these authors agree that standardisation is not seen as beneficial in and of itself to the patient; rather benefit is gained by the patient, only by proxy – through potential, competency benefits gained by the healthcare professional who may treat them.
Discussion

In their study of practice nurses, McDonald et al. (2009) report that some participants felt that their work was increasingly being directed by standardised templates and protocols, which the authors suggest raises questions about the exercise of professional judgement and the ability of professionals to tailor care to an individual; rather than seeing the patient as a ‘disease-bearing object’. Similar concerns are also highlighted by Campbell et al. (2008), relating to a ‘tick box’ approach to patient consultations. Inappropriate levels of standardisation are highlighted by Hewitt-Taylor (2004) in relation to the development of clinical guidelines and care protocols and the potential for these types of standardisation to be used, devoid of the associated clinical experience and judgement. However, Hewitt-Taylor (2004) is careful to acknowledge that this should not mean:

…that the best method of providing a single aspect of care should not be identified and used. (Hewitt-Taylor 2004:49)

The issue of standardisation is also reported by McDonald et al. (2007), who found that practice nurses (PNs) and GPs questioned the appropriateness of ‘blanket’ standardisation for all patients and also reported concerns from some healthcare professionals, that information about patients and their care was being harvested, sometimes unnecessarily. The study also highlighted that the impact of standardisation was felt differently between PNs and GPs, as according to McDonald et al. (2007), bureaucratic elements of modern healthcare provision, were often delegated to PNs by the GPs, which resulted in the PNs being more uncomfortable with the monitoring of compliance to standards, because they felt less able to professionally resist. This differentiation between doctors and nurses’ perceptions is also reported by McDonald et al. (2005) in their study of rules and guidance on practice in the operating theatre. However, the acceptance of standardisation in this study had the opposite effect to the previous one, in that, theatre nurses welcomed the standardised guidance as a key element of providing
good quality patient care. This was in contrast to the doctors who perceived the guidance as useful only to trainees and seemed to imply, that ‘proper’ doctors should not need to resort to guidance (McDonald et al. 2005).

It seems then, that some health professionals feel that standardisation – in its many forms – is unnecessary and can be an unwelcome intrusion to meaningful, interactions with patients (Checkland 2004; McDonald et al. 2007; Campbell et al. 2008), whilst others feel it is a beneficial element that contributes to providing good care (McDonald et al. 2005) and see standardisation, as playing a positive role in maintaining and indeed improving, quality and consistent patient care (Campbell et al. 2008). Standardisation being used as a catalyst for improvement is supported by Checkland (2004) who maintains that both GPs and PNs in her study, acknowledged the practical help in managing patients, through the use of good guidelines and whilst a number of GPs raised concerns about increasing levels of ‘surveillance’, they nevertheless endorsed the standardised framework that had been introduced.

Other Perspectives

A number of concerns were highlighted by Campbell et al. (2008), which may be defined as unintended consequences of standardisation in the NHS and are therefore, relevant to a general discussion on the topic. The first is that doctors were concerned that in order to meet standardised targets, they had become proactive and over-zealous at following up patients. The second is that doctors expressed concern that (perhaps subconsciously) conditions, or illnesses that were not the subject of standardised targets and incentives, were being ‘downgraded’. Another perspective on increased standardisation within healthcare is taken by Bolton (2004), who suggests that it is a device to control the work of health professionals, through techniques, similar to those of scientific management. This view makes the assumption that the deployment of organisational reforms is a deliberate action by management to gain
control over the day-to-day work of professionals, who (as we have seen earlier in this chapter) may be perceived to be self-serving and have too much control. This view assumes a traditional interpretation of the relationship between management and professionals – one of conflict, resistance and struggle. This perspective on the relationship between management and professionals is illustrated further by Bolton (2005) who suggests that some nurses are caring, altruistically-driven professionals who are not willing to bend to every management whim. This somewhat idealistic view is also supported by Hoyle (2014) who states that some of the nurses in her study saw their primary role as delivering good patient care, irrespective of financial constraints and performance targets.

In contrast to some of the literature I have already discussed on the standardisation of healthcare processes and procedures and this potentially leading to loss of professional autonomy and increased management control; Ruston (2006) shows that the nurses in their study retained control of their work through explicit and implicit manipulation of the decision-support software they used, whilst working for NHS Direct. In her study, Ruston (2006) found that nurses at NHS Direct continued to use their professional judgement, even though they were working in a highly, standardised and controlled environment. A study by Russell (2012) presented similar findings and Smith et al. (2008) showed that informal cooperation between nurses, enabled the sharing of specialist knowledge between nurses working in NHS Direct.

I discussed in a previous section, nursing as a profession and Berg (1997) believes that standardisation can be seen as a means to improve the scientific status of some clinical occupations and in so doing help to strengthen their position as a profession and progress their professional project (Larson 1977); Berg (1997) includes nursing in this category of clinical occupations. However, this view should be tempered by those of Traynor (2013), who suggests that too much emphasis and reliance on scientific evidence within nursing could lead to too close an association with medicine; a comparison that Traynor (2013) argues is unlikely to be
favourable to nursing, because it will inevitably lead to nursing been seen as having a less developed scientific base.

Summary

In this section, I have shown that authors vary in their view on the motivations for developing and the impact of standardisation; some suggest that the quality and consistency of healthcare may improve as a result, whilst others suggest that it is a technique primarily employed to erode professional autonomy and increase management control. In this section, I have also explored the impact of some forms of standardisation within the healthcare environment of the NHS and seen that there are contradictory perspectives on standardisation by both doctors and nurses; often depending on the suitability of the standard process or protocol to the context in which it has been deployed. I have also shown how nurses in NHS Direct retained their professional autonomy, despite working in a highly standardised environment, controlled (superficially at least) by decision-support software.

In the next section, I will discuss compliance, non-compliance and professional discretion. I will also look at how compliant, non-compliant and professional discretion are manifest in a healthcare environment, where increasing amounts of standardisation are a common feature.

2.2.5 Is discretion possible, in a healthcare environment of increased standardisation and control? How is this discretion perceived?

Compliance and non-compliance with standardised practise may, in certain situations be referred to as professional discretion, which is itself a broad and subjective concept. To aid in an understanding of these terms, in this section I will attempt to illustrate behaviours which may be perceived by some as professional discretion and by others as a form of deviation or violation of standard practise. In this section, I will also look at the influence of organisational context on behaviours by organisational members.
It is important to establish in the first-instance why non-compliant behaviour occurs within the workplace and this is because of the existence of rules, which are organisational attempts to manage and control individuals’ work practices and behaviour (Lawton 1998). A number of authors differentiate between deliberate deviation from standard methods for carrying out a particular task and errors; which is an unintended lapse, slip or mistake made by an individual (Lawton 1998; Fogarty & McKeon 2006). This distinction between violations and errors is questioned by Busby and Iszatt-White (2016) who argue that constructing them as two disjointed categories is too crude; labelling an incident as an error or assigning a perceived intention and calling it a violation are both social acts.

There are a number of disadvantages to setting rules and practices as a means of organisational control – not least, the fact that policing compliance is resource intensive (Lawton 1998). Rules and standard practices can also contribute to an aggregate reduction in overall understanding of organisational functions, which can then lead to ‘blindness’ in new, uncodified situations (Lawton 1998). There is also the more obvious consequence, that organisational control in the form of rules and practice standards can cause resentment in organisational members (Lawton 1998).

Violations

A violation act may conjure up an image of malevolence, but can in actuality, stem from the positive exercise of initiative – rather than any negative motivation of malice or neglect (Busby & Iszatt-White 2016). Types of intentions are usefully categorised by Busby and Iszatt-White (2016) who suggest that intentions are constructed by the violator, to justify and create order from an action (the violation), that on appearance may seem to be a source of disorder. According to Busby and Iszatt-White (2016) these ‘orders’ include; predictability, purposefulness, progress, affiliation and humaneness. The order of predictability constructs an
intention that derives from a prior knowledge of circumstances; the order of **purposefulness** constructs an intention that derives from a motivation to maximise efficiency; the order of **progress** constructs an intention that derives from a motivation to improve practice, outcomes or circumstances; the order of **affiliation** constructs an intention that derives from belonging to a particular group, which possesses shared norms, values, ideas and assumptions and the order of **humaneness** constructs an intention that derives from a sense of service to another individual. These orders were developed from Busby and Iszatt-White’s (2016) study of a large infrastructure company, but they do appear to have some relevance to a healthcare setting. Classifications of violations – as opposed to intentions – are described by Lawton (1998) in their study of railway shunters who divide violations into four categories; **erroneous**, **exceptional**, **situational** and **routine**. **Erroneous** violations are those which stem from lack of experience or understanding and are generally not motivated by the need to save time. **Exceptional** violations tend to occur in unusual circumstances and are very risky, but of a low frequency. **Situational** violations are motivated by a desire (on the part of the violator) to keep the work progressing well in ‘less-than-optimum’ circumstances; this type of violation seems to be closely associated with Busby and Iszatt-White’s (2016) order of progress. **Routine** violations occur when a shortcut presents and it is taken on a regular basis; according to Lawton (1998), there is a belief on the part of the violator, that the risks associated with this kind of violation are offset by their skill. In discussing the factors that may influence the carrying out of violations, in a healthcare setting, Fogarty and McKeon (2006) report that organisational and individual factors are a likely influence and they make this rather obvious, observation:

…when the climate is positive, nurses are less likely to feel stressed, less likely to violate procedures and therefore less likely to make errors. (Fogarty & McKeon 2006:454)

The conflict between the organisations control and ultimate objective is pointed out by Lawton (1998), who states:
Employees recognise that they are repeatedly in a Catch-22 situation. If they follow...rules, the job runs less efficiently or stops and management wants to know why. If rules are broken deliberately...the violator is negligent... (Lawton 1998:90)

The intention behind an action is what is perceived by some to distinguish an error from a violation and Fogarty and McKeon (2006) are quick to point out that the violations carried out in their study were not intended to cause deliberate harm. They go on to provide an illustration of the organisational pressure, which is brought to bear on some nurses working in a rural part of Australia; an environment where a shortage of doctors in rural communities meant that nurses had to make drug administration decisions that would not normally be part of their responsibility in a more normative setting, such as a hospital. However, these Australian nurses were forced to work deliberately outside guidelines, through organisational pressures, resulting directly from a lack of appropriate medical resources. This situation illustrates the importance of context within a particular environment on the potential for non-compliant behaviour. In the case of the nurses in rural Australia, these individuals were (out of necessity) forced to act beyond the limits of their responsibility, because of heavy workloads and a chronic shortage of GPs in the rural communities in which they practiced. Using Lawton’s (1998) categories, this kind of violation would be labelled *situational*.

Situational factors such as staff shortages, supervisory pressure, equipment non-availability, poor conditions and high workload, effect the likelihood of violations by increasing the pressure to violate in order to complete targets and keep to time. In this case, violations result not from a lazy or careless staff but from the well-intentioned loyalty of staff whose priority is to keep the job running. (Lawton 1998:91)

The influence of context is also evident in a study by Furber and Thomson (2006), which focuses on the views of midwives in relation to baby-feeding practice. In their study, Furber and Thomson (2006) found that many midwives considered occasional feeding of artificial milk (by the midwife),
as being essential for long-term successful breast feeding by struggling mothers. This was despite the practice being explicitly against established policy and also against the principle of informed consent for treatment – as many of the mothers were unaware that their baby had been given a ‘special cup’ by the midwife. The midwives justified their behaviour by arguing that their actions were in the best interests of their patients; as it allowed a tired mother to rest, which, in the longer-term would be more likely to help mum and baby achieve successful breast feeding.

The intention in the case of the Australian nurses was that they were acting in line with Busby and Iszatt-White’s (2016) order of humaneness. The account of the midwives is different. In their particular case, they were acting in line with the order of progress; because their intention was to see successful breast-feeding between mother and child; that is, the eventual outcome was used to justify a violation of the ‘rules’.

In another case described by Furber and Thomson (2006), several hospital-based midwives ignored policy recommendations, if they did not agree with them. The authors describe one violation carried out by a community-based midwife, who ‘broke the rules’ by giving out her mobile telephone number to patients who needed ‘ad hoc’ support for breast-feeding. A violation, which was clearly a behaviour intended to improve patient care and another example of where the eventual outcome was used as justification for ‘rule-breaking’. According to Busby and Iszatt-White (2016), violations, rather than producing disorder (subject to certain boundary conditions) can actually contribute to the construction of social order; this avoids the difficulties that would be inherent in assessing whether rule violations are good or bad for an organisation.
Workarounds

Non-compliant behaviours, according to Debono et al. (2013) can be defined as *workarounds* and suggest that a number of behaviours can be encompassed in this definition; these include, violations, deviations, problem solving, improvisations, procedural failures and shortcuts; Halbesleben et al. (2010) define a *workaround*, as:

…alternative work procedures that bypass a perceived block in workflow. (Halbesleben et al. 2010:125)

Whilst, Debono et al. (2013) define a *workaround*, as:

…intent to achieve an outcome through handling failures and exceptions in workflow or by bypassing formal rules, protocols, standards or procedural codes. (Debono et al. 2013:6)

Workarounds are potentially more likely to occur in modern, healthcare environments because of the constant pressure to reduce cost and improve efficiency. This is often achieved by increasing the pace of activity being carried out, that is, by increased work intensification (Ackroyd & Bolton 1999; Tucker & Edmondson 2002; Halbesleben et al. 2010). This view links with my earlier discussion in this chapter around NPM (and its impact) and coupled with a healthcare system that is complex, fragmented, decentralised and unevenly regulated may lead to more use of workarounds (Debono et al. 2013). In other words and rather ironically, workarounds may be a response from workers to the complexity of delivering care in a system that strives to maintain consistency and is therefore a response by healthcare professionals to an environment of standardisation and complexity. According to Rathert et al. (2012), the motives for a workaround are different from those associated with deviance, errors and shortcuts – a workaround is completing a task, by ‘getting around’ some perceived, or actual block. This often occurs when processes that are developed to be optimal for the organisation, result in sub-optimisation for an individual (Rathert et al. 2012).
As I highlighted at the beginning of this section, the line between workarounds, errors, shortcuts, violations, deviations, wrongdoing and indeed professional discretion is a subjective and relative one. In their study of nurses and organisational wrongdoing, Orbe and King (2000) found that nurses did not always report situations where a colleague had violated a written policy – if they felt it was trivial and had not had an impact on overall patient care. However, the reverse was true where nurses believed an incident threatened the people they were caring for, or others around them; or where it contravened professional (nursing) guidelines. This exercise of contextual judgment in relation to non-compliance to practice guidelines is supported by Parker and Lawton (2000) who found that both nurses and doctors assessed the severity of the outcome of a violation before deciding whether they felt the violation was inappropriate. By contrast, the same study revealed that midwives judged violating behaviour to be inappropriate, regardless of the outcome for the patient (Parker & Lawton 2000). An indication perhaps that perceptions of violations are also different, in different occupational groups within healthcare.

The perception of workarounds is mixed, but the majority of studies perceive them negatively (Debono et al. 2013), including a rather limited study by Kobayashi et al. (2005) who highlight the destabilising effect of workarounds – due to their tendency to force the need for further, systemic workarounds, within the organisation. However, Kobayashi et al. (2005) do acknowledge that in the event of an emergency (an obvious feature of healthcare settings), workarounds can provide effective solutions to exceptions that may occur. As I discussed earlier regarding violations, there are different perceptions about workarounds amongst healthcare professionals themselves. With particular reference to nurses, some believe that they are necessary to deliver good care, whilst others maintain that they are unsafe and risky (Debono et al. 2013). This is illustrated by Debono et al. (2013) who state:
Rules were perceived as flexible and while on the one hand part of being a ‘good nurse’ was the ability to use one’s judgement to workaround the rules for the benefit of the patient, to do so risked colleagues’ perceptions that one was not a ‘good nurse’. (Debono et al. 2013:11)

To highlight this apparent contradiction, Debono et al. (2013) report that some nurses felt that not adhering to policy, undermined professional ideals and quality of care – indeed, some deemed the use of workarounds as malpractice. This echoes and supports my discussion earlier in this chapter, which highlighted that professionals and in this particular case, nurses, are not necessarily a unified and consistent group (McDonald et al. 2009; McMurray 2010). According to Hoyle (2014), discretion in the form of shortcuts were used by nurses to cope with the continual pressure of large workloads and diminishing resources. This evidence seems to suggest that where work intensification increases amongst nurses (Ackroyd & Bolton 1999), the use of shortcuts is likely to increase. In other words, nurses may be pressured into behaviours perceived to be “short-cuts”, due to work intensification. A study of nurses by Tucker and Edmondson (2002) found that ‘exceptions’ were almost routine.

**Unmanaged Space**

The concept of the ‘unmanaged space’ is one that has some relevance to a discussion on ‘rule-breaking’ in a general sense and is theorised by Bolton and Boyd (2003). They suggest that when a situation occurs where organisation-based rules do not apply or are relaxed, an unmanaged space can develop. However, they argue that these spaces are not always sites used for worker resistance, as might be expected; but rather, they can be useful to an employer, because they allow the employee some limited ‘freedom’, which may counter any tendencies for employees to resist in other ways. It is Vincent (2011) who suggests that even where ‘misbehaviour’ occurs amongst workers, it can still be beneficial to an employer:
…if it makes poor working conditions more tolerable and humane...Even if no value is added immediately, the organisation may benefit from reduced turnover where employees find space to be themselves. (Vincent 2011:1377).

According to Vincent (2011), an employee may decide to remain with their current employer, if some forms of ‘low-level’, rule-breaking is tolerated. Thus, rather than being spaces of potential resistance, Vincent (2011) suggests that these spaces may ‘protect’ against an employee exercising their ‘mobility power’. A concept in LPT that I will discuss in more detail, in the next section of this chapter.

Summary

In this section, I have highlighted some useful labels for categorising non-compliant behaviour and also labels for the created intention assigned to these behaviours. I have highlighted workarounds and how these differ from both violations and errors and can be influenced by organisational environments and contextual factors. I have also highlighted how behaviours referred to as “discretion” and “short-cuts” are viewed differently, between and within occupational groups. Perhaps oversimplistically, I will now refer to this collection of behaviours as non-compliant. It has been suggested that training, expertise and skill make rules unnecessary and redundant in the exercising of control (Lawton 1998). However, this issue of control, how it is exercised in the workplace by management and its impact and implications for non-compliant behaviours, will form part of the research focus of this thesis. In the next section, I will discuss the theoretical framework I propose to use for my analysis of the data in this study.
2.2.6 How might labour process theory support the analysis and understanding of standardisation and control in the NHS in England?

The focus of Braverman’s (1974) *Labour and Monopoly Capital* is the degradation of work under the capitalist system of production and is largely responsible for focusing attention on labour process theory and seeing work as a labour process (Spencer 2000; Ackroyd 2009). The central theme of Braverman’s (1974) thesis is the separation of conception and execution of work – a development which Braverman sees as a degradation of the work (Littler 1990). A definition of Labour Process Theory is provided by Littler (1990), who states that it is the examination:

…of the ultimate function of management and asserts that this function is the conversion of labour power (the potential for work) into labour (actual work effort)... (Littler 1990:48)

Despite its foundational status, Braverman’s (1974) thesis has been heavily critiqued by a succession of authors (Littler & Salaman 1982; Littler 1990; Thompson 1990) in particular for his apparent neglect of the subjective elements of work (Spencer 2000). In this section, I will look at Braverman’s (1974) thesis and sketch the main elements that make up labour process theory. I will also look at some of the criticisms of Braverman’s (1974) work and the views of other authors who have written about the labour process and labour process theory.

The theoretical background to Braverman’s (1974) thesis comes from a Marxist tradition, which is evident from his definition of the *working class*, who he maintains are individuals who do not own, or have access to the means of production and are forced to sell their labour power to those who do. The Marxian foundation in Braverman’s (1974) work is further evidenced by his belief that the primary focus of management is cost reduction and effective control and any apparent focus on workers’ conditions is incidental and pragmatic; that is, it is only attended to in order to alleviate issues that may be having a detrimental impact on the means of production; Braverman states:
...they [corporate managers] are concerned to ameliorate it only when it interferes with the orderly functioning of their plants, offices, warehouses, and stores. For corporate management this is a problem in costs and controls...it compels their attention because it manifests itself in absentee, turnover, and productivity levels... (Braverman 1974:36)

The issues surrounding the labour process are not, according to Braverman (1974) confined to workers on the assembly-line and he broadens the application of his analysis to include so-called ‘white-collar’ occupations:

The office today, where work is segmented and authoritarian, is often a factory. For a growing number of jobs, there is little to distinguish them but the colour of the worker’s collar...” (Braverman 1974:34)

In summarising Braverman’s (1974) notion of the labour process, Littler (1990) suggests there are two basic elements of activity – conception and execution of work. I will return to these elements later in this section.

**What is the Labour Process?**

There seems to be a number of different and sometimes necessarily conflicting views on what may constitute the broad essence of labour process and labour process theory. It is Ackroyd’s (2009) view that this is a positive aspect of the LPT landscape:

...complete theoretical agreement is seldom the basis of vigorous intellectual movements in social science. On the contrary, tension between ideas is a source of vitality and renewal. (Ackroyd 2009:266)

According to Littler (1990), there are three key elements of the labour process – the technical division of labour (and job design), the structure of control and employment relations; whilst Thompson (1990) suggests that there are four key elements to the ‘core theory’ of labour process – the role
of labour/capital relations in the analysis of production, a logic of accumulation resulting in continuous change to the production process, a control imperative and the antagonistic nature of the labour/capital relationship. Another description of the labour process is provided by Burawoy (1982) who states:

...the labour process is nothing but the ‘human’ relations into which workers and managers enter as they transform raw materials with particular technical instruments of production. (Burawoy 1982:139)

According to Burawoy (1982) there are two forms of labour process within the capitalist system; despotic organisation of work and hegemonic organisation of work. The former operates through the coercion of workers, whereas the latter uses workers’ consent. A perspective provided by Knights and Willmott (1990) maintain that coercion is the only form of operation in the capitalist labour process; because it is the outcome of the exploitive and contradictory nature of the capital/labour relationship and is a product of domination and the dialectic of control and resistance, as a way to secure (some) autonomy. They also suggest that the exploitative structure of the labour/capital relationship is the only way to analyse its domination and thus forms the basis for emancipatory action (by labour). Their perspectives on the labour process are caveated by an assumption that the world is too complex to be captured in a single theory and that a theory can only ever, partially reflect the ‘reality’ of work. A view supported by Burawoy (1982) who states:

There are no general theories, only general concepts and particular theories. (Burawoy 1982:14)

This perspective on theoretical integrity appears to be supported by Spencer (2000) who argues that Braverman was only ever interested in ‘tendencies’ and not a comprehensive explanation of all complex phenomena.
In the next sections, I will summarise these different perspectives to provide an understanding of the key analytical elements of the labour process namely the nature and structure of control, the nature of the division of labour and the nature and characteristics of employment relations. This will be beneficial in providing a conceptual basis for the analysis of the nurses in my study, which will be the focus of the latter chapters of this thesis.

Labour

According to Braverman (1974), the labour process begins with the employment contract, which subsequently governs the conditions of sale of labour power by the worker and its procurement by the employer; Braverman (1974) argues that what the worker actually sells is not an agreed amount of labour, but rather the power to labour over an agreed period of time. This is a crucial concept in any analysis of a labour process and is described by Smith (2006):

Labour power, what the employer hires and the worker exchanges, is indeterminate because the precise amount of effort to be extracted cannot be 'fixed' before the engagement of workers, machinery and products for purposeful action in the labour process. (Smith 2006:390)

It is Braverman (1974) who also suggests that whilst human labour is potentially infinite – its execution is limited by the subjective state of workers, their previous history and the conditions in which they work. This practical restriction on the theoretically, limitless nature of human labour is at the heart of Braverman’s (1974) argument throughout his book and it is this indeterminacy that according to Smith (2006) gives rise to struggles at the point of production around wages, conditions and the pace of work. It is also the indeterminacy of that labour that does not guarantee an automatic outcome for the buyer (Thompson & Smith 2009). A peculiar characteristic of labour power is argued by Friedman (1977) who suggests that it is possible for labour power to create greater value through the
labour process, than its cost; which is a fundamental concept of Marxist economics. It is Smith (2006) who also suggests that labour power is split into effort power and mobility power and that a worker’s choice of employer and an employer’s retention strategies have an impact on the labour process. Effort power is the output by the worker following the ‘production struggle’; mobility power is the control by the worker of their employer – they become a “consumer” in the marketplace of employers and can use the threat of exit to improve pay, conditions and training (Smith 2006). As Smith (2006) points out, this mobility power is owned by the individual and if wielded, can become a form of worker resistance.

Not surprisingly, given the foundations of his work, Braverman (1974) suggests that capitalism creates a society where it is assumed everyone pursues their own self-interests, at the expense of pride in their work:

> Tradition, sentiment, and pride in workmanship play an ever weaker and more erratic role and are regarded on both sides as manifestations of a better nature which it would be folly to accommodate. (Braverman 1974:68)

This seems a rather uncritical and overly generalised way of looking at the labour process in a capitalist society. It is a view that is not supported by the findings of my study and an argument that I will return to later in this thesis.

**Division of Labour**

The division of labour is a significant theme in Braverman’s (1974) book and he maintains that the social division of labour subdivides society and he also believes that the detailed division of labour, subdivides humans and is a crime against the person and humanity, as a whole. This is an emotive position and indicates Braverman’s depth of feeling on the issue of the subdivision of human labour. However, to liken its occurrence to a crime against humanity seems somewhat extreme; his strong view on the subdivision of labour is typically illustrated in this statement:
That the first step breaks up only the process, while the second dismembers the worker as well, means nothing to the capitalist, and all the less since, in destroying the craft as a process under the control of the worker, he reconstitutes it as a process under his own control. (Braverman 1974:78)

As a result of division of labour, Braverman (1974) argues that two objectives have been achieved – firstly, increased productivity and secondly, management control. According to Braverman (1974), the capitalist mode of production systematically destroys existing skill and then subsequently nurtures and develops skills and occupations, which are required by this mode of production; any technical capacities are distributed on a “need to know” basis. Indeed, the focus for employers is to minimise the cognitive and technical input of their workers into the production process (Spencer 2000). The outcome of this results in the labour process developing according to the needs of the employer, not the employed (Braverman 1974). According to Braverman (1974), a small number of workers are retained for their possession of specialist knowledge and training and these individuals are freed from ‘simple labour’; this process has the effect of differentiating and thus polarising workers.

**Scientific Management**

Another central theme of Braverman’s (1974) thesis is that the discourse of contemporary management is dominated by so-called ‘scientific management’; a view supported by Wigens (1997):

> Perhaps the greatest influence of Taylorism was its legitimating of the management discourse which dominates today. (Wigens 1997:1116)

The view of Braverman (1974) on scientific management is evident here:
Scientific management, so-called, is an attempt to apply the methods of science to the increasingly complex problems of the control of labour...It enters the workplace not as the representative of science, but as the representative of management masquerading in the trappings of science. (Braverman 1974:86)

Claims that the application of ‘scientific management’ and the consequential changes to work arrangements have increased productivity are scorned by Braverman (1974); he argues that these supposed increases in productivity are the result of ‘close and frightening’ supervision and not (supposed) increased efficiency and he goes on to argue that this is consciously known by managers but hidden within the guise of faux science. It is not so much that Taylorism has regained favour; but rather, according to Braverman (1974) has become so pervasive in management thinking that its presence is not consciously acknowledged. This seems to echo the effectiveness (or otherwise) of NPM-inspired reforms that I discussed earlier in this chapter, which were at best unproven and may only have been perceived to be effective because of their tendency to foster an environment of work intensification. A concept I will discuss in the next section, along with work extensification.

**Work Intensification and Extensification**

A traditional Marxist view of capitalism suggests that profit is created by increasing unpaid labour (Burawoy 1982) and this can be performed in two ways; either by increasing work intensification or increasing work extensification. Work intensification is the intensification of labour undertaken by a worker within a fixed period of time; whereas work extensification is the extending of the time period in which labour is carried out for no additional remuneration. Both have the outcome of increasing effort power expended by the worker for the same amount of labour cost by their employer and both are key concepts within LPT, which I will go on to use in my analysis of the nurses in this study.
Separation of Conception and Execution

In a contemporary organisation, Braverman (1974) argues that the design, planning, calculating and documenting of work become a separate function. In other words, the control, management, maintenance and verification of the production process moves from the immediate, production site, to the 'management' office and he believes that this means:

…the process of production is replicated in paper form before, as and after it takes place in physical form. (Braverman 1974:125)

There is an obvious distinction between physical and mental labour – the former produces a physical output, whereas the output of the latter, often consists of marks on one or more pieces of paper and Braverman (1974) argues that the separation of conception and execution evident in physical labour is also possible in mental labour. He also argues that there are two ‘unwritten’ principles of capitalism; the first is that the better paid or educated labour should not be ‘wasted’ on activities that could be accomplished by others with lesser training; the second is that those with little or no training, cost less and are less likely to be mentally distracted when performing routine work. It is Braverman’s (1974) contention that these ‘unwritten rules’ underpin and propel the continuing degradation of both physical and mental work and as a natural progression of this argument, it is my contention that these principles can be used as a basis for analysis of workers in mental or service occupations in the public sector.

It is Burawoy (1982) who criticises Braverman on his views of the separation of conception and execution and the implication that there is a narrowing of scope for workers to use discretion within the labour process. According to Burawoy (1982), worker choice continues to expand within ever narrower boundaries and in a further work, Burawoy (1985) choses to focus on the social relationship between workers, which he calls the ‘relations of production’ and which he argues are distinct from the ‘relations of exploitation’, which exist between labour and capital; Burawoy (1985) makes a further distinction, that of the ‘relations in production’, which he
defines as the social relations of men and women to nature. Later in this thesis, I argue that there is another production relationship between some workers and their product of production, where the product of production is human.

**Emotional Labour**

Elements of labour are confined by Braverman (1974) to mental and physical; however, it is Hochschild (2012) who suggests the concept of *emotional labour*. In her seminal thesis, Hochschild (2012) argues that parts of a workers ‘emotional self’ are surrendered for use by their employer:

> This labour requires one to induce or suppress feelings in order to sustain the outward countenance that produces the proper state of mind in others...This kind of labour calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honour as deep and integral to our individuality. (Hochschild 2012:6)

However, Hochschild (2012) makes the distinction between emotional work and emotional labour; the former, she defines as the management of feelings by an individual, within a private context. Whereas, she defines the latter as the management of feelings to orchestrate a publicly, observable display. It is emotional labour that Hochschild (2012) suggests is sold for a wage and as such (in Marxist terms), has exchange value. In other words, Hochschild (2012) is suggesting that all individuals from time to time undertake emotional management in their everyday private lives; but she argues that when this is an expectation of a worker, by their employer, it forms part of their labour. This expectation by an employer to undertake emotional activity, is in the same way that physical and mental tasks are also parts of an individual worker’s labour (Braverman 1974). This is a view supported by Brook (2009) who maintains that where emotional management is undertaken as part of an individual's
employment; it forms part of the broader conditions of wage labour. This is also supported by Vincent (2011), who states:

…workers lose control over their own emotions, which become ‘owned’ by employers and directed as part of the service offered. As a result, workers become detached from their own displays. (Vincent 2011:1372)

This idea of detachment is akin to both the Marxian concept of alienation and one of Braverman’s (1974) primary arguments, that the separation of conception and execution, disconnects workers from their own labour. In the quote, Vincent (2011) is applying this to emotional labour, which he suggests results in a worker being alienated from their own emotional displays.

According to Hochschild (2012), emotional labour forms part of the commodity being produced and in the case of flight attendants, she states:

…part of the job is to disguise fatigue and irritation, for otherwise the labour would show in an unseemly way and the product – passenger contentment – would be damaged…it is easier to disguise fatigue and irritation if they can be banished altogether, at least for brief periods, this feat calls for emotional labour. (Hochschild 2012:8)

Emotional labour also takes on the characteristics of a commodity, where it enters a ‘marketplace’ and the demand for it can rise, as well as fall (Hochschild 2012). This idea that emotional labour is commodified is supported by Brook (2009) who argues that the cost of suppressing an employee’s true self means:

…deepening the individual’s subordination to her or his commodification and its alienation. (Brook 2009:534)

It is Hochschild’s (2012) belief that acts of emotional management are used under the guidance of “feeling rules” and she suggests that when the
management of emotion is sold as a form of labour, “transmutation” occurs. Hochschild (2012) defines transmutation as:

…what it is that we do privately, often unconsciously, to feelings that nowadays often fall under the sway of large organisations, social engineering and the profit motive. (Hochschild 2012:19)

This transmutation of feelings is theorised by Hochschild as being unstable and subject to the same antagonism within the wage-labour relationship as mental and physical work (Brook 2009). It is Hochschild’s (2012) belief that feeling is not:

…a periodic abdication to biology but as something we do by attending to inner sensation in a given way, by defining situations in a given way, by managing in given ways, then it becomes plainer just how…susceptible to reshaping techniques a feeling can be. (Hochschild 2012:27)

It is this susceptibility to manipulation that Hochschild (2012) suggests is used at times, by large organisations to create surplus. However, Hochschild (2012) is criticised by Bolton and Boyd (2003) who argue that her concept of emotional labour is absolutist and denies the possibility of employees having any control over their relationships with their customer, or their employer (or the employer’s proxy). According to Bolton and Boyd (2003), as well as emotional work and emotional labour, there are two other types of emotional management; which they designate ‘prescriptive’ and ‘philanthropic’ emotion management. Prescriptive emotion management occurs when an employee decides to follow occupational rules for reasons other than cost-efficiency; philanthropic emotion management occurs when an employee decides to give ‘a little more’ as part of their social exchanges at work.

In relation to the concept of alienation (discussed earlier in this section), Bolton and Boyd (2003) disagree with Hochschild (2012). According to Hochschild (2012), an employee who is undertaking emotional labour can become alienated from their work in the same way as an employee can,
who is undertaking physical labour; this is disputed by Bolton and Boyd (2003), who state:

They [the emotional labourer] do not have to feel estranged from the emotional labour process. Unlike the factory worker, they own the means of production… (Bolton & Boyd 2003:293)

This claim by Bolton and Boyd (2003) around emotional labourers owning the means of production is disputed by Brook (2009), who believes this is based on a misunderstanding of what ‘means of production’ (in the Marxist-sense) actually means and argues that the commodification of an employee’s emotions should not be confused with the commercialisation of those emotions, at the point of service production; Brook (2009) goes on to state:

…irrespective of workers’ witting intentions during the execution of emotional labour, their performance and display…is bought and paid for labour-time and capacity and therefore primarily a commodified product; albeit of a contested, open-ended variety. (Brook 2009:539)

Indeed, this idea that emotional labourers own the means of production seems an unusual position for Bolton and Boyd (2003) to take, because it seems that the same could be said of a factory worker’s physical labour. It could be argued that factory workers own their means of production i.e. their arms or legs and yet when they are employed, their limbs are under the technical control of their employer. However, Bolton and Boyd (2003) go on to argue that an employee is in control of the amount of ‘feeling’ that they invest in their ‘performance’ and state:

…the deterministic feel that the term ‘emotional labour’ carries with it undervalues the vitality and independence of outlook that participants bring to organisations… (Bolton & Boyd 2003:294)

This is a curious statement, given that this could be equally applied to employees undertaking physical or mental labour and one that is not
supported by Brook (2009) who argues that Hochschild (2012) recognised that an employee performs a mix (to differing degrees) of all three forms of labour i.e. physical, mental and emotional; all of which are integral components of labour power. That said, Bolton and Boyd’s (2003) views on the employee owning the means of production (in relation to emotional labour) does seem to hint at their concern with Hochschild’s (2003) perceived neglect of employee subjectivity and one whose oversimplification, appears to be supported by Brook (2009), who maintains that:

...her [Hochschild] failure to conceptualise workers’ consciousness as routinely contradictory, yet dynamic, where their capacity to act independently of management control is constrained and variable but still a daily reality. (Brook 2009:543)

This concept of subjectivity amongst workers is not a new debate within LPT and has been around for several decades. I include a brief discussion on the issues around worker subjectivity later in this chapter.

**Middle-Layer Worker**

In developing the idea of a ‘middle-layer’ of workers, Braverman (1974) argues that this portion of labour, are involved in specialist technical, or scientific activities, or are the lowest ranks of supervision and management; he also includes in this group ‘professional’ employees involved in activities such as administration, finance or marketing; including workers involved in similar activities in the public sector:

…outside the corporation proper, in governmental, educational, and health establishments, these gradations are reproduced in forms peculiar to the work processes carried on in each of these areas. (Braverman 1974:406)

It is Knights and Willmott (1990) who point to Braverman’s prediction that the ‘middle layers’ of employment e.g. nurses, teachers etc. will
increasingly experience their work in ways that strengthen affinity with more traditional working-class employment.

Worker Subjectivity

One of the major criticisms of Braverman’s (1974) work is his neglect of worker subjectivity and resistance (Knights & Willmott 1990; Thompson 1990). This criticism is reflected by Thompson (2009) who states:

…Braverman’s preference for analysing only the objective characteristics of the capital-labour relationship had left a hole where agency and subjectivity should have been… (Thompson 2009:101)

It is Thompson (1990) who also suggests that Braverman’s image of management is both ‘omnipotent and omniscient’ and highlights other authors who have been critical of Braverman’s idealisation of craft workers. A point, incidentally that Braverman himself rejects, at the very beginning of his book. Indeed, Thompson (1990) himself disputes these criticisms of Braverman (1974) and suggests that he does not ignore worker resistance and class struggle, but sees it somewhat differently:

…an unseen constant or hidden hand in the development of capitalist production. (Thompson 1990:114)

Knights and Willmott (1990) also come to Braverman’s defence and note that much of the criticisms of Braverman are directed at the level of fine detail and arguably beyond the scope of his analysis – which was intended as an overview of trends, not a detailed specification of all forms of the labour process under capitalism. However, Knights and Willmott (1990) suggest that Braverman (1974) does not explain relations between capital and labour, outside an antagonistic relationship and they also argue that he fails to explain the inherent contradictions within the capitalist mode of production:
…Braverman’s study is confined within an objectivist framework in which the ‘subjective dimension’ of class is simply bracketed out of the analysis. (Knights & Willmott 1990:15)

This highlights a very important issue in the development of labour process theory, which is that it should not be taken for granted that the interest of capital and labour are pre-established, nor should it be assumed that they are always antagonistic (Knights and Willmott 1990). It seems then, that like other orthodox Marxists, Braverman appears constrained by a theoretical construct in his analysis of capitalist production, rather than any consistent evidence that the capitalist labour process creates class struggle of the type envisaged by Marx (Thompson 1990). It is Burawoy (1985) who suggests that Braverman’s standpoint allowed him to ignore the day-to-day dynamics that could reveal why workers yield to the organisation of their labour, even at the expense of their own happiness and wellbeing. A point that Burawoy (1982) attempts to address in his own work on consent and one which I will discuss briefly, later in this section.

The argument around worker resistance has been developed further by Fleming and Spicer (2008) who argue that resistance as an academic concept fell out of favour, due to the rise in popularity of Foucauldian explanations of workplace power relations; these centred on post-modernist concerns around identity, rather than notions of exploitation and class struggle (Jaros 2000). The limitations of ‘core’ LPT are highlighted by O’Doherty (2009) who argues that phenomena within work are not easily categorised using the dualistic characteristics of orthodox LPT; that is structure/agency, management/labour and control/resistance and O’Doherty (2009) goes on to state that:

> Once we are prepared to acknowledge that there is no referential backstop or foundational bedrock to secure and guarantee reality, we are better prepared to examine subjectivity and identity as a medium and outcome of a social construction of power and inequality. (O’Doherty 2009:115)

In relation to worker subjectivity, it is Jaros (2000) who valiantly attempts to find commonality within LPT and suggests:
The common ground on the issue of subjectivity seems to be that...workers and managers have a capacity for agency (i.e. subjectivity), but that subjectivity is constructed both at work and by broader political and economic institutions. (Jaros 2000:35-36)

However, Jaros’ (2000) attempt at consensus on subjectivity is questionable, given Thompson’s (2009) suggestion that a post-structural perspective fails to recognise labour as an agency with interests in the employment relationship; instead, post-structuralists focus on the indeterminate nature of human nature, through their ongoing concerns about identity. In discussing Hochschild’s (2012) concept of emotional labour, it is Brook (2009) who maintains that despite emotional labour being an element of the antagonistic wage-labour relationship, it is important to understand that workers’ consciousness should be conceptualised as contradictory and dynamic and any control on their independence by their employers, is constrained; but variable.

**Resistance**

As I have discussed earlier in this section, the Marxist view of labour is that an employer purchases the potential for labour, not a specified amount of labour; this means that it is up to the employer (or their proxy) to extract labour power from the labour that they have purchased, through control of the labour process. It is Thompson (1989) who maintains that only when the size of the workforce grew beyond personal links with the employer, that the foundation for resistance amongst workers was established. However, Fleming and Spicer (2008) maintain that resistance should not be limited to the narrow perspective left by traditional Marxism of organised and overt opposition; but should include other, more individual forms of opposition, such as cynicism, foot-dragging and as Mather et al. (2007) suggest – moaning and gossiping. It is also Fleming and Spicer (2008) who argue that a lack of blatant resistance, is not an indication that workers agree with a given situation; they state:
Just because workers are not directly organising opposition towards a management initiative does not mean they agree with it. (Fleming & Spicer 2008:303)

It is Fleming and Spicer (2008) who also suggest that a better word to encompass all ‘resisting behaviours’ – both collective and individual – is “struggle”. They maintain that “struggle” moves the debate beyond the familiar power/resistance dualism and incorporates the more ambiguous moments found in contemporary workplaces. It is often the case that moments fall between resistance and consent and the word “struggle” encapsulates them all (Fleming & Spicer 2008). Struggle is a concept that I have incorporated into my analysis of the nurses in this study and I take it to include worker resistance in all forms, including those discussed here that are found in contemporary workplaces.

Management

According to Braverman (1974), two types of ‘labour’ are hired within a capitalist society; a labour force to work and a labour force to represent capital ‘on the spot’, which I will refer to as ‘management’ – who are in effect, a proxy for capital (Vincent 2011). To counter any suggestions that this is not the case Braverman (1974) states:

Their formal attribute of being part of the same payroll…no more robs them of the powers of decision and command over the others in the enterprise than does the fact that the general, like the private, wears the military uniform… (Braverman 1974:405)

A more pragmatic view of management is taken by Burawoy (1985) who suggests that management’s task is to reduce or eliminate uncertainty when deploying labour, whilst simultaneously ensuring the production of a surplus. The relationship between management and workers is always an area of interest in any analysis of the labour process and in particular with regard to the mechanisms of control. Two interpretations of the control relationship between management and workers are outlined by Littler (1990). The first interpretation is the most obvious and is one that sets the
relationship within the diametrical context of control and resistance (to control). The second interpretation is that there is a dual nature to the relationship; a tension and contradiction about how to treat their employees, because the nature of their exchange is not simply an economic one – the employer needs workers to produce for them; but equally, the workers need their employer to remain viable because their livelihood depends on it. This inherent tension within Littler’s (1990) second interpretation of the relationship between the employer (or their proxy, management) and the worker, will have analytical significance later in this thesis.

Management Control

As I have discussed earlier in this chapter, the labour power that resides in an individual worker can only be realised within a labour process and for this to be effective, it must be controlled by management (Smith 2006). The imprecise nature of the concept of control is discussed by Burawoy (1985), who states:

> If there is a single concept that has served to generate ahistorical accounts of organisations and to mystify their operation, it is the concept of control. (Burawoy 1985:26)

Burawoy (1985) believes that this is due to its use as a general concept, but also because of a lack of precision about who, or what is being controlled. However, Edwards (1978) is more specific and suggests that any system of control contains three elements; the direction of work tasks, the evaluation of the completed work and the rewarding (and sometimes disciplining) of workers. It is also Edwards (1978) who provides a topology of control systems and divides them into three types; simple, technical and bureaucratic. Simple control involves the direct supervision of workers by employers (or their proxy) and this is achieved using threats and rewards. This type of control mechanism is characterised by a personal connection between employer and worker (Edwards 1978). Technical control developed as a response to the failure of simple control mechanisms,
particularly in large organisations and is characterised by a reduction in the importance of supervisors and the consequential increase in importance of the design of machinery and workflow processes, which are used to control workers and the pace of work; an example in a manufacturing environment would be an ‘assembly line’ (Edwards 1978). A disadvantage of this type of control is that it can result in the alienation of workers and an increase in worker resistance. As a consequence and to mitigate the disadvantages to technical control, bureaucratic control was developed (Edwards 1978). This type of control mechanism works by setting explicit rules for governing the workplace; where workers are placed in clearly defined roles (Edwards 1978). Edwards (1978) believes that bureaucratic control:

…institutionalised the exercise of capitalist power. (Edwards 1978:287)

According to Edwards (1978), this results in power being centred around a formal organisation, rather than a specific employer (or their proxy). However, a rather simpler definition of control is provided by Friedman (1977), who states:

To control is to exercise restraint or direction upon the action of a force or thing. (Friedman 1977:83)

It is also Friedman (1977) who suggests that there are two key strategies utilised by employers (and their proxies) to control workers; these are direct control and responsible autonomy. The former uses close supervision and coercive threats to control workers and also tries to contain the scope of a worker’s labour power, as well as minimising a worker’s responsibilities. Responsibly autonomy – on the other hand – endeavours to harness the adaptability of labour power and encourages workers to adjust to dynamic situations in a way that will benefit their employer. This type of control, Friedman (1977) argues gives workers status, authority and responsibility in exchange for loyalty; but it does not remove exploitation – merely softens it operation. In general, responsible
autonomy is applied to ‘privileged workers’ (which would include professional occupations) and direct control is applied to other types of workers (Friedman 1977).

The exercising of control by employers is a key theme of LPT and in a contemporary organisation, relies heavily on information (Braverman 1974; Littler 1990); Littler (1990) argues that this ability to control is in direct proportion to the capacity of the channels (between the manager and their subordinates) to carry this vital information and he refers to this capacity as ‘observability’. He also argues that this ‘observability’ is dependent on four general factors; physical separation, congruence of manager/subordinate skills, production-system insulation and social insulation. I will now briefly outline each of these factors in turn.

A large and dispersed organisation limits the opportunities for visual inspection of subordinates and their work and often results in the exercising of greater discretion by those same subordinates; this is the physical separation factor, identified by Littler (1990) and is likely to have particular relevance where subordinates are not confined to working in a defined building, which is located in a specific geographical area. The assessment of work performance requires skill and knowledge on the part of the supervisor. If this requisite knowledge and skill is not possessed by the supervisor, their ability to assess the work performance of their subordinates is likely to be hampered. This highlights the congruence of supervisor/subordinate skills factor, identified by Littler (1990) and is likely to have analytical relevance where the employer (or manager) has limited knowledge and experience of what is required and involved, as part of a subordinate’s work activities.

All work systems vary in their degree of indeterminacy of the activities involved in the system; service work is likely to have a higher degree of indeterminacy than say, assembly-line work. This is an illustration of the production-system insulation factor, identified by Littler (1990) and is likely to have significant analytical relevance to work activities where
indeterminacy is high, because the work is variable and individualistic in nature. Despite what might be supposed, managerial authority is not necessarily a guarantee of access to subordinates. There are conventions of privacy within organisations, where managers are not at liberty to interrupt the work of subordinates; this is found amongst the professions and some craft occupations and highlights the social insulation factor, identified by Littler (1990). This factor is likely to have analytical implications for activities associated with the management of professionals, semi-professional and craft workers.

Consent

It was Burawoy (1982) who introduced the concept of worker consent into labour process theory; this is the idea that a worker could consent to their own exploitation by an employer. According to Burawoy (1982), the basis of consent within the labour process is achieved by employers through the arrangement of activities in such a way, as to provide the worker with perceived choice. In any analysis of the labour process, Burawoy (1982) maintains that it is inadequate to focus only on the antagonism between workers and their employers:

The labour process…must be understood in terms of the specific combinations of force and consent that elicit cooperation…
(Burawoy 1982:30)

In his seminal thesis, Burawoy (1982) argues that workers have too often been represented as objects being manipulated by their employers. Yet relations of production are more complicated than that and according to Burawoy (1982), workers create ‘games’, which provide them with satisfaction in their work and provide their employers with their workers’ consent. The consequences of this industrial, game-playing is two-fold; firstly, it disguises the relations of production – despite the game’s construction being a response to that and secondly, it produces consent to the social relations in production that determine the game’s rules. However, Burawoy (1982) maintains that any perception by workers that
their employers are ‘not playing by the rules’, results in resistance – not because the workers feel they are being exploited; but rather, because they feel they are being cheated in the game. Like any game, participation indicates an implicit consent to the rules of the game; so, workers who participate in this industrial gamesmanship, consent to its ‘rules’ (Burawoy 1982) and they assume that their employers will do the same.

According to Burawoy (1982), workers are now better educated and less tolerant of unrestricted authority and as such, employers must resort to persuasion, through manipulation; rather than command, through domination. However, Burawoy (1982) also suggests that the state facilitates the disorganisation of the dominated classes by emphasising the individual and their rights, before the law, in elections and in education. If this is replicated within the workplace, the consequence could be fewer opportunities for workers to collective resist. This is an issue that will have some analytical significance later in this thesis.

Theoretical Application

Employers and managers will suggest that standardisation and control within healthcare is always to maximise efficiency and streamline interactions with customers (or in relation to this study, patients) (Waterworth 2003); but efficiency and time pressure may not be the only factors in their enthusiasm for this idea. Other authors have referred to the “industrialisation” of the care of diabetes patients, characterised by “treating large numbers of patients, dealing with their ‘numbers’ (glucose, HbA1c, blood pressure, and lipid levels) and influenced by a plethora of directives, guidelines, and consensus statements” (Richardson & Kerr, 2002, p. 5). In this context, patients become items or commodities to be processed rather than individuals with distinctive personalities, profiles, and needs. Imposing a standardised structure and routine, reduces the opportunities for patients to present themselves as individuals and as a result, reduces the potential for patients to disrupt their own rapid processing. In this sense, standardisation imposes a control on patients,
as well as workers. In his paper on *protocols*, Berg (1997) highlighting the advantages and disadvantages of protocols, states that:

Even if medical personnel are aware of their existence and ‘use' them, protocols are often circumvented, tinkered with, and interpreted in many different ways. (Berg 1997:1082)

It is the extent and understanding of this circumvention, revision and interpretation amongst community nurses, which part of this study seeks to address.

Within this thesis, I use LPT as an analytical tool, which I believe is an appropriate theoretical framework to analyse the extent and nature of control and discretion, as well as other aspects of the labour process of a group of community nurses, employed by a NHS Trust in England. The application of LPT has developed since the comparative studies of the 1980s and has been used in different industry sectors, as well as the public sector and professions (Ackroyd 2009). It is Thompson (1990) who believes that labour processes in the state sector are different from those in the private sector and argues that the output of labour processes in the state sector are directed towards a form of distorted, use-value. However, Ackroyd and Bolton (1999) have shown that LPT can be applied to the study of healthcare professionals – specifically nurses – to analyse the mechanisms used to control workers. This thesis will continue that traditional and explore the labour process of a group of community nurses, who are employed within the public sector in the UK.

My thesis will endeavour to show that LPT can and should be used within the public sector to analyse the labour process of professions who work within it. This thesis will also show that LPT is a theoretical framework, capable of providing real insights into the nature and character of the labour process of healthcare workers in the UK – in particular, how management controls the labour process of a group of community nurses and how 'surplus' is extracted from these workers through work extensification and work intensification. My thesis will also show how the
application of LPT to the analysis of the labour process of community nurses has highlighted some theoretical challenges, as well as unexpected insights.

2.3 Summary

In this chapter, I have looked at NPM and its impact on public administration, particularly in the UK and then specifically within the NHS. I have also discussed some of the characteristics of NPM-inspired policies, in particular the seemingly inevitable tension between professionals and an organisational environment of increased managerialism. I have also explored the increasing tendency for NPM-inspired reforms to demand a degree of standardisation and rigidity of practice.

Within this chapter, I have discussed professions and their characteristics – specifically autonomy and I have looked in particular at health professions. I have also briefly explored Lipsky’s (2010) concept of a street-level bureaucrat and how his conclusions may suggest an increase in levels of standardisation within the public sector.

A suggested research focus by Evetts (2009) is a greater understanding of the possible links between NPM, organisational forms of professionalism and the erosion of professional norms and values. It is my belief that this research study may go some way to contribute to those links. I have also looked in some detail at standardisation – within healthcare – including some of its characteristics. I also examined within a healthcare context, the terms compliance and non-compliance and professional discretion and how these terms are themselves relative and I looked at how they are manifest and referred to in different ways, depending on environmental context and the perspective of the individual actors involved.
Also in this chapter, I discussed in some detail the broad foundation of labour process theory and its theoretical components: in particular the nature of labour, the relationship between workers and their employer, the impact of resistance and the inevitable aim of management; that of maximising labour effort, through the application of management control.

In the final section of this chapter, I will detail my research questions, which I have developed from my research interests and my review of the literature.

2.4 Research Questions

In this section, I provide a brief introduction to my research interests and then state my research questions, which I developed from a review of the literature and my own research interests.

As part of my research, I wanted to understand the nature and detail of the labour process of the nurses who participated in my study using LPT. As part of my analytical effort, I also wanted to explore the use and suitability of LPT as an analytical tool within the context of professional healthcare workers.

I was interested in the impact of standardisation within the contemporary NHS, particularly in the context of a NPM-influenced NHS. I was also keen to understand, how the nurses in my study were controlled, given the geographically dispersed nature of their work environment and whether standardisation in its many forms, was used as a mechanism of control. I was also keen to explore how standardisation might conflict with the nurses, as autonomous professions; able to exercise discretion.

I was also interested to understand when the nurses who participated in my study used discretion, how this discretion was justified and to what extent the nurses' work relied on the exercising of this discretion.
In answering these questions, I was keen to understand and explore the theoretical implications for LPT as a result of my findings and how the concepts of emotional labour (Hochschild 2012) and a ‘gift’ (Bolton 2000; Bolton & Boyd 2003) may complement LPT.

a. What relevance does labour process theory have for an understanding of the work of community nurse?

b. What forms of control are exercised over nurses working in the community?

c. To what extent does nursing in this context, rely on the exercise of discretion?

d. How can this analysis of care work in this context, inform a broader conception of the labour process within healthcare?
Chapter 3

Method
3 Method

In this chapter, I describe the methods and methodology that I used in this research study. I begin the chapter with a discussion on both my ontological and epistemological positions; the underlying foundation of any research study. I then discuss the aims and objectives of my research, including academic justifications and devote a significant portion of the chapter to the actual methods and methodology that I used in this study. In this section, I discuss my approach to data collection and also how I produced and selected data for inclusion in my analysis. In the final section, I discuss the issue of ethics; more generally at first and then how they related specifically to my study. The chapter ends with a short summary.

3.1 Ontological and Epistemological Positions

This research study has been conducted within an interpretivist paradigm – a paradigm which makes the ontological assumption that reality is a product of human cognition and the epistemological assumption that reality can only be understood from the perspective of the individuals that are involved in the activity being studied (Burrell & Morgan 1979). Given my ontological position, it seemed that the most appropriate context for conducting my study be one that based understanding and knowledge, on interpretation of the meaning and values that individuals attributed to themselves, their organisational reality and the behaviour of themselves and others (Richie & Lewis 2003).

There has been recognition that positivist research principles are not adequate for addressing the complex issues and elements associated with contemporary healthcare and that there is an essential place for research using qualitative research methods (Savage 2000; Hewitt-Taylor 2004) and this research is adding to that body of work. My research has been conducted within the qualitative research tradition of social constructivism (Berger & Luckmann 1991), which has its origins in sociology (Richie &
Lewis 2003) and it has been carried out under the assumption that social reality is an interpreted world; one which is constructed from the individual and collective interpretation of meaning (Berger & Luckmann 1991; Emerson et al. 2011).

This social constructionist approach, however, does create some degree of personal conflict in me, which I will elaborate here. My social constructionist ontology inevitably leads to a form of relativism, which as a Christian, I have significant theological concerns with and its consequential ontological and epistemological implications for the Christian faith’s claims to truth and a framework for conduct. I also have concerns that whilst I may regard reality as socially constructed, I can see from my own experiences and those of others that consequences in a socially constructed world, do appear to have ‘real’ implications. However, over the course of my doctoral studies I became increasingly persuaded by the arguments for social constructionism; in relation to the research process itself, to the ontological status of social settings of all kinds and to how these settings are developed and constructed. I have found myself therefore, in the midst of two extremes; I am uncomfortable with adopting a purely relativist stance because of the consequential implications for the foundations of my personal faith; yet the realist alternatives with their incumbent notions of absolute truth and reification are also of some concern to me. My concerns, however, are tempered when I consider Ford’s (1975) argument that a person’s view of truth is predominantly down to belief. To this end, I have endeavoured to broker an ontological and epistemological truce with myself, which I will now briefly describe.

My research and its findings do not have any direct consequences on the foundations of the Christian faith (aside from a certain moral and ethical commitment in my research) and so it seems to me that the adoption of a relativist stance for this research study has no theological implications, which might make me feel uncomfortable. Furthermore, the specific areas that receive particular attention in my research – identified from my research questions – are themselves social constructions and as such, it
seems to me appropriate, to study them from within a paradigm of interpretivism.

To illustrate the socially constructed pedigree of my areas of academic interest, I have examined each of my research questions and illustrated them using a word; they are – nurses, community, labour, process, theory, work, control, discretion, care. All these areas of research interest are ontologically-speaking a social construction; their meaning is negotiated collectively and as such they are epistemologically-speaking an interpretation. It is for these reasons that I was satisfied that I could take a social constructionist position for this study. The idea that people construct the social world by interpreting it and then act on those interpretations is the fundamental principle of ethnography.

### 3.2 Aims and Objectives

In relation to the focus of my research, it was to understand nurses and nurses’ behaviour, within a specific organisational context; through the analysis of qualitative data, in the form of interview transcripts and field notes. My study is therefore:

...looking for explanations in the richness of data, not the counting of it. ([Busby and Iszatt-White 2016:40](#))

The overall aim of my research was to understand how nurses interpret and adapt to the diverse range of demands placed upon them – by themselves, their profession, their patients and the employer for which they work. I was also interested in how control was exercised by their employer on this particular group of workers and how this was achieved; given that the nurses in my study were not confined in their work, to one specific geographical area. An objective of this study was to explore the attitudes and behaviours of nurses to the exercising of discretion within their own working environment – that is, the specific organisational context of community nursing. Another objective of my study was to draw
conclusions as to the impact and implications that the exercising of professional discretion by these nurses may have for control by their employer, within this community-based setting. Further objectives were to establish how useful LPT was in the analysis of public sector workers within a healthcare environment and to suggest any theoretical implications resulting from the findings of my research.

3.3 Methods and Methodology

In recent decades, ethnography has taken a more central place as a methodology within the social sciences (Hammersley 1990); Watson (2011) goes further and argues that ethnography should take a more prominent role in the particular field of organisation and management studies. My research supports this aspiration, as I took an ethnographically-orientated approach and combined two qualitative research methods; that is, field observations and semi-structured interviews. As Wolcott (1990) describes, I wanted to produce an account of nurses that merged descriptive elements together:

...to speculate how the members of some particular group organise their lives to manage everyday routines, communicate what they know and what they expect of others, and cope with forces within and beyond their control. (Wolcott 1990:51)

To meet the demands of Walcott's (1990) challenge, I believe that a combination of methods helped me to explore and understand, complex social relations within their own context (Delbridge 1998). With its origins in social anthropology (Savage 2000), the observational method used in ethnography involves the systematic and detailed recording of people and events, with a view to gaining an insight into their attitudes and behaviour in a ‘natural’ setting (Mays & Pope 1995). According to Wolcott (1990), it is a commitment to looking at and then trying to make sense of the social behaviour of humans in cultural terms; it is not, he argues, the production of description based on the assumption that ‘facts’ can speak for
themselves. In discussing the methods employed by ethnographers, Van Maanen (1988) points out that it:

…rests on the peculiar practice of representing the social reality of others through the analysis of one’s own experience in the world of these others. (Van Maanen 1988.ix)

Although it is not inevitable, it seemed reasonable to me that I should use ‘peculiar practice’, that is, an ethnographically-orientated approach to explore and understand the socially constructed world that I occupied during my time in the research setting. An ethnographically-orientated approach, which tends to centre on the ‘everyday’ activities of an organisation was very appealing to me, because my interest has and is always drawn to the mundane activities and the day-to-day relationships of individuals within an organisation. In the past, I have been employed by the organisations that have similarly provoked my interest; what made this work significantly different was that I was freed from the incumbent obligations of employment. An ethnographic contribution to knowledge is neatly described by Hammersley (1990), who, in outlining the value of this type of research, states that it will:

…lead us to see things differently, to see possible parallels and links that we had not noticed; and, perhaps most important of all…enable us to free ourselves from those frameworks that we employ so routinely that we have come to take them for reality. (Hammersley 1990:599)

Therefore, an ethnographically-orientated method is particularly suited to the understanding of contextual, social relationships because it produces writing, which relates to the cultural context of a particular setting (Watson 2011); in this particular study, community nurses at work. As a research method, an ethnographic approach enabled me to ‘embed’ myself within the world that I was studying and allowed me to ‘get to know’ the people in that particular environment (Watson 2011). However, there is an innate peculiarity with the ethnographic method (Van Maanen 1988); according to Rosen (1988), the purpose of ethnography is to explain how social
structures are constructed and reconstructed and to do this, Emerson et al. (2011) argue that the ethnographer does not experience the experiences of another; but rather they interpret through their own experiences, the experiences of others. To the lay-person, this may seem like a convoluted and faintly narcissistic (Savage 2000) way of reaching an outcome, but this is the recognised and established lot of the ethnographer. If the subject of study is complex, involving multiple layers of meaning and interpretation, it seems somewhat inevitable that the method used to study it, is likely to be similarly complex.

Unlike Hammersley (1990), I believe that the value of ethnographic work comes from the celebration of the rich and diverse scope of human social life, which at times can produce patterns that we recognise and may on occasions remind us of something of a more general nature. In extending constructivism to the research process itself (which I accept), I do not see that the interpretations and meanings of participants and their world is in contradiction with the development of inductive theory. However, I do agree with Hammersley (1990) when he suggests that the purpose of ethnographic analysis is to produce sensitising concepts and models, whose value is to be judged by others and which may not be seen as theories in the conventional sense – that is, they do not allow prediction or control; but rather they are there to make sense of our world; as Ford (1975) states:

The point of theorising is to invent things that might be there, to pretend that they are there, because by imagining the existence of such things we can make better sense of whatever we feel we can observe in the real world. (Ford 1975:150)

The imagined theories generated from ethnographic enquiry can apply to a particular situation, but equally they may not and in the end, it is anyone who can make that sense:

Whatever sense is to be made is made because some human observer attempts to make that sense. (Wolcott 1990:60)
As Wolcott (1990) argues it is those ‘others’, carrying out their own work, who decide what that sense might be. Having provided this overview of my overarching methodology, in the next section, I will outline the approach and design of my study in more detail.

### 3.3.1 Approach and Design

The qualitative methods used in my study were interviews and field observations. I interviewed participants towards the end of a period of observation and I conducted these interviews on a semi-structured basis to enable me to draw out from my participants their observations about the research areas I was interested in. My observations also took a semi-structured approach and involved observation of participants at their office base, in meetings and also (accompanying them) as they travelled to and from patients’ homes. I did not accompany participants or observe them when they were delivering direct care to patients. This combination of methods was deliberate, as it often highlighted discrepancies between how participants say they behave (when they were interviewed) and how I observed them to behave over the course of my period of fieldwork (Mays & Pope 1995; Savage 2000; Taxis & Barber 2003). My interest in this divergence was not to ‘trip-up’ participants; but rather, I was interested in the insight that it can provide, when comparing espoused discourse with observed behaviour (Hancock & Essen 2006). In other words, the ‘gap’ between what participants say they do and what they are observed to do; as Ishiguro states:

> I’m more interested in what people tell themselves happened rather than what actually happened. (CNN 2001)

This element of observation is an important feature of the overall research design for this study, because it enabled me to record behaviour that was not expressed in an interview. It is the reason for a research design, where interviews with participants were conducted after a period of observation. A further reason for interviewing participants after a period of observation was to follow-up and explore with participants, certain observed and
recorded behaviours. This design allowed me to probe in more detail with participants, behaviour I had previously recorded during an earlier period of observation.

As a researcher using an ethnographically-focused research method, I inferred intentions about behaviour based on conversations that I had with participants and a continuously evolving knowledge of their work and environment. I also assessed – perhaps at times subconsciously – whether the intentions that a participant offered regarding their behaviour, matched my own perceptions of their intentions. This was inevitably a subjective exercise.

During the observational phase of my fieldwork, I sought to understand and explore the low-level, daily interactions of nurses within a community setting from a nurse’s perspective; Watson (2011) suggests that it is at this level that we learn most about how things work. This observational phase of my fieldwork enabled me to gain an ‘approximation’ of the experience of the members of the world I was studying (Emerson et al. 2011) – that is, community nurses within a NHS Trust. As discussed earlier in this chapter, this meant that I endeavoured to understand through my own interpretations and experiences, the experiences of others. This approach is consistent with the ontological position of my study; a position which is emphasised by Emerson et al. (2011), in their discussion on participants’ (or members’) meanings:

Members meanings…are not pristine objects that are simply ‘out there’ waiting to be ‘discovered’. Rather, these meanings are interpretive constructions assembled and conveyed by the ethnographer. (Emerson et al. 2011:129)

A benefit of using multiple methods was to enable collaboration, a word I use deliberately, instead of triangulation (Bryman 2008; Collis & Hussey 2009); which for me implies a positivist association. Multiple methods also help to contrast and make comparisons across data and through my analysis I developed a more complete view of my research setting. This is
supported by Watson (2011) who takes an inclusive approach to the interpretation of an ethnography; he argues that an ethnography can include and be strengthened by the conducting of interviews – a view also supported by Tope et al. (2005). In the following subsections, I address both methods in turn – namely, interviews and observations; I also discuss the use of field notes and a field diary.

**Interviews**

Interviewing as a research method has been described as a ‘conversation with a purpose’ (Tope et al. 2005; Thorpe & Holt 2008) and their varying formats have been generalised into three forms – structured, unstructured (in-depth) and semi-structured (Saunders et al. 2000; Bryman 2008).

A proportion of the data for this study has been produced from face-to-face, semi-structured interviews. As I have already stated, I interviewed participants towards the end of my period of observations. The semi-structured approach I adopted for the interviews enabled me to be flexible and allowed opportunity for the discussion to flow between myself and each individual participant – if and when this was appropriate. This degree of flexibility around the structure of the interview meant that I did not follow the order on the interview schedules rigidly, but rather the interviews developed organically, as the discussion naturally progressed between myself and the nurse. The location of the interviews varied; some were conducted in the health centre – in a conventional ‘office environment’. Other interviews were conducted in the nurse’s car, during a natural break in their clinical responsibilities and associated activities.

During the initial stages of my observations, all participants provided me with basic information on their work history and personal characteristics. This information was gathered informally and included name, pay band, contract type, hours worked, years of experience since qualification and years of experience at the research site. I used this data for two purposes; firstly, it was used by me to ensure that all participants fulfilled the inclusion
criteria (that is, a qualified nurse with a permanent, or fixed employment contract at the research site) and secondly, it was used by me to gain a better understanding of the professional background of participants and assess any influences that work experience, qualifications, grade, contract type or hours worked may have had on their perceptions of their work (Pollard 2003). With the appropriate consent having been given, I digitally recorded and then transcribed (verbatim) all interviews – accepting the limitation that a transcript is never truly ‘verbatim’ (Emerson et al. 2011). That is, I did not usually transcribe words such as “ahem”, “oh” or “like”. Occasionally, I also changed the syntax and tense of the sentence, as well as adding or removing connecting words. This was to preserve the anonymity of my participants; because not changing these idioms may have revealed my participants as non-native English speakers and this could have resulted in their identity being revealed. I ensured however, that these changes never altered the meaning of the nurses’ dialogue. Sometimes, the recording of my interviews was inaudible; when this happened, I indicated this to be the case in the transcript. Occasionally, my interviews with participants were interrupted and then resumed later. If this was the case during a particular interview, I indicated the event in the transcript and the transcribed interview was appropriately divided into numbered parts.

I would define myself as a localist in relation to the ontological status I ascribe to interviews – that is, they are a social construction like other social situations and must be interpreted in their specific and localised context (Thorpe & Holt 2008). I agree with Thorpe and Holt (2008) that an interview is a ‘co-production’ between myself and an individual participant. This approach to the interview process is consistent with my stated ontological and epistemological position for this research.

Observations

Methods of observation differ in the degree to which the researcher is involved and interacting with research participants (McDonald & Harrison
2004). If a researcher maintains some distance between themselves and their participants, they can take a more detached view of their participants’ activities. However, this can lead to participants modifying their behaviour because they are aware that they are being observed (McDonald & Harrison 2004). Four roles of a researcher in the field have been classified by Gold (1958): complete participant, participant as observer, observer as participant and complete observer. According to Gold (1958), the complete participant role involves covert observation, whilst the complete observer role demands that the field worker has no social interaction with participants at all. However, Gold’s (1958) rather static categorisations fail to capture the shifting roles that I encountered, during my fieldwork.

In relation to my approach to observations, I believe I was somewhere between Gold’s (1958) observer as participant and participant as observer (Cassell & Symon 1994; Saunders et al. 2000; Bryman 2008), because I dynamically shifted between these constructed categories, throughout my period of fieldwork. During my period of field observations, I found the ‘distance’ afforded in observer as participant, at times to be beneficial to me, as it allowed me to record and begin to analyse my observations with greater reflection. However, on occasions I moved beyond observer as participant and towards the category of participant as observer, as defined by Gold (1958); for example, I interacted with the nurses and administrative staff in the Team and we exchanged banter and on occasions the nurses asked my opinion on certain aspects of ‘office politics’. I was always careful about what I said during these exchanges; but nonetheless, they indicated a level of trust between myself and my participants. What does seem obvious is that I did not reach Gold’s (1958) extreme of complete participant; because my role as a researcher was overt and according to Gold (1958), this extreme of the spectrum can only truly be achieved by remaining a covert researcher. It seems to me that Gold (1958) has incorrectly linked the participant/non-participant and the covert/overt spectrums together, when they should remain quite separate.
My goal of complete transparency and overt objectives may not have been possible, especially in a study that sought to capture aspects of the informal and unofficial organisation (Calvey 2008). Indeed, Lugosi (2006) maintains that:

…completely overt research can never be guaranteed. It is certainly a mistake to assume that ethnographic fieldwork can ever be fully open and overt, with all the relevant participants giving their continued support based on a consistent understanding of the research. (Lugosi 2006:544)

This is an issue that has obvious ethical implications and it is one that I will return to later in this chapter.

In light of my use of observations as a research method, I was mindful to consider the advice of Emerson et al. (2011) who suggest that researchers should take ‘time outs’ from observation and note-taking and allow a period of ‘natural’ participation in member activities. This seemed a useful idea, which I considered following during my period in the field. The practice could help to counter the pressures and demands of intense and prolonged, ethnographic fieldwork, which I experienced and manifested as physical tiredness. However, I only consciously took a ‘time out’ on the days when I had scheduled a participant interview. It was a conscious decision on my part during those shifts, to take a break from writing field notes; however, if anything piqued my interest during the day – I did resume note-writing.

In their study of ‘rule-breaking’ amongst midwives, Furber and Thomson (2006) argue that what is actually practiced in a local context is established by social groups. To this end, I felt that it was important in this study to understand the norms within the local context and see how these had developed amongst the community nurses in the Team. To enable me to do this, I followed a ‘semi-structured’ approach to observations, which enabled me to ‘follow the action’ and also allowed me to ‘hang around’ the organisation and its members, when that seemed appropriate. This
approach also afforded me the flexibility to include some deliberate
observations, which I felt were key to answering my research questions
and analysing the impact of associated theory.

Whilst I spent a proportion of my time in the field undertaking observations,
I did not observe nurses providing direct care to patients. This was a
deliberate decision that allowed me to focus purely on the nurses’
perceptions, attitudes and behaviours in an environment where neither
myself nor my participant was ‘distracted’ by the (justifiable) needs of
patients. I do not believe that I ignored the demands placed upon nurses
by their patients in this study. However, I deliberately did not observe
nurses during the times when they were providing direct care and
treatment to patients, because I wanted to understand these particular
demands from the perspective of the nurses themselves and not be
distracted by the views and demands of patients and their families on me,
as the researcher. This perspective from the nurses on their handling of
the demands of patients is evident in the research design and meant that
I did not make observations (and subsequent field notes) when a nurse
was delivering direct care to a patient; however, observations and notes
were recorded by me, at all other times.

By observing and spending time with nurses within their own environment,
I gained an understanding of their opinions, feelings, circumstances and
backgrounds and in so doing was able to address both my research
questions and the associated theoretical considerations – through intimate
contact and detailed information (Braverman 1974). Commenting on the
practice of some sociologists, Braverman (1974) states:

…some sociologists…as sometimes happens…have put aside
their questionnaires and listened to workers with both ears, they
have often established relationships of trust, learned to
comprehend the milieu, and written creditable accounts.
(Braverman 1974:30)
I trust that my time in the field came somewhere close to Braverman’s (1974) anticipated output; an outcome which was more likely to occur, the more time I spent within the research setting. Observations conducted over a period of time enabled me to appreciate and (at some level) understand the norms, values and practices within my research setting (Watson 2011). A longer period in the research setting may have added greater depth and understanding to my study, but I felt that I had sufficient time to develop trust and rapport with the nurses who participated in my study and gain an understanding of them, their work and their work environment.

According to Delbridge (1998) sufficient time enables an ethnographer to engage with the members of the social group they are studying, to such a degree that genuine trust develops. According to Tope et al. (2005), the development of an ‘insider’ status is critical because without it the ethnographer risks only writing about things that are obvious. A point that appears to be supported by Silverman (2013) who states:

…ethnography is not only seeing remarkable things in everyday situations. It also asks us to see the mundane elements of remarkable events and contexts. (Silverman 2013:9)

I believe that I achieved an ‘insider’ status during my time in the field. Indeed, the level of trust that the nurses conferred on me during my period of fieldwork, was somewhat disproportionate to the amount of time that they had known me. However, I believe this reflected my effectiveness at building a rapport with my research participants, as well as the nurses’ willingness to accommodate my research study into their working lives.

My choice of observations as a research method recognises the significance of social interactions, behaviours and rituals in the research setting and assumes that this type of data reflects the social reality (Thorpe & Holt 2008). This approach is consistent with my stated ontological and epistemological position for this research study.
Field Notes

It was impossible for me to record everything that I observed in my field notes (Wolcott 1990; Mays & Pope 1995) and the selection of activities to be recorded was decided by me. However, my observations were systematically recorded after each shift that I spent with the nurses (Mays & Pope 1995). Contrary to the recommended practice of some authors (Hunter 2006, Bryman 2008; Emerson et al. 2011), I wrote very limited ‘scratch notes’ whilst I was with the nurses – as I felt taking of notes in front of the nurses could be a barrier to a more natural conversation; so I used ‘head notes’ (Emerson et al. 2011) and a good memory (Mays & Pope 1995) to recall the detail for my systematic noting writing, immediately following a shift. My research design meant that I had long periods sitting alone in a car (whilst I waited for the nurse to complete the care of their patient) and so it was during these periods that I wrote fairly detailed notes from memory, then edited them and added additional detail later, when I typed them up. I believe I followed Delbridge’s (1998) advice, which states:

…it is important to try and record the events of the day as soon as possible since there is a greater likelihood of ethnocentric bias creeping into the data the longer the records are left. (Delbridge 1998:21)

The need to write-up field notes as soon as possible is also underlined by Emerson et al. (2011) who argue that it is more likely to ensure rich, nuanced detail. Upon returning from the field, Emerson et al. (2011:50) suggest that fieldworkers should go directly to their computers – without talking about the events of the day with others – to ensure that the write-up is a ‘cathartic outpouring’, rather than just a ‘stale recounting’. On most days I think I succeeded in doing this. Occasionally, where writing was a required or an accepted activity – such as in a formal meeting – I did take scratch notes (Delbridge 1998) and then wrote up full field notes later.
Field Diary

During my time in the field, I kept a field diary; this was in addition to any written and audio record of interviews and observations with participants. The diary enabled me to purposively reflect on the activities of each day and helped me to identify and understand my ‘taken-for-granted’ assumptions about events and their significance. It also enabled me to develop my ideas around themes for coding (Mays & Pope 1995), which helped to some extent later in the analysis phase of my research. The field diary also helped to ‘protect’ me against ‘over rapport’ with my research participants (McDonald & Harrison 2004); which was something that I was aware of during my time in the field. At times, I felt it was difficult to maintain the balance between an ‘insider’ role and risking ‘over rapport’ with the nurses who participated in my study. However, for the majority of the time, I felt I achieved this balance successfully.

3.3.2 Data

The methods used in my research study produced both (verbatim) interview transcripts and field notes (which as I have already stated earlier in this chapter), I created during periods of observation of participants. This method of producing data, Van Maanen argues, has already undergone a transformation process; that is, data produced in the field has been ‘textualised’ and has thus transformed unwritten behaviour, beliefs, values and rituals into written form. However, as Van Maanen points out:

Only in textualised form do data yield to analysis. (Van Maanen 1988:95)

In the following section, I will address elements associated with data and analysis – namely, data production, data selection and data analysis.
Production

Data production in the field was dictated by the vagaries of who was available for me to shadow on a particular shift. However, I did ensure that I accompanied all the nurses in the Team at least once. Inevitably, I accompanied some of the nurses more frequently than others and the prominence of one participant (key informant) over another is recognised in ethnographic research, as Bryman (2008) states:

The ethnographer relies a lot on informants, but certain informants may become particularly important to the research. (Bryman 2008:409)

However, I do not feel that this had implications for data validity; this is inevitable in any ethnographic study, where fieldwork is undertaken over a limited period of time and where I, as the researcher, had only limited control over my research environment. The subjective nature of qualitative data is openly accepted, as Bolton (2000) states:

The subjective qualities of qualitative data are openly acknowledged but how else is the ‘prose’ of lived emotion to be captured? (Bolton 2000:583)

There is however a danger, which is pointed out by Bryman (2008), that a researcher can begin to see social reality through the eyes of their ‘key informant’, rather than through the eyes of the members of the social setting. This is a peculiar temptation of the ethnographically-focused research method; but is one that I do not believe I succumbed to.

Selection

As I have discussed earlier in this chapter, coding of my data – that is, interview transcripts and field notes – was comprehensive. The selection of data to be included for analysis in my study was also comprehensive. However, some themes emerged and developed during analysis, which were more relevant to the research questions than others. Therefore,
some of the data contained within these themes featured more prominently in the findings and discussion chapters of this thesis. This is a consequence of an ethnographically-focused approach to fieldwork and analysis; one that values inductive, emergence of themes, as the analytical process progresses. The nature of the data that I produced and included as quotes in this thesis, reflected the views of some of the nurses in the Team, as opposed to others. This occurred because some individuals (more than other individuals) in the Team, expressed views that related to the themes (that addressed my review questions) more often and as such, their views where included more frequently, than other individuals. In a group of six individuals, I maintain that this is an inevitable aspect of this type of intimate and time-limited, research approach. I also argue that whilst some may see this as a limitation of my research method; I see these intimate portraits of participants, as a strength of the ethnographic method. It is also consistent with my stated ontological and epistemological position for this research study.

In selecting data that I had produced (both field notes and extracts from interview transcripts) to be included in this thesis, I was careful to ensure that the information was ‘typical’ of the individual nurse and where appropriate, it was typical of the nurses generally, who participated in my study. I was conscious not to take data ‘out of context’ and thus misrepresent a situation, or a feeling, for the sake of an academic argument.

Analysis

I took an inductive and thematic approach to analysis, which included the close examination of field notes and interview transcripts, through reading and then coding – an activity which was supported by the use of qualitative data analysis software (NVivo). I assembled the data thematically and then analysed for patterns, associations and connections (Breslin & Wood 2016). I coded transcripts and field notes alike; that is breaking down the text into small portions and assigning thematic codes to each textual
portion. This meant that (with the exception of some connecting words) every part of the transcripts and field notes I produced, were assigned a code, or codes. Where a portion of text related to more than one theme, I assigned multiple codes. I also created secondary codes to which I assigned my primary codes and in some cases I assigned these secondary codes to overarching tertiary codes; this coding was continually compared with the literature, which resulted in some theoretical convergence (Breslin & Wood 2016).

Prior to entering the field, I gave some consideration to developing some coding categories and I decided to construct some categories based on high-level themes, associated with my research questions. I used these categories as a framework to guide and direct my fieldwork – a view supported by Wolcott (1990), who suggests that qualitative researchers need some structure through which they can assess social action and its subsequent analysis. This was important in the early stages of my fieldwork, as I endeavoured to ‘find my feet’, as a novice ethnographer. However, these categories were never meant to be exclusive, or exhaustive and they developed and changed as my period of observation progressed and once my analysis began.

I began to analyse my data before the completion of interviews and observations (Mays & Pope 1995). Indeed, this preliminary analysis informed both the nature and structure of my interviews with participants, as well as the nature and focus of some later observations. Analysis also occurred – almost by default – as soon as I began the task of transcribing interviews. The decision to transcribe my own interviews was deliberate and was taken for two, beneficial reasons. Firstly, the process of transcription enabled me to really ‘get to know’ my data and over time, allowed me to develop an intimate knowledge of interview content. Secondly, as I have already inferred, analysis began subconsciously, as soon as the process of transcription started and occasionally before this stage; that is during and after interviews took place. Both these benefits of
transcribing enabled me to develop and then maintain, a proficient knowledge of the content of my interviews with participants.

Coding

I reviewed and revised my initial coding choices after I had left the field and begun data analysis in earnest. I created nodes within NVivo, which were my “first order” codes. As my analysis progressed, “second order” codes began to emerge and some of my “first order” codes were clustered into “second order” codes, as new “first order” codes emerged from my analysis. This is a process suggested by Carter and Stevenson (2012) for the coding and analysis of qualitative data.

Where new codes emerged and subsequently new nodes were created in NVivo, I assessed their relevance to my previously coded notes and where appropriate, I endeavoured to recode or code (for the first time) previous sections. This recoding and new coding occurred mainly at the beginning of the coding phase of the process, where new themes were emerging more frequently and when it was more practical to code and recode previous sections of data.

As new codes emerged, I continuously reviewed, revised and refined the criteria for attaching a code to a particular piece of data, as I progressed through the coding of my field notes and interview transcripts. I continued with this coding process until I was satisfied that all field notes and interview transcripts were coded appropriately. This process was followed by sorting and further analysis and a comparison and connection with themes that I was aware of from the literature (Baines & van den Broek 2017).
3.4 Access

At the beginning of this research study, the selection and then access to an appropriate organisation was the critical issue – my ability to collect and generate useful data relied on access (Saunders et al. 2000) to an appropriate NHS organisation. Indeed, Watson (2011) believes that the level of ‘high grade’ access required for ethnographic research can make some researchers reluctant to use this kind of method. Three reasons for the difficulty in accessing organisations are suggested by Saunders et al. (2000):

i. The organisation is not prepared to engage in additional activities due to time and resource limitations.

ii. For various reasons, the access request does not garner the attention of the recipient

iii. An external factor (unrelated to the request) may prevent the granting of access

By their nature, these elements largely depend on internal dynamics within the organisation itself and are therefore unpredictable and difficult to manage. However, the complexity of gaining access to an organisation within the NHS is subject to these and other inter-plays of prevailing influence. I experienced some of these challenges when trying to secure access to a NHS organisation; as well as the impact of poorly documented, complicated and unforgiving bureaucratic processes, associated with gaining formal approval for research within the NHS.

In the next section, I describe how I gained formal access to a suitable research site, at the corporate level. I broadly followed a strategy for gaining access, which is outlined by Bryman (2008). It is Bryman (2008) who also comments on the unsystematic nature of this type of endeavour. The following account of my successful attempt to gain access to a suitable research site, supports Bryman’s (2008) characterisation.
3.4.1 Formal Access – Part I

Having previously worked for the NHS, I had a number of NHS contacts who could possibly help with access. Several of these contacts were former colleagues and worked for a NHS Community Trust. As my research interest was community nursing, I nurtured these contacts with a view to potentially using their organisation as the research site for my study. The specific NHS Trust was an ideal organisation for me to carry out my research for practical, as well as research reasons. The location covered by the NHS Trust was geographically broad but had good transport links. It was also a NHS Trust with an obvious focus on community-based healthcare, so had the potential for me to undertake my research in a team that included community nurses; these factors made the research site both promising and relevant. To this end, I discussed my broad research aims with a former colleague whom I knew had the ‘the ear’ of the Director of Operations within the particular NHS Trust. The purpose of this discussion was to try to mitigate reason ii) above, by generating some interest and understanding of my research study and its aims and objectives; Ritchie and Lewis (2003) agree that co-operation is more likely to occur, if those participating in the research see it as valuable. Following this informal meeting, I discussed my research with the Director of Operations who verbally agreed to provide me with access to the Trust for the purposes of my research and I subsequently provided a research proposal for the Director of Operations for presentation at their Trust’s Senior Management Team. In an ensuing discussion (on the telephone), the Director of Operations and I agreed that a meeting should be set up with a clinical manager responsible for nurses to discuss how the research study would be conducted at a more practical level.

3.4.2 NHS Approval

After being granted access to a Trust ‘in principle’, there followed a protracted period of liaison between myself, the Director of Operations and a member of the Trust’s R&D Team. This resulted in me producing a revised research proposal (or protocol, as it is referred to within the NHS),
applying for an NHS ‘research passport’ and completing an (online) Integrated Research Application System (IRAS) application form – which requires the same kind of information that is requested as part of the University’s ethical approval process. I submitted my IRAS application through a central body for research and development in the NHS, known as the Health Research Authority (HRA). The process of approval through the HRA was very new (having been implemented only a month or so earlier) and this introduced an additional layer of bureaucracy to the whole procedure. There followed a further protracted period of liaison between myself and an assessor at the HRA, culminating in me receiving confirmation that my proposed study had received approval from the NHS.

3.4.3 Formal Access – Part II

Armed with the necessary ethical and R&D approvals, I contacted my research site with great optimism. I initially spoke with the R&D contact who asked me to contact the senior manager of the adult care division, via email, which I did. Within a week or so, the R&D contact confirmed that there was no capacity in the team (reason i, referred to earlier in this section) and I should contact the clinical manager in another division. They in turn asked me to contact (again by email) a senior manager within their division, which I did.

There followed a protracted period of back and forth with clinical managers at various levels within the Trust. Eventually, I spoke with the lead nurse who asked me to attend one of their regular team meetings. This turned out to be my initial meeting with the Team that included the nurses who participated in my research study and the start of my fieldwork, proper.

3.4.4 Informal Access

An NHS organisation may grant access to speak to their staff and to observe their operations – but I knew that for this research to be meaningful and effective, I needed to build relationships with individual
members of the organisation, in order that I might produce data that would enable me to answer my research questions (Delbridge 1998; Saunders et al. 2000). Not surprisingly and as I have discussed earlier in this chapter, Thorpe and Holt (2008) suggest that trust is a key value to unlocking interesting data – trust built with participants (not just their managers) is vital.

As a researcher whose methods included interviewing and observations, it was essential that I had the ability to develop a rapport with potential participants of my study, quickly; which I believe I did and this was critical to producing good data capable of being used to answer my research questions. This informal acceptance of my presence was important, particularly in research studies which explore sensitive areas of behaviour at work (Lawton 1998); as Tope et al. (2005) points out:

…frank expression of positive practices may be as contingent on trust and rapport with the researcher as is admission of negative sentiments and behaviours. (Tope et al. 2005:477)

The development of rapport and trust did not prove to be too difficult for me (as I discussed earlier). However, any ‘stranger’ in the workplace is going to arouse some suspicion, particularly in the early stages of fieldwork, as individuals may be concerned that the researcher might report what they find to management; trust and rapport are therefore vital and also important in the context of general, social interactions in the field, as Delbridge (1998) points out:

The researcher will need to make acquaintances and friends just in order to live their life while researching, never mind to actually assist in the research process. (Delbridge 1998:19)

I believe my personable nature and ability to build rapport with individuals quickly, helped in these crucial areas of the research process. I also believe that my significant experience of working in the public sector meant that I already carried with me, some degree of credibility and commonality
with my participants. However, this may have meant that I took some of the things I observed and heard for granted and suffered from a form of blindness brought on by familiarity. A similar situation is highlighted by Emerson et al. (2011) who suggest a number of ways in which an ethnographer can impose their own exogenous meaning on events in a particular setting.

I am unsure about the impact that my past employment at the research site may have had on my effectiveness in the field. I certainly carried with me a number of assumptions about the organisation, which I had constructed based on my previous employment there and which I inevitably carried into the research setting with me. These included a perception that the organisation was risk averse, a perception that to be valued by senior staff within the organisation, an individual must have been employed there for a significant amount of time and a perception that administrative processes were not as effective as they might be. However, I do not believe that these perceptions had a significant impact on my research, because this was a study primarily about clinical staff and I was previously employed at the Trust in a non-clinical, management role. Time had also passed since I worked in the organisation and the organisational environment of my fieldwork setting was different and more removed from the corporate world that I had previously inhabited. My previous employment seemed to me to have had less impact than I previously thought it might. I must admit however, that I did not specifically refer to the seniority of my previous role in the Trust; as I was concerned that this may create a barrier between me – in my current role as a researcher – and the participants in my study.

3.4.5 Research Context

My ethnographic research focused on the Antibiotics Team (the Team), which was a small, clinical team based in the south east of NorthCity. The Team was part of NorthCity Community Healthcare NHS Trust (NCHNT), which provided a broad range of community-based healthcare services
across NorthCity. The Antibiotics Team itself consisted of six staff nurses (Band 5), one lead nurse (Band 6) and one clerical staff member, responsible for administrative support. All staff worked full-time (37.5 hours per week), with the exception of one of the staff nurses who worked 23 hours per week. The patients treated by the Team were referred by the consultant on the Infectious Diseases Ward in the local hospital, which was part of a different NHS organisation – the local hospital trust.

The lead nurse had been with the Team since it was established, approximately three years ago (before the start of my fieldwork) and from conversations I had with this nurse prior to entering the field, they had played a vital role in establishing the Team as a service provided by NCHNT. A summary of the staff within the Antibiotics Team is detailed in Table 1, including the gender-neutral pseudonyms I assigned to each nurse, to protect the confidentiality of my participants (Apesoa-Varano 2016).

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billy</td>
<td>Lead Nurse</td>
</tr>
<tr>
<td>Alex</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>Ashley</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>Chris</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>Dale</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>Max</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>Sam</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>Pat</td>
<td>Administrator</td>
</tr>
</tbody>
</table>

Table 1 – Details of staff in the Antibiotics Team

I began my fieldwork at the end of July 2016 and my first contact with members of the Team was in a team meeting. My initial impression of the Team – as a collective – was that they were friendly and welcoming and not afraid to engage in banter and gentle mockery between each other. Following this introductory meeting, I reflected that this seemed their normal behaviour and not a product of my unusual presence and this was confirmed as I became more familiar with the individual nurses in the Team.
It is inevitable that as a person (and a researcher), I had a greater rapport with some individuals in the Team, than others; however, every member of the Team – without exception – was patient with my many questions and never showed any visible signs of annoyance at my sustained presence.

During my time with the Team, I carried out 140 hours of observation, which was spread over 22 individual shifts and was carried out between 25th July 2016 and the 23rd November 2016. I also conducted six interviews with each Band 5 staff nurse in the Team during this same period.

3.5 Ethics

Ethics in research is concerned with what is appropriate and acceptable behaviour and practice, when carrying out research (Thorpe & Holt 2008). It is rightly concerned with the treatment of research participants, which is particularly important if the research involves human participants (Thorpe & Holt 2008). According to Richie and Lewis (2003) ethical issues are of particular importance in qualitative studies because of the unstructured and in-depth nature of the research. Some authors identify two key schools of thought in relation to ethics; Universalists and Situationists (Bryman 2008; Thorpe & Holt 2008). Universalists believe that ethical principles apply in all situations, whilst Situationists believe that in certain circumstances, the violating of ethical principles can be justified to enable particular kinds of research to be carried out (Bryman 2008; Thorpe & Holt 2008). I classify myself as a Universalist; however, as I have shown earlier in this chapter, ‘schools of thought’ are often the extremes of a spectrum, whose ends can never quite be reached.

The inability to conceive of a purely Universalist approach to ethics is highlighted by Lugosi (2006) who argues that any kind of concealment in research might be regarded as unethical. In outlining his concerns, Lugosi
(2006) questions why ‘social lies’ are not seen to be ethically problematic
and states:

…insincere compliance with social etiquette or exaggerated empathy was deemed to be appropriate when building rapport with informants. (Lugosi 2006:544)

Whilst I appreciate Lugosi’s (2006) concerns and reflect on my own behaviour during my time in the field, I suspect that Lugosi’s (2006) motivation for taking this rather extreme view of concealment is to deflect criticism of his own covert research methods. The imprecise nature of ethics is also highlighted by Richie and Lewis (2003) who warn about the ‘seductive quality’ of interviews – where participants relax and disclose information in that setting, which they may later regret. They rightly argue that researchers have a responsibility to be alert for signs of discomfort during an interview and re-check a participant’s willingness to continue, if appropriate. I believe this was relevant, during my discussions with the nurses in the Team – when we were sat in their car.

In the planning and design stages of my study, I was very aware that travel and travelling would be a key feature of my fieldwork experience. Indeed, the research design itself meant that the majority of my time was spent within the confines of one of the nurses’ cars. A significant proportion of my conversations with the nurses happened in a car; it became our shared world. The car enabled the nurses to accept my presence on their terms; I was the guest, the interloper, the genial intruder into their world. I had to accept the conditions of my sojourn without complaint, as well as accepting apologies about those same conditions, if they were offered.

The forced intimacy of the car seemed to accelerate the development of a bond of trust between me and some of the nurses. On reflection, I believe that a lack of eye-contact – often characteristic of conversations held by two people sitting in the front of a car – also supported the advancement of a less-inhibited communication environment. The car was our ‘safe space’; an environment where discussions could take place about the
work, about patients and about managers – in an atmosphere of confidentiality and cathartic release, as described by one of the nurses in our interview:

…it probably gives us an opportunity to express some issues that we might not be able to express. Sam, Interview

The ethical implications of this environment were always at the forefront of my mind and I was aware of not consciously taking advantage of this. A trust developed between myself and the nurses, which they had no logical business placing with me; having only known me for a very brief period of time. I felt humbled that they had put this trust in me and I did not want to disrespect it. As my study progressed, I had a growing sense that most of the nurses welcomed my presence with them in the car. During our interviews, several of the nurses cited my company with them as one of the benefits of taking part in the study.

This discussion raises important issues about the subjective nature of decisions regarding ethics, which I feel demonstrate that the ethical schools of Universalist and Situationist are all too simplistic. This ethical tension felt by a researcher is described by Delbridge (1998), who states:

Nearly all ethnographers feel torn at times between their research commitments and their desire to engage authentically those people whose worlds they have entered. (Delbridge 1998:36)

In terms of the ethical implications for my own research study, I believe that I satisfied the issues generally covered by ethics, which are given below (Richie & Lewis 2003; Bryman 2008; Thorpe & Holt 2008):

i. Avoiding physical or psychological harm
ii. The voluntary nature of participation and the right to withdraw
iii. Maintaining privacy of (possible and) actual participants
iv. Ensuring confidentiality and anonymity of participants
v. Informing (possible and) actual participants of the research context
vi. Gaining informed consent from those agreeing to be participants
vii. Declaring funding sources of the research

The process that I was required to undertake to gain ethical approval by the University of Manchester forced me to address some of the less obvious, ethical issues that I might otherwise have overlooked; for example, the need to re-check consent with participants and not assume that consent at the beginning of a study would last for its entire duration. However, my perception of the overall process for gaining ethical approval was that it was at times both unclear and unhelpfully bureaucratic.

As part of the conditions for gaining ethical approval from the University of Manchester, all potential participants of my study received a ‘participant information sheet’, which provided information on the study in a ‘FAQs-style’ format. All participants were also given time to consider whether they wished to be involved in the study. If a nurse decided to participate, they were required to sign a consent form before taking part in the study, which as I have discussed earlier was reaffirmed during the course of my time in the field. The consent form followed good practice and required the potential participant to initial the form to indicate their informed, individual consent for the various ways in which the data might be used, in addition to overall consent. All the documents I produced received ethical approval from the University of Manchester. My study also received approval from the NHS Health Research Authority.
3.6 Summary

In this chapter, I have detailed the method and methodology for my research, as well as discussing some of the practical issues I encountered during the course of my research study. The chapter ended with a discussion on ethics and a description of the ethical practices I adopted for this research study.
Chapter 4

Findings – The Labour Process
4 Findings – The Labour Process

As I have discussed in chapter one, this research is a study of a group of nurses, working for a NHS Community Trust. In this chapter, I use analysis informed by labour process theory (LPT) to exemplify the work of the nurses in the Team and understand how their labour process was controlled by their employer.

In this chapter, I will consider how the capacity to work is transformed into labour. I will also examine the relations between the nurses and their employer (NCHNT), which are associated with the conversion of labour power into actual labour; in particular, the methods used by management to control these healthcare workers and the nature of the struggle in relations, between the nurses and their employer. In this chapter, I will focus on the elements in my analysis, which appear to correspond to current understanding of LPT. In chapter five, I will continue my analysis of the nurses in the Team and explore how the nurses exercised degrees of professional discretion within this controlled environment and how their labour appeared to provide for them a measure of personal and professional satisfaction – a finding, which I argue, theoretically jars with a more orthodox understanding of LPT.

This first findings chapter will be split into sections, which are structured around key elements of LPT; work and skill, control, compliance, consent and resistance (or struggle). The chapter will conclude with a summary and an introduction to the next chapter.
4.1 Work and Skill

In this section, I look at two elements of LPT, the nature of work and worker skills. In the first section, I endeavour to explain the nature of the nurses’ work in LPT terms and in the second section, I explore the nature and context of the skills I observed being used by the nurses in the Team and support my analysis with a framework developed by Aspesoa-Varano (2016). I also suggest an additional category of skill – not included in Aspesoa-Varano’s (2016) framework – which is nonetheless relevant to the work of the nurses in the Team.

4.1.1 Work

Product and Point of Production

A central concern of the capitalist mode of production is how to extract labour power from workers, or as Edwards (1978) puts it:

… capitalists and workers clash in the sphere of production over the general issue of the transformation of labour power into labour. (Edwards 1978:124)

Under capitalism, the central focus is to find ways to make workers work harder (Braverman 1974; Burawoy 1982). As I discussed in chapter two, there is a continuing need to improve productivity and efficiency in the public sector because this is a primary feature of the rhetoric surrounding NPM. (Mather et al. 2007).

To understand the work of the nurses in the Team, it seems appropriate to begin my analysis, by explaining the work of the nurses in labour process terms. The primary function of the Antibiotics Team was to continue the treatment of patients (who had been discharged from an Infectious Diseases Ward) in the patient’s own home. The Team almost exclusively cared for patients like these; that is those suffering from an infectious disease – who needed treatment with antibiotics, administered
intravenously. At the end of all labour processes there is a ‘product’ and in the case of the nurses in the Team, the product of their labour was the transformation of an untreated patient into a treated one, using the labour power of the nurses themselves (Thompson & Smith 2010). As discussed in chapter two, labour power incorporates two elements – effort power and mobility power; in the case of the nurses in the Team, their mobility power was the choice (or constraint) that had resulted in them working for their present employer; their effort power was the effort extracted by their employer, in order for them to successfully transform untreated patients into treated ones. In this study of the labour process of peripatetic nurses, the point of production may seem less obvious, than more geographically-stable workers. A view of both product and point of production in the nurses’ labour process is provided by Bolton and Wibberley (2014), who maintain that in terms of the caring labour process, the home can be a workspace and the person receiving treatment, an object to be produced. I suggest that the point of production for the nurses in the Team was their patients’ homes; it was in the patient’s home, that the nurses used their effort power to transform untreated patients into treated ones; it was in the patient’s home that they produced their product.

The nurses’ point of production was unusual, in that it was not consistently in the same place, nonetheless, it was bounded by the geographical limits of NorthCity. This meant that the nurses carried out their labour within a geographically-dispersed, physical space and this was somewhat different (in terms of point of production) to the obvious comparison with nurses working in an acute setting, or indeed workers on a line in a factory, whose point of production would be generally limited to a single building and usually a specific area of that building. This has implications on mechanisms of control, as visual surveillance of workers (by their employer) is not possible and so links to the concept of “observability” (Littler 1990) that I discussed in chapter two, which I will discuss again in this chapter, in relation to its relevance to management control.
Relations of Production

By way of context, I will now outline in more detail the nature of production for the nurses in the Team. The Team provided a seven-day service from 07.15 to 21.00 each day and the nurses worked on a rotating shift pattern that consisted of an ‘early’ shift (07.15 to 15.15), a ‘core’ shift (8.30 to 16.30) and a ‘late’ shift (13.00 to 21.00). Each shift included an unpaid meal break of 30 minutes. Figure 1 provides a visual representation of the nurses’ shift pattern.

![Nurses' shift pattern](image)

To produce treated patients, NCHNT arranged the instruments of production, raw materials and the effort power from the nurses into relationships of production, during the timeframe of each nurse’s shift. From my observations in the field, the instruments of production were, clinical equipment, a patient’s home and a nurse’s car and navigation equipment; the raw materials were, an untreated patient, saline and prescribed antibiotics. These elements were all brought together with effort power - extracted by NCHNT from a nurse – to produce a treated patient. It is my suggestion that the means used to extract this effort power from the nurses was through the allocation of work; that is, untreated patients allocated to each nurse, on each shift. I will discuss how this mechanism operated and how it led to work intensification and work extensification.
later in this chapter; for now, to understand the significance of work allocation on the control of nurses in the Team by their employer, it is necessary that I first provide a brief outline of the method used to allocate work in the Team.

“Off-Duty” Rota

The document that detailed the work pattern for the Team and included the shifts that each nurse was scheduled to work was called the “off-duty rota”; this is a somewhat ubiquitous term, used throughout nursing (Holland 1993, Beringer & Julier 2009). The off-duty rota was published two months in advance and at least two of the nurses (Chris and Sam) confirmed to me, that once the rota was published it should not be changed. This extract from my field notes outlines one of these encounters:

I asked Sam if I could shadow them for a day, as I hadn’t yet accompanied them on a shift. Sam immediately agreed and so we checked when they were working on the “Off-Duty Rota”, which was pinned to the wall of the Team’s office. The rota wasn’t clear to me and so I asked Sam what shift they were working, on a particular day.

“They changed my shifts. They shouldn’t do that”
“How come?” I asked
“Not sure why” they replied. Sam explained that once the rota is published, “they” are not allowed to change it without consultation. “Have you spoken to Billy [lead nurse] about it?” I enquired. Sam confirmed that they had and then they went on to explain that once the rota is published, “You work your life around it” and it is very frustrating, if shifts change significantly after that time… Field notes, 15th September 2016

The “off-duty rota” seemed to me to be a manifestation of the control exercised by the nurses’ employers on their employees’ time and this discussion with Sam highlights the degree to which the nurses had to accommodate their time outside of their work, around the rigidity of working shifts. I am not suggesting that this imposition was resented by Sam (which I did not sense); but what I am suggesting is that Sam felt
aggrieved when the “off-duty” rota was changed after they had made these time accommodations to their life outside of work. In common with all workers, public sector workers – including nurses – sell their capacity to labour (Reid 2003; Mather et al. 2007) and in common with all employers, NCHNT required ownership of the time they have paid for in the form of capacity to labour. In relation to the nurses in the Team, this ownership of time went further and NCHNT required “first call” on their time outside of work too and this was accepted by the nurses, as part and parcel of their work as a nurse. However, when this “first call” on their time was deemed to have been given by the nurses and then their employers changed plans and expected a “second call” on their time, resentment and conflict surfaced. I am suggesting that from Sam’s perspective, to change shifts once the rota was published, was to control and own more of their “out-of-work” time, than they were comfortable in conceding. I also sensed that Sam perceived shift changes as a sign that the organisation did not respect their commitment and professionalism as a nurse and they were being treated as an unskilled worker, who had to accept the changing whims of their employer; rather than being respected as a skilled and valued professional.

Work Allocation

As I have already stated, the product of the nurses’ labour process was the production of treated patients from untreated ones; or in other words, an untreated patient was transformed into a treated patient, through the effort power of a particular nurse, on a particular shift. Based on this understanding, the allocation of work in the Team was in effect, the allocation of untreated patients to a nurse, with the expectation that they would produce a set of treated patients, by the end of their shift. This allocation process was carried out by the lead nurse in the Team – supported by the Team’s administrator.

The outcome of this allocation process resulted in each nurse working on a particular shift being allocated a set of untreated patients and the
expectation from their employer was that all the patients allocated to them, would be treated by the end of their shift. The number of patients a nurse was required to treat in a single shift was not consistent, because the time required to treat a patient varied (sometimes) significantly – depending on the type of treatment a patient was receiving. This difference in length of treatments was due to variations in the time taken to introduce and administer the prescribed antibiotic into a patient’s vein. Table 2 presents a summary of the treatments administered by the nurses in the Team and the approximate length of the patient visit associated with each treatment, based on my own field observations of the nurses in the Team.

<table>
<thead>
<tr>
<th>Type of Treatment</th>
<th>Method of Administration</th>
<th>Approximate Duration of Patient Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Bolus”</td>
<td>Injection</td>
<td>30 minutes</td>
</tr>
<tr>
<td>“Half-Hour” Infusion</td>
<td>Infusion (over 30 minutes)</td>
<td>40-50 minutes</td>
</tr>
<tr>
<td>“Hour-Long” Infusion</td>
<td>Infusion (over 60 minutes)</td>
<td>90 minutes</td>
</tr>
<tr>
<td>Eclipse Device</td>
<td>Infusion (over 24 hours)</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

Table 2 – Summary of Treatments

This variation in treatment length and thus patient visit duration meant that a nurse in the Team could produce five treated patients (say, who were being treated using a bolus), much quicker than they were able to produce three treated patients, who required treatment, via an infusion. A point that I realised, during my fieldwork:

I have found that the number of patients allocated to a nurse, doesn’t reflect the amount of work required of a nurse... The length of the administration of the antibiotic is the key factor in determining how long the nurse’s work will take. Field notes, 28th September 2016

During my time with the Team, several of the nurses suggested to me that the individuals responsible for allocating untreated patients to the nurses each day, did not sufficiently understand the nature of the work being
carried out and were unsympathetic to time pressures resulting from delays. The nurses also spoke to me of the consequential feelings of stress and anxiety that they experienced as a result of these delays; comments from Ashley in our interview, were typical of the nurses’ general view:

Ashley: Yes, the perception of…let’s say you’ve got your patient definitely. The understanding of – maybe there’s traffic jam…if you say, oh you are late, you are running late, nobody seems to understand. So, it is so frustrating. That’s the only…

Me: Does it cause you stress Ashley…?

Ashley: Yes. It causes me so much stress and…let’s say, for example, you go to see a patient and they need a cannula. And at times they’ve got poor veins. You can see the location of the work, the way it is making you…and then [you] go there and you stay for almost two hours. But nobody will try to understand, you took long there, trying to get a cannula. So, it is…

Me: And so, they’re wondering then why you’re not on to the next patient?

Ashley: Why are you not to the next patient? It is…so stressful…

Ashley, Interview

This lack of understanding (by their employer) of the pressures associated with work is highlighted by Delbridge (1998) who suggests that, despite management presence, workers felt that their problems were not sufficiently understood and there was a lack of understanding of the issues faced by workers. It is Delbridge (1998) who also observes (in his study of a manufacturing environment) that control of effort power was achieved through adjusting and increasing the “line speed”. I want to suggest that this perceived lack of appreciation of the work carried out by the nurses was a way for their employer to control the labour process of the nurses in the Team and extract from them the effort power required to produce treated patients, as they required. Within healthcare, this type of control mechanism is identified by (Ackroyd & Bolton 1999), who suggest that control of nurses in their study was achieved through manipulation of
patient throughput. In the next section in this chapter, I will discuss in more
detail, the ways in which control of the nurses in the Team was achieved
by their employer.

Before I conclude this section on the mechanism for work allocation in the
Team; I want to highlight a series of events that occurred, during my time
in the field relating to the work allocation system. At a team meeting part-
way through my period of fieldwork, a new system of work allocation was
proposed; I described the incident in my field notes:

A system for improving allocation of work was presented by Sam at
this point in the meeting. An elaborate, colour-coded chart was
produced and passed to each person in the meeting. The new
system developed and proposed by Sam involved the allocation of
standard units of time (15 minutes in length) to each activity carried
out by a nurse. Everyone present at the meeting, agreed that the
new allocation system should start next week. Field notes, 20th
October 2016

A few days later, I happened to be accompanying Sam on their visits and
was not entirely surprised to learn that the new work allocation system had
not been implemented as agreed at the team meeting. Here is an extract
from my field notes for that day:

In the car Sam raised the issue of the allocation system that they
had presented to the meeting last week:
“Billy [lead nurse] says they are not going to do it – it doesn’t work!”
“I thought it was due to start this week” I said; seeking clarification
as to whether my assumption was correct.
“It was, but Billy says it doesn’t work!”
“That’s a shame – because they were all ready to go at the meeting.
What’s happened?” I asked.
Initially, Sam said they weren’t sure; but then, without any prompting
they said:
“I’ll tell you what the problem is; Billy can’t fit in all our current patients
and so they say it doesn’t work. It does work – we just have too many
patients!” Field notes, 25th October 2016
This account of Sam’s response to the proposed new allocation system not being implemented highlighted the work extensification and intensification that was ‘built in’ to the nurses’ labour process through the work allocation system and it is an issue that I will return to and discuss in more detail later in this chapter.

4.1.2 Skills

In this section, I want to focus on the nature of the skills possessed by the nurses I observed and interviewed and also outline a framework developed by Apesoa-Varano (2016), which will help to categorise the skills used by the nurses in the Team.

There are four categories of nursing skill described by Apesoa-Varano (2016): observational, analytical, interactional and comforting; in the remainder of this section, I will outline each category of skill in turn and then suggest an additional skill set, that I observed during my time with the nurses in the Team, one that is not covered within the categories suggested by Apesoa-Varano (2016).

Observational Skill

*Observational skills* centre on the sensitivity of nurses to non-verbal signs from their patients and these could be signs relating to emotion, physical behaviour or social background; Apesoa-Varano (2016) comments:

Observational skills required nurses to develop an ability to observe without deliberately or noticeably watching; to be sensitive to information that was not formally given or elicited but was available nonetheless. Apesoa-Varano (2016:34)

During my time with the Team, the nurses recalled to me, multiple incidents where they had used this skill. The following extract from my interview with Alex is a typical example:
I think it’s hard not to when you’re there to make an overall kind of assessment, in your opinion. I think it’s difficult not to do that, because you do spend time with them. You might be unaware of it, but you are constantly thinking and assessing with things that they say, the mood, with what the house is like, what their relationship is like with other people. You are constantly assessing; you are aware of it… Alex, Interview

This extract from my interview with Alex illustrates well how the nurses performed this skill and how the skill relies on an element of covert observation.

**Analytical Skill**

*Analytical skills* are a natural progression from *observational skills* and relate to the interpretation and evaluation of observational information (Apesoa-Varano 2016). According to Apesoa-Varano (2016), these skills rely on a nurse “knowing” their patient in order to appropriately assess social, behavioural and attitudinal information that they have already observed. The nurses in the Team often recalled incidents to me, where they had used these skills and I also observed their use, first-hand. The following extract from my field notes is my reflections on the exercising of these skills by the nurses in the Team:

I’ve noticed that as well as a purely clinical assessment of their patient in terms of their immediate illness; the nurses assess their patient’s moods, character, foibles and family dynamics. This appears to me to be part of the process of assessing the whole patient, to decide how best to manage their care. The nurses I have spent time with are all very skilled at this aspect of their work. Field notes, 21st September 2016

This analytical skill builds on the previously discussed skill of observation and uses the information the nurses receive and their knowledge of the patient to assess the current situation, as it confronts them and then decide on the most appropriate course of action.
**Interactional Skill**

*Interactional skills* are learned and centre on the ability of a nurse to relate to patients and provide support; Apesoa-Varano (2016) adds:

Nurses talked about encountering a variety of patients and having to be flexible in adjusting the nature of interactions as they learned and analysed a patient’s social background and current condition. Apesoa-Varano (2016:35)

During my time with the Team, the nurses recalled to me, many incidents where they had used this skill. The following extract from my field notes is an example of Ashley’s approach with their patients:

Ashley explained their general strategy when they visited a patient, which was to spend five minutes or so asking about them and their general health; before delivering their patient’s treatment. Ashley felt that this time was “well spent” because they often picked up on general contextual issues during this time – that may, or may not, impact on their overall assessment of their patient. Ashley also said that they found that patients respected the time that they had to spend writing up notes and calculating and then mixing antibiotics, if they had devoted the time to them [the patient], early on in the visit. Field notes, 11th August 2016

This skill has obvious links to the other two skills outlined in this section. However, a nurse who possesses this skill can effectively interact socially and clinically with their patient. The strategy for enabling this interaction seems to be effectively illustrated by Ashley in the example from my field notes.

**Comforting Skill**

*Comforting skills* are a developed ability to provide appropriate, emotional support to enhance a patient’s treatment and help their ongoing recovery, or stability; Apesoa-Varano (2016) states:
nurses spoke about comforting skills in terms of expressing emotions such as happiness or sorrow in the context of a patient’s situation. Apesoa-Varano (2016:37)

Of all the skills I have outlined in this section, *comforting skills* is perhaps the one most associated with nurses and nursing and yet due to the nature of my research method – that is, I did not observe the nurses in the Team, dealing directly with their patients – it was a skill that I found most difficult to observe. However, the sympathy and concern about their patients, which motivated the use of this skill was evident and common amongst the nurses in the Team; as typically illustrated in this extract from my interview with Max:

...generally, this patient is quite a small build. He’s quite slim-looking for an Asian – sometimes you can’t tell if they are pale, because obviously they have darker skin. But you can see that he’s dehydrated and the eyes. I mentioned his wound would heal much better if he ate more protein in his diet, which is prepared for him, to help him recover quicker. He admitted himself – after the conversation – that he’s not eating; doesn’t have any appetite. That is something which we need to keep an eye on and make sure that he is getting his nutrition. Max, Interview

Here Max discusses their concern for the patient and signals the need to “keep an eye” on them – to ensure their nutritional intake is improved. An example of their concern for this patient, which will have been manifested in comfort and care when they visited their patient, in their home.

**Logistical Skill**

However, there is a skill set, that I also observed in my time with the Team, which is not covered in the categorises outlined by Apesoa-Varano (2016) – that is, *logistical skill*. Skills in logistics is not something that is usually associated with nurses and nursing and yet the nurses in the Team were (by their employer) expected to navigate to and from the points of production; that is, to and from the homes of their patients in the large city.
in which they worked. This required a degree of skill, possessed by all the nurses I observed, which included the application of tacit, travel knowledge and continual awareness of their environment and surroundings. The knowledge that the nurses applied, as they drove between the points of production, related to traffic and traffic behaviour in NorthCity.

This learned skill, which involved appropriately applying information on the behaviour of traffic to an immediate situation and also anticipating potentially aggravating factors that could result in traffic delays at certain times during the day. I discussed these skills with Alex in our interview:

> You definitely slowly learn where to avoid and at what times...because we cover such a wide area as well...you have to take it into consideration where you’re going and at what time. I’ve got two patients – later on today – who live within a mile of each other; so luckily for me, that’s not really a problem. But I know on the late shift, just to see one patient – to get from the office to their house and back – is 30 miles away. So, you have to take [traffic issues] into consideration, otherwise, you’re just going to be losing time stuck in traffic...Especially if that’s the school run as well, at that time.
> Alex, Interview

It is my suggestion then, that a further category is appended to my analysis relating to nursing skill in a peripatetic context and that *logistical skill* is added to complement the four other skills described by Apesoa-Varano (2016).

This categorisation of skills is important, because I want to argue in the next chapter that some of the skills used by the nurses and associated with their labour were not acknowledged by their employer; indeed they were ‘invisible’ and yet these skills were a vital part of the nurses’ labour process, were valued by their patients, benefited their employer and also contributed to the forming of a sense of self-satisfaction from their work.
4.2 Control

As I discussed in chapter two, control of workers by their employer is a central theme of LPT. In this section, I explore and analyse how the work and labour process of the nurses in the Team was controlled by their employer – a central theme in any analysis of work, informed by labour process theory. In chapter two, I outlined Edward’s (1978) typology of control systems and in this section, I reference these types of control systems, as they related to the Antibiotics Team.

I begin by looking at how the allocation of work and the expectations of NCHNT led to work intensification and work extensification and the technical control of the nurses’ labour process by their employer. I will then go on to explore how other mechanisms – namely, clinical standards and bureaucratic requirements – were also used by NCHNT to control the labour process of the nurses. Finally, I explore how patients themselves were used as agents of control.

Before I begin the detailed analysis of control mechanisms at work within the Team, I think it is necessary to understand what is meant by control; Baines & van den Broek (2017) suggest that control is the:

...power to influence or direct people’s behaviour or the course of events. Baines & van den Broek (2017:136)

As I outlined in chapter two, Littler (1990) argues that the ability of a manager to exercise control of subordinates relies on information and this ability is in direct proportion to the capacity to carry this information between the manager and their subordinates. According to Littler (1990), this ‘observability’ is dependent on four general factors; physical separation, congruence of supervisor and subordinate, production system insulation and social insulation.
Physical separation indicates the geographical disconnect between a manager and their workers, which may limit the opportunities for visual inspection by a manager and as a consequence can result in the exercising of greater discretion by subordinates. This observability-varying factor is particularly relevant to a community setting and the practice of the nurses in the Team, who were not confined to a fixed location in one building but whose point of production was dispersed over a wide geographical area. Based on Littler’s (1990) work, the observability by the lead nurse of the activities of the nurses in the Team was limited, due to physical separation and it is complicated further by the point of production, which is in a patient’s own (private) home. Indeed, the lead nurse in the Team remarked to me on at least one occasion that they “get out there”, as often as they can; which suggested to me, a desire to undertake visual surveillance of the nurses in the Team on a regular basis. This is an example of what Edwards (1978) would describe as a ‘simple control’ method.

The congruence of a manager and subordinates’ skills is the second factor – according to Littler (1990) – that influences observability between a manager and their subordinates. If a manager possesses the necessary skills and knowledge to assess task performance of a subordinate, observability is high; if they do not, observability is drastically reduced. In the case of the nurses in the Team, their immediate line manager was a nurse with congruent skills and knowledge; however, their manager’s manager did not have a clinical background and so according to Littler (1990) this would suggest that observability from a senior management perspective of the nurses’ work was severely limited by their lack of congruent knowledge and skills. This suggests that the employer’s ability to control the nurses’ work would have to rely on technical and bureaucratic control; which I would argue that it did.

The production system insulation, that is, the nature of the labour process and the degree of indeterminacy of activity, according to Littler (1990) also influence observability. The contrast between the labour process in other
studies within a manufacturing setting (Roy 1952; Delbridge 1998) and the labour process of the nurses in the Team illustrate how higher degrees of indeterminacy of work activities, reduces observability by managers and again forces employers to rely on technical and bureaucratic control mechanisms; as well as responsible autonomy (Friedman 1977) from the nurses. This observability-factor and responsible autonomy was relevant to some elements of the work of the nurses; particularly in relation to their interactions and assessment of information, during a patient visit, which was informal, emergent and not generally acknowledged by their employer.

Social insulation is another factor highlighted by Littler (1990), which has an impact on a manager’s observability of workers. As I discussed in chapter two, managerial authority does not necessarily guarantee observational access. There are institutions within and outside organisations, which mean that managers are not free to interrupt the work of subordinates. This type of insulation can be found amongst the professions and also amongst some craft occupations and is relevant to the nurses in the Team, because of their status as nurses. A status that places professional obligations on them, which cannot be overwitten at the whim of their employer; as such, Littler (1990) argues, it reduces observability of the nurses, by their managers. This external limitation placed upon the nurses sometimes conflicted with the wishes of their employer and this was openly expressed by them during my fieldwork; it often manifested in their concerns to me about a particular course of action (suggested by their employer), which risked them losing their professional registration as a nurse.

According to Littler (1990), the organisational objective of any control strategy is a frictionless machine and yet this ignores the consciousness inherent in all workers. These potentials for contradiction are outlined by Littler (1990) in two interpretations of the control relationship between employer and workers; which are, the dialectic between control and resistance and the dual nature of the relationship between the employer and labour, which results in tension with the employer. This tension is a
result of treating labour as both a commodity and a non-commodity and also the tension from acknowledging that, to harness their workers’ creative energies – workers’ labour cannot also be simultaneously treated by their employer as a simple, economic exchange. A point developed by Burawoy (1982) in his work on consent, which I discussed in chapter two.

As I will explain later in this section, the control exercised by their employer (NCHNT) on the nurses in the Team was not applied direct – it was a form of technical control (Edwards 1978) as well as responsible autonomy (Friedman 1977). There was limited visual surveillance of the nurses and no electronic monitoring of workload (as has become increasingly common in many care settings). Indeed, there was only limited, simple control attempted by NCHNT over the organisation of untreated patients by the nurses (for example – the document that included the names of the patients to be treated by the nurse on a particular shift) and there was no attempt (that I observed) to influence the social interaction between the nurses and their patients. The idea that nurses’ work can be directly controlled in any simplistic way is questioned by Bolton (2004), who argues that:

The very nature of nursing work…reasons against the possibility of reducing the whole of…patient care into easily quantifiable tasks and designing the ‘one best way’ for nurses to carry out their duties. (Bolton 2004:323)

Indeed, I believe that the nurses’ employer (NCHNT) had only limited interest in the mechanics of how an untreated patient was transformed into a treated patient; rather, they were more focused on quantitative outputs. That is, NCHNT’s main concern was that the required number of treated patients were ‘produced’ in the appropriate timeframe. NCHNT had some concern for the clinical integrity of these outputs; that is, that clinical standards were maintained during the treatment of all patients. However, aside from specific, clinical considerations, NCHNT seemed to value the production of ‘products’ in an appropriate timescale.
4.2.1 Work Intensification and Work Extensification

The intensification and extensification of work was seen by Braverman (1974) to be an inevitable consequence of activity under capitalism. Yet as I have discussed in chapter two, a fundamental issue within capitalism is that, the capacity to labour remains within the worker and it is the function of management to extract (and maximise) this effort power (Thompson & Smith 2010). In relation to the nurses in the Team, it was NCHNT’s responsibility to extract the effort power from each individual nurse, in order to produce and reproduce treated patients. For this capacity to be maximised, NCHNT needed to be able to effectively control the work of all the nurses in the Team. In this section, I highlight how this mechanism of control was exercised resulting in both work intensification and work extensification.

As I have previously explained, the allocation of work within the Team was undertaken by the lead nurse and the administrator. I have also explained that the amount of labour required from each nurse to produce a treated patient, varied depending on the type of treatment being administered to the patient; nevertheless, the expectation of NCHNT was that all untreated patients allocated to a nurse, would be treated by that nurse by the end of their shift. This expectation was a key element in the mechanism of control by NCHNT, which was an example of a technical system of control (Edwards 1978).

I observed work intensification within the Team and one of the ways I suggest that this manifested was in the form of stress – experienced by the nurses – as they travelled between points of production; that is, between patients’ homes:
If I've seen them in good time and at least I have a bit of time to go to the next patient without getting late...When I'm driving, I'm so relaxed. But when I'm already late with the first patient and I'm going to the second one; I'm [be] so pressured; I get so stressed...I feel so stressed and...then for the next one definitely now the stress-levels start going up...later, late, late and more late, to the next...you are looking at your last patient, but you can never rush anything with a patient – especially with antibiotics. You can't, say it's half-an-hour, I'm going to give this [to this] patient maybe in 15 minutes. You can't do that. Ashley, Interview

This account (given by Ashley) illustrates the stress that built up inside them as their shift progressed and they drove from one of their patients, to the next. The account is typical of the view of the nurses in the Team, in relation to driving and lack of time. Ashley's view was that they were unable to rush the clinical aspects of their work with their patient and this seemed to create an erroneous perception in Ashley (and indeed, the other nurses in the Team), that time “lost" elsewhere could be “saved" when they were travelling between their patients – of course, in many cases, it could not. I believe that when this perceived “time-saving plan” was thwarted – as inevitably it was; it added to the nurses’ feelings of stress and anxiety and resulted in them resorting to the only solution left open to them, working beyond the end of their shift. This extensification of work immediately gave the nurses the additional time they needed to complete the transformation of all their untreated patients into treated ones. However, it was time that they would not be paid for; it was unpaid labour. This distorted view (typically held by the nurses), that somehow, they could ‘save time’ whilst travelling between patients, meant that this work intensification, inevitably led to work extensification when the required time was not saved, during travel.

As I have noted, the expectation of NCHNT was that the number of allocated, but untreated patients at the start of an individual nurse’s shift would be transformed into treated patients by the end of their shift. This was irrespective of the disruptions to production which the nurse may face, in the eight hours between the start and the end of their shift. I have also
already stated that the point of production for the nurses in the Team was geographically-dispersed, in multiple-locations, across the large area that was NorthCity. This meant that routinely the nurses were delayed due to traffic, yet no account for this was made in the number of treated patients that NCHNT expected the nurses to produce by the end of their shift. This extract from my interview with Dale was a typical example of these types of delay:

The only thing I don’t like is the traffic... Especially when you’re running out of time; you’re late already. Let’s say you spent too much time with one patient ... then you’re getting late to the next appointment; the rush hour, the traffic. That one is a disadvantage for me. Dale, Interview

As Dale’s comments also highlight, the nurses could be delayed as a result of a particular issue with a patient and yet no systematic account for this was made, in terms of expectation of treated patients to be produced, by NCHNT. The following extract from my field notes is a good example of the kind of patient-centred delay that could be experienced by the nurses:

“Don’t ask!” they said, as they slammed the car door shut – with slightly more feeling (I thought), than usual.
“I couldn’t do it!”
“What do you mean?” I asked, puzzled
“Terrible veins. I couldn’t cannulate. I tried 5 times; we’re only supposed to try 4”
Using their own hand, Max explained the process they had attempted, which had resulted each time in the vein collapsing.
“So what did you do?” I asked.
“Well, it was [the patient]’s last dose, so I called [name of consultant at the hospital] and suggested that we call it a day” Field notes, 20th October 2016

This exchange between Max and I was somewhat unusual; in that it was an example of a nurse in the Team justifying to a senior doctor, why they thought it was unnecessary to treat a patient. In other words, Max justified why they did not feel that they needed to transform an untreated patient
into a treated patient. The example shows the pressure placed upon the nurses to produce a “treated patient” within the required time and how much effort power had already been extracted from the nurse (without the production of a product) and incidentally, how effort power was also required to justify not producing a product. The actions of Max are consistent with a worker who is working within an environment of responsible autonomy (Friedman 1977); a form of control that I discussed briefly in chapter two and is typically illustrated here by Max’s willingness to adapt to a dynamic situation for the benefit of her employer, as well as her human product.

The mechanism of extracting effort power from workers used here is not unique to NCHNT and is observed by Lloyd (2017) in a call centre environment where worker resistance was present but had little impact on the operational effectiveness of the labour process. A similar mechanism of extracting effort power in a nursing environment is also observed by Ackroyd and Bolton (1999) in their study of a day ward:

The day ward had to be cleared before nurses can leave, leading to drift in times for finishing work. (Ackroyd & Bolton 1999:379)

During my time with the Team, I routinely saw this same “drift” in finishing times, by the nurses in the Team and this was typical on any of their shifts; that is, early, core and late. It was also routine practice within the Team to work through the 30-minute meal break. I personally recall stopping only twice for a meal break, in the 20+ shifts that I worked with the Team. Working through meals breaks to increase effort power is also not unique to my study and is reported by Baines and van den Broek (2017) in their study of care workers. The expansion of shifts and working through (unpaid) meal breaks seems to confirm that work extensification was routinely happening amongst the nurses in the Team.

I mentioned briefly, earlier in this chapter about a new work allocation system that was proposed by one of the nurses. Initially, the new system was to be introduced but its implementation was thwarted because there
was an apparent perception by the lead nurse that “it didn’t work”. It seemed evident to me that the system would not work with the number of patients being treated by the Team at that time, because the whole labour process was being “propped up” by work extensification. This work extensification was effectively masking the true amount of time required to transform the Team’s patients from ‘untreated’, to ‘treated’ each day. The proposed new system was a process based on the systematic allocation of blocks of time for each activity undertaken in the labour process of the nurses in the Team. This system would have shown immediately that there was not sufficient time to undertake all activities in the labour process, in the current allocation of time and so the system was not implemented. It could not be implemented without additional amounts of labour and so the new system was aborted before it began. This aborted system was another manifestation of the level of work intensification and extensification undertake by the nurses in the Team.

4.2.2 Clinical Control

There was some clinical control of the nurses in the Team, as I have already mentioned in the introduction to this chapter and I will now explore the nature of that control and its impact on the nurses’ labour process.

Visual inspection of the nurses’ work at the point of production was periodically carried out by the lead nurse in the Team; this was to check the quality of the nurses’ individual clinical practice and was carried out in the form of an accompanied visit. As I have discussed in an earlier section, this was only possible because of the congruence of skills between the lead nurse and the nurses in the Team. The lead nurse discussed this inspection activity with me one morning when we were alone together in the Team’s office:
I go out with the staff nurses quite regularly; just to make sure they are practicing as they should be. There’s a lot of autonomy in this job and it can be easy to develop different practices. Of course, sometimes they are good practices, which we can all benefit from.

Field notes, 27th July 2016

A similar finding is reported by Breslin and Wood (2016) and this perspective of the lead nurse is consistent with Littler’s (1990) contention that all control systems decay; in other words, they experience increased entropy over time and it is Littler (1990) who suggests that this results in loss of control and a gap between policy and practice. The lead nurse suggested to me that there was opportunity for the nurses’ in the Team to deviate from established practice and the inference was that the purpose of their visual checks was to ascertain if this was the case and if it was, to take correctional action. The lead nurse checked the work of the nurses in their team, to mitigate against this entropy, which could result in ‘different practices’ and reduced control and my exchange with the lead nurse suggested to me that the primary reason for the check on a nurse’s clinical work was to ensure that their work was consistent with established practice. This was a form of simple control (Edwards 1978) of the nurses’ labour process.

As something of a “postscript” to our exchange, the lead nurse also seemed to suggest to me that their checks sometimes highlighted practice amongst the nurses, which was an improvement on established methods and therefore there was a potential for positive outcomes from their visual checks, in the form of spreading of good practice. However, I believe the primary purpose of the visual inspection by the lead nurse was to ensure the nurses in the Team were following established practice and procedure; as laid down by their employer and subjectively assessed by their immediate manager, to ensure that clinical standards were maintained in the transformation of untreated patients into treated ones. My perception of the purpose of the lead nurse’s presence on some of the nurses’ visits to patients, appeared to be confirmed during a conversation that I observed, between several of the nurses in the Team:
Prior to Billy’s [lead nurse] arrival in the office, there was a discussion about tourniquets. Chris announced that they should all be using the paper ones.

“Tell Dale”, someone suggested.
“I use my own” responded Dale.
“Don’t let Billy see you when they come out with you – use the paper ones”, someone advised.
“But they are disposable, I buy them myself” responded Dale again, somewhat wearily. Field notes, 28th July 2016

This exchange between the nurses indicated that the nurses’ viewed Billy’s presence with them on a visit to a patient, as a visual inspection to ensure that they were conforming to established practices and procedures. In this particular instance the issue the nurses were discussing was associated with tourniquets and related to a view shared by the nurses in the Team, that the “paper ones” were clinically ineffective, but had to be used (according to their employer) to reduce the risk of infection. Hence, Chris’ advice to Dale that they should use the paper tourniquet, when the lead nurse accompanied them on a patient visit. The perception of these nurses in this exchange was that Billy’s visits were for the purpose of checking and correcting any divergent practice; an example of simple control.

4.2.3 Bureaucratic Control

In chapter two I outlined the broad mechanism of bureaucratic control, as described by Edwards (1978). However, according to Littler (1982), it is fruitless to try to achieve a single definition of bureaucracy that covers all meanings and use. Notwithstanding, bureaucratic organisations are usually seen as rational places, where control and compliance of subordinates relies on their attitude to and perception of the nature of control relationships (Littler 1982). The mechanism of bureaucratic control depends on the interpretation of formal rules by supervisors and managers and the legitimacy of this control being accepted by subordinates (Littler 1982).
As I have outlined in chapter three, the Antibiotics Team was part of the NCHNT, which in turn was an organisation forming part of the NHS in England. In this respect, the Team was part of the fabric of a large, networked bureaucracy and as such manifested the usual signs of that type of organisation; standard pay grades, recognised career progression, stable employment and formal rules for clinical and management activities. As such, the nurses in the Team were subject to a myriad of policies and guidance, an example of this was highlighted in the previous section relating to the use of tourniquets. The policies and guidance were published by the nurses’ employer (NCHNT) and sometimes by the local hospital who were the source of the Team’s patient referrals. I discussed this arrangement with Chris, during our interview:

Chris: We’re in a unique position in that; some of our work, we work with our Community Trust guidelines and policies; but these are underpinned by the guidelines we are given by the Acute Trust – who give us most of our patients…So, this can mean, we work to their guidelines as well; so we have our own guidelines plus their guidelines…It’s just in terms of how you administer drugs and how they want them administered. We work to their guidelines, that’s the main guideline that we work to…

Me: Right. So, can you give me some examples of them?

Chris: How long you would run an infusion for a specific drug, at a specific dose over…that’s the main thing…because that’s the majority of what we do

At the point of production – that is, the patient’s home – the nurses in the Team were required to work in accordance with documents that they referred to variously as “care plans”, “treatment plans” and “medical management plans”. These plans were patient-specific and informed the nurses in the Team of the patient’s required treatment, including the antibiotic they were to be treated with, the dose and the method of infusion. Within the Team, the nurses had their own views about the effectiveness and legitimacy of these plans:
Chris told me that the consultant had provided the team with a “medical management plan” for the patient, but it was too “woolly” in Chris’ opinion. Chris contrasted this with the plans produced in acute settings, which they said were very specific about what should happen… Field notes, 16th September 2016

In this extract from my field notes, Chris was complaining about the lack of detail in the plans, compared with their previous experience of similar documents in an acute setting; yet these plans had a controlling purpose and as Bolton and Wibberley (2014) point out, they are not benign artefacts, but are designed to reflect dominant interests and priorities; the completion of doctors’ instructions at a distance. This was suitably illustrated in the negative reaction of the nurses, when the care plan layout was changed:

…almost immediately there was a chorus of disapproval about the new ‘care plan’ form, which had been introduced over the last week or so. Chris directed their comment, but not their anger at me: “You see, this is what we have to put up with….” They then proceeded to explain that the form had been designed for medics without consulting the team…I was keen to show interest in a topic that was of concern to at least some of the nurses and so I looked intently at both versions of the form. The nurses in the team liked the old form because (according to them) everything they needed to know was clearly visible on the front page – they described this as a “snapshot” of the patient. The new form had the same or very similar information on it, but this had been moved to the reverse of the form and did not at first glance, seem to be set out as clearly as in the original form – it was very ‘busy’ in terms of layout. All the nurses present seemed unhappy with the new document and complained that the information now on the front of the form was not relevant to them; it was microbiology information, which the nurses felt was useful only to the medics and which would only be looked at by them, about once a week. In contrast, the nurses claimed that they looked at the information relevant to them, on a daily basis. Field notes, 9th August 2016

This chorus of disapproval amongst the nurses supported Bolton & Wibberley’s (2014) claims about the care plan document – it reflected the
dominant interest of medical staff, whose use of the form was prioritised despite not utilising it as regularly as the nurses in the Team. It is Bolton and Wibberley (2014) who also acknowledge that these types of documents are not all-encompassing reflections of a carer’s work with a patient:

The care plan attempts to create a standardised, task-based model…in reality, it is unlikely that the…setting would support such a simplified approach. (Bolton & Wibberley 2014:692)

This lack of detail about the nurses’ work, described by Bolton and Wibberley (2014) was also typical of the nurses in the Team. There appeared to be a lack of comprehension (by their employer) of the nurses’ work and this is an issue that I will return to in the next chapter.

A further example of bureaucratic control being exercised on the nurses in the Team was the processes associated with the recording of patients’ treatments post factum. The nurses in the Team – like all other nurses – had to record the details of treatments and visits to patients; as highlighted by the Nursing and Midwifery Council in their code of professional practice and behaviour:

Keep clear and accurate records relevant to your practice. (Nursing and Midwifery Council 2015)

The recording arrangements were somewhat unusual, in that the nurses had to document their visits twice; once on paper records kept in the patient’s home and then again electronically, on records held in the NCHNT’s patient records system. This meant that the work of updating records was effectively done twice, by each nurse for each patient. The paper record was used by all the professionals involved with a particular patient, to facilitate the management of a patient’s care; it was viewed as the central record for all involved parties. If a social worker, GP or district nurse visited a patient, they would also document their visit in the same paper record – kept at the patient’s home. In something of a contrast, the
The electronic record was updated with patient information and the clinical outcome of a visit, solely by the nurse, on NCHNT’s computer system. I never observed the nurses in the Team using the computer system to retrieve information in “real-time” on patients. Here the mechanism of bureaucratic control was more obvious. The information input by the nurses into the computer system was used to measure the outcome of their labour and to compare with perceived norms within, across and outside the organisation; it appeared to have no direct benefit to the nurses themselves. The following exchange with Sam – taken from my field notes – highlights their frustration and personal perspective on the double-recording element of their job, as well as perceptions of their professional obligations and the legitimacy of the electronic record:

As we neared the health centre, Sam said that they wouldn’t have time to update [name of computer system]:

“I’m already three days behind with input – but if they don’t give you time to do it, what am I supposed to do?”

“Anyway, as far as I’m concerned, I discharged my duty when I wrote up the patient’s notes in their home.”

It was after 9.30pm when we arrived back at the health centre. I got to my car, almost too tired to drive home. Field notes, 25th October 2016

I have deliberately included my feelings of tiredness in the extract above, to illustrate my physical state after a long shift. I can only assume that Sam felt similar. It was 30 minutes beyond the end of Sam’s shift and work extensification had already occurred and this would have been extended if Sam had updated their patient records on the computer system for that particular shift. Sam’s remarks to me emphasised the view I had already formed, that the nurses saw the paper record in the patient’s home as the ‘real’ record; the updating of a patient’s electronic record was seen as something that was done, only when a nurse had “the time”. This act of untimely record-keeping was one of the few opportunities, the nurses had open to them, to reduce the impact of intensification and extensification of their work.
4.2.4 Patient Control

In this final section on control, I want to briefly explore how patients treated by the nurses in the Team were used as unconscious agents of control. Here is a short extract from my interview with Sam:

…trying to get to patients for a specific time – might cause a bit of trouble or stress, if struggling or battling through rush hour, or wherever it is. Sam, Interview

This statement from Sam illustrates how patients themselves were unconsciously used as a mechanism to control the nurses in the Team. The nurses felt a professional and indeed a moral obligation to their patients and did not want them to be anxiously waiting for them to arrive to carry out their treatment and the nurses ‘owned’ this problem of time and felt obliged to carry out their work as quickly and efficiently as possible. An extract from my field notes, provides another example of how patients were used as part of the mechanism of control:

Chris returned to the car, having received a call from Billy [the lead nurse], whilst in their patient's home. The next patient had been calling Billy to ascertain what time Chris would arrive. Billy had called to chase up with Chris; Chris was furious.
“I haven’t stopped”
“I even gave that infusion quicker than I should, because of time”.
Field notes, 27th September 2016

This incident shows how patients became unwitting agents in the mechanism of control within the Team. As Billy [the lead nurse] called to check on Chris’ progress, their action, I believe was seen by them to be legitimised, because they were acting as a proxy for the patient. Chris reacted to this time-pressure and control by behaving in a non-compliant way; I might even suggest Chris was showing signs of what LPT would label ‘resistance’. However, it is clear from this example that the patient’s actions impacted on the pace of the nurse’s work and their behaviour may well have impacted negatively on the quality of the final “product”; that is,
Chris admitted to running the infusion quicker “…than I should…”. It is Delbridge (1998) who argues that management control is legitimised through a worldview which accepts that a quality and efficient manufacture are paramount and it seems that on this occasion, that control may have extended to healthcare; where a hybrid of direct and technical control is legitimised, through an organisational and professional view, that patient care (superficially, at least) is paramount.

4.3 Compliance, Consent and Struggle

Any analysis of the labour process of a group of workers, which is informed by LPT should include an understanding of compliance, consent and struggle amongst those workers. It is Burawoy (1982) who suggests:

Conflict and consent are neither latent nor underlying but refer to directly observable activities that must be grasped in terms of the organisation of the labour process under capitalism. Burawoy (1982:12)

It is a central theme of LPT that workers consent to their exploited role in the labour process and continue to reproduce and reinforce the power and control dynamic between managers and employees (Thompson & Smith 2009; Lloyd 2017). In the earlier sections of this chapter, I have outlined what Burawoy (1982) calls the practical aspect of my analysis of the nurses’ labour process; that is the activities which transform raw material into useful objects (or services). In this section, I will outline what Burawoy (1982) calls the relational aspect of my analysis; that is the nature of the relationship of the workers with each other and between the workers and their employer – or a proxy for their employer. To understand this relational element of the nurses’ labour process, I will use the concepts of compliance, consent (Burawoy 1982) and struggle (Fleming & Spicer 2008).
4.3.1 Compliance

Satellite Navigation

All the nurses in the Team, relied heavily on satellite navigation technology to direct their journeys between patients. The technology they used was not that usually embedded into smartphones, but rather, satellite navigation equipment, dedicated to the purpose and mounted on the dashboard of their car. This equipment was commonly referred to as the “satnav” by all the nurses and its impact on the nurses’ day-to-day activities and thus the labour process, was significant. The satnav had primacy for navigation and was used by the nurses to move between their points of production. The geographical area that the nurses covered in NorthCity was extensive – approximately 20 miles across in both a North/South and East/West direction. The extent to which the satnav was relied upon by the nurses in the Team is typically illustrated in this extract from my field notes:

> It was around 2pm when Alex and I headed out to our first call. As I settled into the passenger seat, Alex input the postcode for our destination in the SATNAV.

> “It won’t recognise the postcode” Alex said

> “Really? How come?”

> Alex re-input the code and I watched, to confirm that the postcode on the visit sheet was the same as the postcode they were typing in.

> “Address Not Found” the SATNAV proclaimed.

> “I can close in on the address using the map” Alex said, hopefully,

> “Sounds good, do it” I said, trying to seem confident.

> Alex found the address using this method and we were on our way.

> “It’s a new SATNAV” Alex said proudly

> “I thought it was different somehow. Could the other one have done that?” I asked

> “No” confirmed Alex.

> “Good job, you got this new one”

> “Yeah, otherwise I’d have had to phone Pat in the office”

> “How much?” I asked, pointing at the SATNAV,
“£150” replied Alex. I reflected on this; Alex used their own money to purchase a tool, to do the job the way their employer expected it to be done. Field notes, 19th October 2016

This extract from my field notes is illustrative of the importance placed upon satnav technology by the nurses in my study. It was only because Alex had recently upgraded their satnav equipment – at their own expense, that we were able to gain the expected navigational support from the technology. The alternative would have been to contact the office, confirm the address of the patient and then use the ‘old-fashioned’ method of navigation by way of a map or ‘street by street’ book. If this had been the case, it would have used up valuable time and that time loss would have been “owned” by the nurse; an issue I have already referred to within this chapter.

The satnav was an essential tool for carrying out the work expected of the nurses in the Team. It would be practically impossible for an individual nurse to possess all the geographical knowledge required, such that they were able to navigate their way around NorthCity and visit all their patients in the time expected of them by their employer. Yet, as I learned from several of the nurses I accompanied during my fieldwork, the satnav equipment was not supplied by NCHNT, but rather purchased by the nurses, at their own expense.

**Mileage Allowance**

This financial outlay on technology was not the only source of financial cost to the nurses, relating to navigation around the point of production. Alex confirmed to me that they always set the satnav equipment to the quickest route. This meant that the technology directed them on the fastest route to their destination – to make the most effective use of their time – but not necessarily the shortest one:
I watched Alex input their expenses on to a computer system and they also explained how the system worked...they mentioned that the mileage is automatically worked out by “the system”, which bases calculations on the shortest route. Alex always sets their satnav for the fastest route, which could be longer.

“So, the Trust benefits” I concluded. Alex agreed, but said they could set the satnav to give them the shortest route; then added: “I wouldn’t, because we always want to get there in the quickest time.

Time is important.” Field notes, 27th July 2016

As illustrated in this extract from my field notes, Alex appeared unconcerned by the inconsistency of their employer’s approach to effective use of time and seemed unaware that if time was so important, the burden was on NCHNT to supply appropriate, technological tools and to financially incentivise their employees to take the fastest and not the shortest route, when these routes differed. Alex’s primary concern was treating their allocated patients in the time expected of them by NCHNT and yet the system of mileage payments did not incentivise the nurses to do this and yet they did it anyway. NCHNT relied on the nurses to have this motivation for themselves – as I have outlined, often to their financial disadvantage. In the purchasing of appropriate technology and accepting inadequate reimbursement for fuel, the nurses in the Team were complicit in their own financial exploitation.

This issue of compensation for mileage came up again later in my fieldwork, when I accompanied Chris on a late shift one evening. We were on our return journey to the health centre at the end of the shift, when a road closure meant we were diverted. For once, the satnav was silent – as the technology tried to calculate a new route. The extract from my field notes about the incident, typically illustrates the issue I want to highlight:

On our way back to the office, we were diverted due to a road closure. Chris commented that the mileage they drove as a result of the diversion would not be paid by the Trust. Chris did acknowledge that there was a “diversion allowance” that could be claimed, but it was obvious from their vague understanding of this allowance, that they had never claimed it. Field notes, 27th September 2016
As I reflected in my field notes, Chris was unlikely to claim this “diversion allowance” it was too inconvenient and ‘fiddly’ to claim. They would have had to note down manually the mileage covered by the diversion and then remember to claim this back at the end of the month. It was not convenient to do this work and it would also waste more of the nurses’ most valuable resource (time) to do it.

The satnav is an example of how the nurses were impacted – to their financial cost – for carrying out their day-to-day work and it seemed to me that this was accepted by them, without resistance; their attitude appeared to be one of resignation and acceptance. The absence of appropriate technology supplied by NCHNT, had forced every nurse in the Team to purchase the necessary equipment at their own expense and then set up that same technology in such a way, as to ensure that the work they were required to do, was done at a speed acceptable to their employer, their patients and indeed (based on the degree to which they complied), themselves; even if they were financially disadvantaged by their own actions. This compliant behaviour by the nurses in the Team, again demonstrated that any time-delay in production was owned by the nurses themselves; not their employer. I suggest that it was this burden of ownership that dictated their attitude to the purchasing and set up of their own “satnav” equipment. I also suggest, based on my observations, that this ownership of the ‘time problem’ was also the reason for the nurse’s lack of interest in claiming mileage allowances that they were entitled to claim from their employer.

4.3.2 Consent

It was Burawoy’s (1982) seminal work that introduced the concept of worker consent into labour process theory. In his book, Burawoy (1982) argues that the games played by workers are not created in direct opposition to management; but rather, they emerge from within the conditional limits placed on the worker by their employer; he states:
...just as the possibility of winning or maximising one’s utility makes a game seductive, so the possibility of realising one’s interests, of satisfying one’s needs, defined by capitalism...is the very means for generating consent to rules and relations, presenting them as natural and inevitable. (Burawoy 1982:93)

It is from the context and concept of consent that I begin this section and outline some of the ways in which the nurses in the Team consented to their own exploitation.

Car

Since Burawoy (1982), the concept of consent has been developed further with some authors maintaining that workers consent to their own exploitation and continue to reproduce and reinforce the power and control dynamic between their employer and themselves (Thompson & Smith 2009; Lloyd 2017). During my time with the nurses in the Team, I observed a number of examples of consent and one was the contractual requirement for all the nurses in the Team to have a “reliable” car. This issue came up spontaneously during a conversation with Sam, as I accompanied them on a shift:

In passing, I commented on Sam’s car.
“I’ve only had it since Christmas” they said and then they told me that their previous car was getting old.
“There is something in our contract about having a good car” they added
I probed about what that meant in practice.
“You can’t not come into work because of problems with your car, you have to be able to find an alternative.” Field notes, 28th September 2016

Just like another problem in production (around time), the nurses’ employer had successfully transferred the problem of unreliable equipment effecting production, to the nurses – who also owned any problem associated with motor equipment failure. Sam was not complaining about this aspect of their employment contract; they were
merely stating it in a matter-of-fact manner and yet this is exactly what Lloyd (2017) predicts:

> Capitalism structures our social relations and social reality and whilst we believe that we know about its exploitative conditions and oppressive practices, we wilfully participate as if we did not... (Lloyd 2017:276)

This unconscious inevitability was also suggested by Marx and referred to as fetishism (Thompson 1989).

### 4.4.3 Struggle

As I discussed in chapter two, the word “struggle” seeks to encompass all moments of resistance – both individual and collective – within a contemporary organisation. I have chosen to use the word “struggle” in my analysis of the work of the nurses in the Team, rather than the more traditional word “resistance” – because I feel that it better describes the moments that I observed during my time with them.

**Individual Resistance**

There were several incidents that drew my attention, in relation to the whole concept of struggle, but a key one was a particular nurse’s reaction to the rejection of the proposed new work allocation system, which I discussed earlier in this chapter. I was with Sam all shift on the day they told me that the proposed allocation system would not be implemented that week. Sam’s reaction was one of both disappointment, anger and a motivation to resist both individually and possibly collectively:

> From what I could gather from Sam, Billy [lead nurse] had accepted a number of new patients over the weekend and then told Alex that the allocation system didn’t work. Alex had then told Sam...Sam talked about it being demoralising for the team, because overwork was, as I think I described it “built into the system”.

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“Exactly. We need to come together as a team, not just me” said Sam

Later Sam talked about getting the unions in “as a last resort”. Sam seemed frustrated and quite angry at what they perceived as a poor way of managing…I tried to be a little more optimistic and suggested that the lead nurse may decide to implement at a later date.

“They might, but I doubt it” Sam said

“If they say we have to work faster, well…” Field notes, 20th October 2016

I have included this extract from my field notes, to illustrate two aspects of Sam’s resistance. Firstly, they were individually resisting the burden of work that they felt was being placed upon them by their employer, through moaning and a sense of disappointment and anger. In this exchange between Sam and myself, I sensed a growing anger within Sam about the situation surrounding the proposed work allocation system, which was palpable as we sat together in the car. Secondly, Sam suggested that they and their colleagues should galvanise and collectively resist the demands being placed upon them by their employer. Sam also suggested that (if necessary) they and their colleagues should initiate formal support from their trade union. This was a suggestion of collective resistance, as well as the individual resistance manifest by Sam alone.

**Collective Struggle**

This need to “come together” was manifest again in my interview with Sam, where they discussed a colleague in the Team who – according to Sam – seemed to be unconcerned by the habitual pattern of working beyond the end time of their shift; something that I discussed earlier in this chapter and I had observed to be somewhat normalised within the Team:

Sam: …most of us are just very conscious of how precious the time is and we don’t want to be [like] staying over, every day – which is what most of us are doing. So, I suppose if you weren’t bothered about it, like [name of colleague] isn’t – doesn’t seem bothered and you were happy to be late off
every day, then maybe it’s not a stress and you just breeze through it

Me:    Yea and it takes as long as it takes…

Sam:   But I think most of us actually want to go home on time…it’s just a different type of time management. It’s not the end of the world…and actually it can be resolved very easily with decent scheduling, it’s just a shame we’ve not got there yet (laughs). Interview, Sam

In this interview extract, Sam is unhappy with the attitude of one of their colleagues who they believe is not showing the appropriate attitude to the work extensification that Sam believes is now normalised in the Team. Sam also makes the link between the work extensification they experience and with the work allocation system that they themselves proposed and which was subsequently rejected. There is a degree of cynicism in their comments, which as I have previously discussed is a manifestation of individual resistance.

However, the opportunity to discuss work-related issues together as co-workers was very limited amongst the nurses, due to the arrangement of their shift patterns (see Figure 1) and so opportunities for organising any form of collective resistance were logistically, quite limited. This seemed to me to be of some benefit to their employer; Edwards (1978) suggests that this can be deliberate on the part of an employer:

…organise production in such a way as to minimise workers’ opportunities for resistance and even to alter workers’ perceptions of the desirability of opposition. Work has been organised…to contain conflict. In this endeavour employers have sometimes been successful. (Edwards 1978:112)

I have no basis on which to comment about the consciousness of these arrangements by the nurses’ employer; but what I want to suggest is that it almost certainly had the consequence of reducing the overall level of overt resistance and struggle by the nurses, as a collective:
Conflict at work then, must be understood as a product of the strategies or wills of the combatants and of definite conditions not wholly within the grasp of either workers or capitalists. (Edwards 1978:112)

The nurses in the Team did have the opportunity to exercise some resistance in the form of the exercising of mobility power; as there was always the threat to their employer that they could leave and find alternative employment (relatively easy to achieve within the NHS, which has high numbers of nursing vacancies). Mobility power is a concept that I will discuss further; later in this thesis.

4.4 **Summary**

In conclusion, the findings discussed in this first empirical chapter, I suggest are covered in four broad themes. Firstly, work intensification and extensification; secondly, elements of hidden work; thirdly, consent and fourthly, struggle. I will summarise each of these themes in turn.

In this chapter, I have included several examples of the nurses in the Team, experiencing work intensification. As I have referred to throughout, the expectation of the nurses’ employer was that each nurse would treat every patient allocated to them on a shift. However, I have shown that the work allocation system operating in the Team did not consider the different lengths of patient treatments and as a result, there was always the potential for unequitable division of work. The issues relating to the proposed, new work allocation system illustrated well the level of work extensification required to adequately undertake the nurses’ labour process to produce the required number of ‘products’. The nurses in the Team had to update two patient record systems – both electronic and paper; as a result, this work was a form of duplication and often resulted in either work intensification, or non-compliance with professional guidelines by the nurses in the Team. Due to the significant amount of driving involved in the labour process of the nurses in the Team, time
available to treat their allocated patients could be shrunk by delays caused by traffic in NorthCity. These delays resulted in either work intensification for the nurses, or else they were ‘forced’ to work beyond the end of their shift to ‘create’ time for treating their allocated patients and in so doing, supplied unpaid labour to their employer. Indeed, the nurses’ scarcest resource and most precious ‘raw material’ was time and it was the limitation of time that enabled their employers to extract extra effort power from the nurses’ capacity to labour, because the problem of lack of time (a raw material in the nurses’ labour process) was owned by the nurses themselves – not by their employer. Within a capitalist system there is something of an inevitability to this outcome in services which are labour-intensive, like nursing (Braverman 1974; Mather et al. 2007). It has been suggested by Baines and van den Broek (2017) that NPN-influenced services (like healthcare in the UK) produce and reproduce a production environment, where a chronic lack of time is a constant feature. This was certainly my experience of my period observing and spending time with the nurses in the Team and as I have discussed, this was a key element in the mechanism used by their employer to control the work pace of the nurses and also to maximise their effort power.

In this chapter there are several examples of hidden work performed by the nurses in the Team. The gathering and assessing of information, which related to their patients’ social and environmental context was one example of this hidden work. As I have shown in this chapter, this aspect of the nurses’ labour process was not explicitly acknowledged by their employer and not even by the nurses themselves. Another example of hidden work was that performed by the nurses as they drove around, between patient visits, using their tacit knowledge of traffic and traffic behaviour to establish the most efficient order for visiting their patients; like the previous example, this work was also not acknowledged by the nurses themselves and not explicitly acknowledged by their employer (in so far as, it was not accounted for adequately, as part of the nurses’ labour process).
In this chapter, I have also highlighted aspects of consent, resistance and struggle by the nurses in the Team, in response to the demands placed upon them; by their employer, by their patients and by themselves – collectively and as individuals. The extent to which the nurses consented and complied with the demands of their labour process is optimised by their ownership (rather than their employers) of some of the production problems that could befall their labour process; namely, time delays due to environmental conditions and equipment failure. The extent to which the nurses resisted or struggled with the conditions associated with their labour was – at times – minimal. Distinct struggle was evident amongst some individuals, in the form of moaning and cynicism; but collective struggle was notable for its relative absence.
Chapter 5

Findings – A Challenge
5 Findings – A Challenge

In the previous chapter, I considered how the capacity to work is transformed into labour and I examined the relations between the nurses and their employer (NCHNT), particularly those associated with the conversion of labour power into actual labour. I also looked at the methods used by their employer to control these workers and the nature of the struggle in those relations; that is, between the nurses and their employer. In this chapter, I continue my analysis of the nurses in the Team and explore how the nurses exercised degrees of discretion within their controlled environment. I also explore further the nature of some of the invisible work the nurses carried out and how some of this invisible work appeared to provide for them a measure of accomplishment, as well as personal and professional satisfaction – perhaps beyond that which is theoretically suggested, from an orthodox understanding of LPT.

This second findings chapter will be split into the following main sections; invisible work, discretion, autonomy and professional vulnerability and joy and sorrow. The chapter will conclude with a summary and an introduction to the next, discussion chapter.
5.1 Invisible Work

In this section of the chapter, which describes the different forms of invisible work undertaken by the nurses in the Team, I discuss to whom the work is invisible and in the case of these nurses, it is at times to their employer, to their patients and also to themselves. This is not uncommon amongst workers who may not be able to articulate the tacit skills they possess or have the confidence with which to make such claims (Allen 2015). An understanding of invisible work is important, because it forms part of the labour process, in the same way as those elements of work, which are visible and acknowledged. I split this section into two headings; environmental knowledge and informal assessment, social knowledge and commitment, which help to categorise the types of invisible work that I identified, whilst I was observing the nurses in the Team.

5.1.1 Environmental Knowledge

I have outlined in the previous chapter the use of and reliance placed on satellite navigation equipment by the nurses in the Team, which enabled them to locate the homes of their patients quickly and effectively; without the need to resort to hard copy maps. However, it would be presenting only a partial picture, if I did not elaborate on the knowledge that was possessed by the nurses about their environment, particularly relating to traffic and traffic behaviour. In LPT terms, this work is labour undertaken without the explicit direction of the nurses' employers; but is nonetheless necessary to carry out the nurses' work and is therefore a part of the informal labour process, as highlighted by Bolton & Wibberley (2014):

...the informal labour process is activity, which is excluded from the prescribed labour process but, nevertheless supports it... (Bolton & Wibberley 2014:683)
At the start of their shift, the nurses were given a visiting order for patients. However, the nurses’ knowledge of traffic and traffic patterns sometimes resulted in them changing the order in which they visited their patients during a shift; as typically illustrated from this extract from my field notes:

Chris had decided to see this patient before the ‘second patient’ on the sheet of calls because time and mileage-wise, they felt it was more efficient and they also needed their other patient to be more “bright-eyed and bushy-tailed” than they would be if we had gone in the scheduled order. Field notes, 1st August 2016

This field note demonstrates how the nurses combined knowledge about their patient with environmental knowledge, to work out the most appropriate course of action within their labour process. In this case, the action benefited the patient (a more effective visit), the employer (less mileage) and the nurse because it saved time and as I have highlighted in the previous chapter, the “time problem” was always owned by the nurses. This tweak to the order of visiting seemed at first to me like a minor adjustment, but when put in the context of their overall labour process and viewed holistically, this was invisible work within the labour process, because it required a sophisticated knowledge of their environment, their patient’s routine behaviour and needs and the expectations of their employer. It also required the nurse to assess any potential impact that their changes may have on the efficacy of their patient’s treatment.

The impact of traffic and traffic patterns meant that sometimes it was more time-efficient for the nurse to travel directly from their own home, rather than drive to the health centre and then travel from there, to their patient’s home. This practice was discussed in my interview with Alex:
Alex: ...for instance, this morning when I came in. You would usually come to the office for quarter-past seven and then start your visits. But my first patient was closer to my house, than to the office – so I just went to see them straightaway.

Me: Right, yeah.

Alex: So, I was at their house for quarter-past seven, rather than trying to battle my way through the traffic at 8 o’clock. Which wouldn’t really make a great deal of difference to be honest, to their treatment. But it would probably save me an hour sitting in traffic. Alex, Interview.

Alex’s behaviour and attitude were typical of the nurses in the Team; that is, time was their most valuable resource and they would do anything to preserve it, as long as it had no material impact on the treatment of their patients. However, this course of action had been decided upon by the nurse – in this case Alex – using their environmental knowledge of the area they worked in. Like the previous example, this decision by Alex (to see the patient before going to their work base), benefited the employer (less mileage) and the nurse, because as in the previous example, it saved time. It was a revision of the labour process, but one that required Alex to use their knowledge to fulfil a commitment to their patient and due to their continual ownership of the “time problem”, it meant they were consenting to their employer’s need to keep costs down – through efficient use of time and less mileage driven.

During my time with the Team, I realised that the extent to which the knowledge of traffic and traffic patterns was essential to the nurses’ labour process but was largely hidden from the nurses themselves. When I pointed out that they possessed this knowledge, that it was vital to enable them to carry out their role and suggested that it was probably not something generally associated with nursing, Sam said:

...You’d probably associate it more with taxi drivers, or with delivery drivers, wouldn’t you? Sam, Interview.
Sam was typical of the nurses in the Team, who seemed unaware of the importance of this tacit knowledge, which they possessed, and which was an essential, but unacknowledged element of their work. It was knowledge that enabled them to carry out the work that their employer expected them to do; that is, for all patients allocated to a nurse to be treated in a single shift; it was a responsibility owned by the nurse and not those who designed the rota.

5.1.2 Informal Assessment, Social Knowledge and Commitment

During my time with the nurses in the Team, I noticed that as well as undertaking a clinical assessment of their patients they also carried out, what I would like to term an “informal assessment” of their patient on each visit. When I discussed this in my interview with Sam, they suggested that this was because the patients treated by the Team were medically stable:

…because they [the patient] are stable [clinically]…that tends not to be an issue for us, so we probably end up talking about the social side of things more…that is much more fluctuating than their medical issues… Sam, Interview

I believe that Sam was underplaying the significance of this unseen and unacknowledged aspect of the nurses’ labour process; I suggest this, not to imply that ‘I know best’; but as an individual who is not a nurse and an observer who spent many hours with these nurses and saw on a day-to-day basis how diligently they treated the patients in their care. These patients were medically stable, but all were sufficiently unwell to require regular (sometimes daily) treatment of intravenous antibiotics and would have had to remain in hospital, if the community service delivered by the Team was not provided in their area. This informal assessment and the gathering and processing of information relating to their patient’s social circumstances was not, it seemed to me entirely driven by a lack of other medical issues to talk about (as inferred by Sam); but rather a concern on the nurse’s part for their patient, their patient’s family and a desire to
undertake a thorough and holistic, informal assessment of their patient’s circumstances; a view incidentally, supported by Sam:

…I think it should be a holistic thing. And that you shouldn’t be so focused on the medical stuff…You just keep an eye on it. Sam, Interview

The informal assessment carried out by the nurses in the Team was not a process that was in any way operationalised by their employer. Indeed, the way in which the assessment was undertaken was unlikely to have been consciously perceived by the patient and from my discussions with the nurses, was barely acknowledged by them, until I became aware of it and consciously drew their attention to it. I discussed with some of the nurses in the Team how this invisible work was carried out and the differing methods they used to do it. In the following interview extract, Alex discusses their approach to these informal assessments:

I think it’s hard not to when you’re there to make an overall kind of assessment, in your opinion. I think it’s difficult not to do that, because you do spend time with them. You might be unaware of it, but you are constantly thinking and assessing with things that they say, the mood, with what the house is like, what their relationship is like with other people. You are constantly assessing… Alex, Interview

In this interview extract, Alex seems to support my view that the nurses were barely aware of the assessment that they were undertaking – subconsciously – on a regular basis, with every patient. Alex’s view of the effort required to undertake these informal assessments is something of a contrast with Sam’s view of this work, who seems to suggest that the work required little, if any nursing skill:

I think it’s instinctive with everybody; like you would know going into someone’s house if there was an atmosphere…it’s an instinctive thing and it’s not necessarily a nursing thing. It’s just a human thing. Sam, Interview
I disagree with Sam’s view of these informal assessments, in so far as this invisible work is an “instinctive thing” and not “a nursing thing”. Sam’s view seems to infer that the work required no specialist skill, whereas I would argue that these assessments required a high level of skill and a significant amount of experience as a nurse, to perform effectively. I believe that this was easier for me to recognise, because I was not a nurse and so was looking at this work with “fresh eyes”; whereas the nurse (in this case Sam) was underplaying the work associated with this aspect of the nurses’ labour process (perhaps due to familiarity or the sometimes unconscious link to gender caring roles) and was taking for granted the skill and experience required to carry out these delicate assessments. Again, this seems to support the view I expressed earlier, that the nurses in the Team were not really conscious of the different types of skill-requiring work they were carrying out.

The level of commitment shown by the nurses in the Team to their patients was emphasised to me throughout my time with the Team. This commitment is typically illustrated by some comments made by one of the nurses in relation to some of the patients they had treated in the past:

During our journey back to the health centre in the car, Max told me about the frustration they sometimes felt when they did not know what eventually happened to some of the patients they had treated.
Field notes, 20th October 2016

This view expressed by Max of a lack of an ongoing relationship with patients who had been treated by the Team, contrasted with some of the other nurses who felt it was important to understand where the boundary of their responsibilities lay – not just in relation to past patients, but current patients as well:

…I don’t think we should be sticking our nose in too much, but I think we maybe draw a line – like an invisible line. Sam, Interview
This view of limiting their involvement with patients was supported by Alex who in their interview said:

…I think it’s important for us to know our scope as well. What we can do practically and how we can make an impact. Alex, Interview

What is evident from the perspectives of the nurses highlighted here is that the nurses’ labour process is consciously curtailed by them; not because they were resisting, but because they (perhaps reluctantly) understood that they must accept that there is a limitation to their influence, to enable them practically to carry out their work. Indeed, Alex discussed this issue with me and made a link to the constraints forced upon them due to lack of time:

So, in terms of wider things, such as maybe mental health or mobility; it may sound like we see the patient for a long time…but, I feel like sometimes, we’re pushed for time when we’re seeing them…if they’re a bolus…we’ll see them for 30 minutes and…in that time you may not necessarily have the time to be ringing the GP…or making a referral to an occupational therapist. Alex, Interview

Alex’s views highlighted to me the tension confronting the nurses in relation to their patients; they want to do more for their patients and are even concerned about their future health and wellbeing (after they leave their care) and yet the nurses are also acutely aware that their labour must be limited by the expectations of their employer, professional boundaries and the amount of time they are able to devote to each of their patients. This limitation within the labour process, seems less to do with conventional worker resistance/struggle and more to do with personal commitment and job satisfaction, that is vicariously achieved through the proper care of their patients. It is, however, a consent of sorts; a consent to boundaries that are forced upon the nurses in the Team, through their employer and through a pragmatic operationalisation of the care they provide to patients.
In this section, I have discussed the environmental knowledge that the nurses possess to enable them to participate in the labour process. I have also looked at the social knowledge possessed by the nurses in the Team and how this is crucial in undertaking informal assessments of patients in their care. I have suggested at the end of this section, that the nurses undertake invisible work, which is unacknowledged by their employer and by them. I have also suggested that the nurses are limited by time and this lack of time impacts, not only on the work that they are expected to do (as in the previous chapter), but also on the work that they would wish to do, but are prevented from doing, due to professional convention and a pragmatic realisation of the limitations of their role.

5.2 Discretion, Autonomy and Professional Vulnerability

In the previous chapter, I discussed how the work of the nurses in the Team was controlled by their employer and how this was primarily achieved through limitation of time. In this section, I examine the nurses’ use of discretion and how the nurses justified their own non-compliant behaviour, where this was exercised. I also analyse the degree of autonomy and discretion possessed by the nurses. As part of this discussion, I clarify my interpretation of discretion and autonomy. I also explore the ‘double-edged’ nature of autonomy and assess whether the nurses in the Team – at certain times in the day – were left particularly exposed to professional vulnerability.

A key aspect of the work of professionals is their use of discretion, or autonomy. The distinction between these two concepts, in theory and in practice, is important but also somewhat contested. According to Cheraghi-Sohi and Calnan (2013), discretion is the freedom to act within specified boundaries and autonomy usually means the freedom to act and to dictate the pace of work. In relation to professionals, it is Evetts (2002) who argues that discretion is a concept that will remain; but also believes
that autonomy in its traditional sense, that is, in the sense it relates to traditional professions is in decline.

5.2.1 Discretion

Throughout my time with the nurses in the Team there was a general reluctance to admit that they exercised discretion, particularly if they thought their actions could have been viewed as being non-compliant with established clinical guidelines and practice. The following extract from my interview with Sam relates to the length of an antibiotic infusion. During the interview, I asked Sam if they ever changed the speed (and therefore the subsequent length) of the infusion:

Sam: …to me, five minutes, it’s not saving you much time is it? So, no not really. And we have done in the past, but it’s been patients’ express wish – which is an interesting one. Because they’ve got to go out in 15 minutes and you’ve got no chance

Me: So, would you do it then, if they said…

Sam: Yea, but only to a degree – like I might give it an extra five or 10 minutes, if it was on the hour. But it wouldn’t be enough to alter the dose or affect any patient safety aspects. It would just be more of a convenience thing really

Me: For them, as much as…

Sam: Yea, yea. I mean you have got margin for error on either side. Infusions can be slower, and they can be a bit faster. And it’s really not going to – in my experience – make a blind bit of difference to anything. But it wouldn’t be more than that and if anyone was doubling the speed of anything then that would be a serious thing

In this interview extract, Sam reluctantly concedes that changes to infusion speeds happened within the Team. This is justified by Sam as an accommodation for the patient and Sam was quick to point out to me that this non-compliant action had no patient safety implications and was purely for the patient’s convenience. The nurses were somewhat sensitive about this particular type of non-compliant behaviour; I sensed this was
because it was a more obvious transgression of “the rules” and I believe that this was why Sam felt they had to justify the non-compliance with a benefit (in this case, a convenience) to their patient. However, in my interview with Sam, they did admit that the equipment the nurses used to set the infusion speed was sometimes left on a setting that suggested that the previous user may have run the infusion quicker than was usual. Sam was careful to stress it was others in the Team; not them.

During my time with the Team, I noticed that the nurses also exercised some discretion in relation to guidance around clinical matters. One example was described to me by Chris in our interview; the guidance being discussed in this extract, related to pressure ulcers:

Chris: …it’s very different in somebody’s own home…When they’re independent and in theory it [the guideline] expects you to check everybody. I’m sorry but I am not, it’s not appropriate…
Me: In theory, you’re supposed to check to make sure that there aren’t any pressure ulcers and that would involve doing what?
Chris: Looking at them…
Me: Taking sections of their clothes off?
Chris: Ah-ha. The prime risk being the sacrum yea…So if they are at risk; then yea, you look…
Me: Sacrum is…?
Chris: Your bottom
Me: Right, OK
Chris: Yea, like I’m going to ask some middle-age man, when I’m there on my own. I don’t think so…It’s not appropriate…And if someone’s independently mobile… Chris, Interview

This discussion with Chris illustrates how the nurses in the Team balanced the need to follow a guideline with the appropriateness (socially) of the practice suggested by the guideline. This assessment of ‘appropriateness’ was happening within a matter of a minute, as Chris went on to explain and links with my earlier discussion about the unconsciousness of the
nurses’ invisible assessments and the nature of their work; which I discussed in the previous section of this chapter:

Chris: You ask the question in such a way, that you ascertain whether they know what I’m talking about. I’ve already worked out how mobile – or otherwise – they are and if I think...

Me: So, this is all going on as you walk through the door?

Chris: Pretty much, yea and from just generally chatting to them and things. You know whether they are at risk or not and take into consideration their past medical history as well. What other conditions have they got going on? Are they diabetic? Could put at higher risk...Do they sit in that chair all day? Higher risk.

Chris, Interview

My discussion with Chris here is important because it illustrates the level of skill and experience required to undertake the work of the nurses in the Team. It illustrates the speed at which the nurses were required to make these assessments about the patient in front of them; a patient who is not in the structured and controlled environment of an NHS hospital, but rather, in their own home. As I have described in the previous section in this chapter, much of this work was unseen, but also, much of it was subtle tweaks and adjustments to their labour process, which were initiated by the nurses, not by their employer.

However, given my prolonged exposure to this group of nurses it would be easy for me to portray them and their work in an overly romantic way; self-sacrificing carers with altruistic motivations and whose only concern was for their patient and their patient’s welfare. Whilst this may be partially, even largely true, it is not the complete picture and in the following incident – relating to tourniquets – I hope to illustrate that sometimes their non-compliant behaviour did benefit them, in so far as it made the performance of their work a little easier.
“Dale’s tourniquets were ok?” I asked
“Yes” confirmed Chris
“So which one can’t you use?”
“Cloth ones – because of the risk of infection” replied Chris. “Unless you’ve washed it at 60 degrees” they added.

I got a sense from the conversation and discussion on tourniquets, that at least one of the nurses in the Team, used a cloth one on a regular basis. Field notes, 28th July 2016

I initiated a further discussion about tourniquets with Alex, later in the shift:

During our late evening conversation...I mentioned the ‘tourniquet incident’ again and asked Alex what the problem was. They laughed and then explained that a tourniquet is used to help find a vein when injecting a patient with a needle. The tourniquet supports this procedure by blocking blood passing through the veins at the point of the tourniquet but allowing some blood to pass through the arteries – causing the veins below where the tourniquet is applied to become enlarged. This works because the blood pressure in a vein is less than the blood pressure in an artery. The tourniquet must be flexible and ‘give’ a little, to allow blood to flow in the artery but not in the vein. Alex said that the problem with the paper tourniquets was that they did not do this – they had no ‘give’ – consequently colleagues didn’t like using them. The ‘old-style’ tourniquets were made of cloth-like material...but were believed to be a potential source of cross-infection between patients...Alex said that Dale bought their own rubber-like tourniquets, which were disposable and crucially possessed this ability to ‘give’... Alex and I speculated on whether the paper tourniquets were ‘standard issue’, because Alex said they were used at their previous job; Alex joked that if somebody...was struggling to find a vein, they would say: “Has anyone got a ‘real tourniquet’?” I laughed. Field notes, 28th July 2016

This incident illustrates that on this occasion, some of the nurses in the Team may have engaged in occasional non-compliant behaviour to make their work easier for themselves, even though this carried a potential risk to their patients. However, this incident also shows that one of the nurses was willing to incur personal cost in order to use a more clinically effective
piece of equipment; rather than risk the possibility of cross-infection between their patients.

5.2.2 Autonomy

Following on from the previous section relating to discretion, it seems that the levels of discretion possessed by the nurses in the Team (within their own labour process) may indicate a degree of autonomy. Indeed, several of the nurses highlighted to me that one of the positive aspects of their job – as a nurse working in the community – was that they had “autonomy” over their work; this notion of autonomy was typically illustrated in this extract from my interview with Alex:

…for me the positives of community are more autonomy within your practice. Alex, Interview

One of the nurses appeared to reaffirm the view that autonomy was a positive aspect of the Team’s work by stating that it would be “the autonomy” in their job that they would miss, if they were to leave. Yet I found the nurses perception of their level of autonomy curious, as the degree to which they could exercise any significant degree of autonomy, seemed to me to be somewhat limited. I believe that the nurses mistook working on their own, for autonomy, which are clearly not the same thing. Alex discussed working alone in our interview:

…actually, it feels nice to be on my own in [the] community…personally I like being out and about. Alex, Interview

Indeed, one of the nurses expressed to me, that they enjoyed working on their own:

Me: That you are on your own…do you find that a negative…?
Dale: No, I like it…I like to work alone…I would rather work alone… Dale, Interview

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Dale’s preference to work alone is a statement that could be interpreted in a number of different ways. Do they prefer to work alone because they find it difficult to work with other people around? This is possible, but less likely given that Dale was an experienced nurse, who had worked in a hospital as well as a community setting. Do they prefer to work alone because they enjoy the independence and freedom of not being limited to the confines of a clinical building? This seemed the most likely reason, given that Dale had chosen to work in the community, where there is ample opportunity to take advantage of being ‘outside’ and where the nurses in the Team were not confined to a hospital or health centre for the entirety of their working day. Do they prefer to work alone because they are not under the watchful eye of their manager, or indeed their colleagues? Again, this is likely and is certainly one of the advantages of working in an environment where observability by both an individual’s manager and by one’s colleagues is limited by the geographical breadth of the point of production. This preference for working alone and outside the boundaries of a building is a preference; it is not necessarily an indication of the level of autonomy within a labour process. I believe that the nurses in the Team confused their level of responsibility, limited support from colleagues (whilst working alone) and the geographical breadth of the point of production, with what they perceived to be ‘autonomy’. To support my argument, I will describe a situation that arose within the Team, whilst I was carrying out my observational fieldwork. The incident related to saline solution and illustrates the nurses’ lack of autonomy and the personal reactions that this prompted in some of the nurses.

Prior to my time with the Team, it was common practice for nurses to keep several bags of saline ‘in reserve’ at the office or in their car, in case a situation arose, where they were due to treat a patient and the saline required to carry out their treatment had not been delivered to the patient’s home. This ‘reserve’ source of saline was usually acquired from a previous patient whose treatment had finished and the saline bags (from a previous patient), were unused. On one particular day, during my time with the
Team, this practice was raised by the lead nurse (Billy) in a meeting attended by the nurses working a shift on that day:

Billy reminded the team that this violated the NMC’s code relating to medicine management. Billy explained that saline was a prescribed item and as such, was assigned to a particular patient – under no circumstances could it then be used on a different patient. Billy inferred strongly that this could have serious implications for individual nurses…Individuals looked uncomfortable and in at least one case, angry. Billy stated that she had ‘found’ 100ml saline in the cupboard and reiterated that there should be:
“…no medicines in this office.”

Billy also confirmed that any saline that might be in a nurse’s car should be disposed of at the local chemist – in other words, there was to be an amnesty on saline solution, currently in the possession of any nurse…Max asked what they should do in future in terms of patient care.

“At the end of the day, it’s not your job to ensure that the medication is given to the patient – it’s the hospitals. If it’s not there, you cannot treat the patient” responded Billy.

“Even if we have the means to do it?” asked Alex

“You don’t have the means to do it” responded Billy – who seemed slightly frustrated with the direction that the discussion was now taking. Billy then went on to reiterate that the saline prescribed to one patient, could not be used for another. Field notes, 1st August 2016

This extract from my field notes provides an example of the lack of autonomy, that the nurses had over their own practice. Following the meeting, some of the nurses in the Team expressed to me their frustration at not being allowed to use, what they continually referred to as “salt water” – as they deemed appropriate – for the sake of patient care:

“I am not happy about this business with saline” Max said to me…”

I didn’t sleep last night, because I was thinking about saline” …” The patient is the priority, aren’t they?” Field notes, 2nd August 2016

This view was echoed by Chris, when I asked them about the saline:
They [Chris] indicated that they felt frustrated with the bureaucracy and that the issue was about the use of relatively small amounts of “salt water”. Field notes, 1st August 2016

These field note extracts are typical examples of the frustration the nurses in the Team felt about the tightening of control around saline use. In terms of my analysis, I want to suggest this lack of control over saline was a reflection of the nurse’s general lack of autonomy within their own labour process.

As I have suggested earlier in this section, the nurses in the Team were reluctant to admit to exercising discretion in areas where they felt, that I might perceive that there was a potential impact on patients. I would suggest then that they had no real autonomy. In the previous section in this chapter, I also discussed how the nurses in the Team had some limited discretion on the order that they visited patients. This was only true if the patient’s treatment did not involve an eclipse device. If it did, then the visit had to be carried out at broadly the same time every day, resulting in a significant limitation to the order of their work and timings of patient visits. The following extract from my interview with Max illustrates the challenges the nurses faced when balancing the demands for good clinical practice, the need to manage organisational resources efficiently and the needs of their patient:

When you know the patients, where they are and what they’re having done and if they’ve got hospital appointments – you cannot schedule your time of the visits as you go. There is sometimes the ‘list printout’ – which tells you, this is your first visit, this is your second visit, this is your third visit...But not necessarily; you make your own judgment. Because if you want...for example, if you’re going to [postcode in the city] I would say and you’ve got another visit in [postcode in the city]; where you know you’ve got a patient...When you look at the mileage, it doesn’t make sense...Unless it’s an eclipse device. Max, Interview
It is important to stress here that whilst the limited discretion that the nurses in the Team did possess was used to benefit both their patient and their employer – there was also some obvious personal benefit to not having to make slow progress in heavy traffic. On several occasions during my observation of the nurses, they interpreted the limitation around eclipse devices somewhat flexibly and visited up to an hour before the time. In this sense, the nurses exercised their discretion to make effective use of their available time. The limited scope for the exercising of discretion is suggested by Burawoy (1982) as a way to gain consent from workers – where employers ‘allow’ a limited amount of discretion within the labour process, as a ploy to keep their workers engaged in their activities.

5.2.3 Professional Vulnerability

The sense by the nurses in the Team of a lack of autonomy contrasts diametrically with their perceptions of their role being one that enabled them to exercise autonomy. This dichotomy was emphasised when some of the nurses expressed concern that their (perceived) autonomy also left them professionally vulnerable. These issues of autonomy and vulnerability were discussed in my interview with Alex:

…the only time there is a downside to the autonomy is when you’re on the late shift. When you’re on a late shift…you’re on your own…But technically after half-past four, you’re on your own. Which can be a bit challenging – at times – if you’re not sure what to do.

Alex, Interview

Similar views to those of Alex were also expressed to me, in my interview with Max:

Sometimes when you’re on your own – like tonight – on the late shifts. It will be just me. So, a negative about the late shift…would be, you have got an issue…there is nobody to help me to deliver the treatment… Max, Interview

As illustrated in these interview quotes, there was a sense from several of the nurses that they felt a level of vulnerability when they were working on
the late shift, because they lacked the clinical support that would be available if they were working during the day, or in an acute healthcare setting. This led one of the nurses in the Team (in my interview with them) to suggest that their role in a community setting was unsuitable for newly qualified nurses:

Me:  ...do you feel that you have more autonomy within the community?
Sam:  ...yea definitely; because you're on your own
Me:  ...do you see that as a good thing?
Sam:  Not necessarily...no because you need eyes really. You need experienced eyes...sometimes you need a second opinion. And I've always worked in groups of nurses, where if you weren't sure about something, you'd just ask your mate...Have a look at this, just check this for me, what do you think of this? I'm not sure about this patient, I'm not sure if they're poorly, what do you think's going on? And you'd discuss it, or there's a doctor you can discuss it with. But out here we have absolutely nothing. In fact, it's probably the worst part of the job. Because you're lonely (laughs) and you don't have anyone to give you a second opinion – other than over the phone, which is practically useless. So, you've got to be very confident and relatively experienced in assessment and stuff...I don't think it's a job for a newly qualified nurse...They haven't got the experience...they could lose the PIN – first day! Sam, Interview

Here Sam describes the difficulties of working relatively unsupported in the community. They highlight the lack of support, not just from doctors, but also from not having colleagues around who they can discuss a particular patient with and get an opinion. Sam’s reference to a “PIN” relates to the identification number given to nurses when they qualify by the Nursing and Midwifery Council to enable them to verify their professional status to third parties. The phrase “losing their PIN” was a way of saying that they would be disciplined for some error and possibly prevented from practising as a nurse. Here Sam was saying that their job in the community was not suitable for an inexperienced nurse, because without support they may end up being brought before the NMC and “losing their PIN”. In my time
with the Team, the nurses sometimes referred to elements of their labour process that would promote or prevent them ‘losing their PIN’. In other words, they often assessed the risk of actions based on their likelihood of putting their current nursing registration in jeopardy. This indicated that they felt there was a professional boundary that they were unwilling to step beyond in their practice. It was an extreme boundary condition – one that they were reliant on for their living – and was imposed on the nurses in the Team, by their professional organisation, not their employer. In the interview extract, Sam seems to suggest a link between autonomy and being alone and this supports the point I discussed earlier; that is, the nurses sometimes seemed to confuse being alone, with autonomy.

5.3 Joy, Sorrow and Mobility Power

On reflection, some of the observations I made during my period of fieldwork, about the nature of the work of the nurses in the Team, did not fit neatly with existing LPT and seemed to jar with a more traditional view of LPT. In this section, I look at these elements of the work of the nurses in more detail. These aspects of the labour process provided the nurses with a source of joy and also sorrow and I discuss this in more detail in this section. I also discuss the concept of mobility power and how it is relevant to the choice of employer, by the nurses in the Team.

5.3.1 Joy and Sorrow

Before I discuss the aspects of joy and sorrow within the nurses' labour process; it is important that I first provide – by way of background – some contextual understanding of the nurses’ perception of their patients. This is an extract from my interview with Alex; which is typical of the attitude of the nurses in the Team towards their patients:
It’s a massive change to see patients in their own homes… because I do think that when you’re in the hospital you sometimes label the patient by the illness – because you’ve got so many patients. Especially in A&E, you’ve only got four hours with them; so, they are the illness in bed nine, or the infection in bed nine – whatever. Whereas we don’t do that here because we know them very well, we call them by their names. And whenever you say a patient’s first name here, everyone knows who they are, which you wouldn’t get…in hospital… Alex, Interview

This focus on a personal identity for their patients was important in the Team and was echoed by Max, but framed in relation to the amount of time the nurses were able to spend with their patients – compared with nursing work in a more acute setting:

Hospital setting is pretty much do your job, tick the boxes, go home. We don’t have the time to spend with patients…My background…did not allow me to stop with the patients and ask him how he actually is and how he’s improving, how he’s feeling, if the treatment’s working. That…is non-existent in the hospital… Max, Interview

Max’s perception of their patients in a community setting is in obvious contrast to their perceptions of patients during their time working in a hospital. Time is (again) a factor in the forefront of this nurse’s mind; the reason for this may be less obvious than first appears. Max values the time spent with their patients in the community; but is this because they see their patients in their ‘own context’ with all the trappings of their individuality – possessions, living environment, family and friends? This it seems is in sharp contrast to a hospital setting, where a patient is treated in the physical structures of the NHS and where they seem to be reduced to a disease-bearing body in a bed. I am suggesting therefore, that the value that Max attributed to time with their patients was influenced by the setting. In purely LPT terms, it is influenced by the difference in the point of production; but is there something else also happening here? The nurses want to spend time with their patients because they know them and their
families; indeed, they have made an emotional investment in their patient and as such, they understandably, also want them to get better.

It is, however, somewhat ironic, that the construct used to control the nurses, which I discussed in the previous chapter – time – is also that which they value the most when used for the benefit of their patients. However, I suggest that the value that the nurses placed on these interactions were largely due to the nature of the connection they made with their patients; whom they saw in their own home, as opposed to the disconnecting experience of treating patients in a traditional hospital setting. Whilst the lack of time was used as a controlling mechanism by the nurses’ employer, the use of that time for the benefit of their patients was seen as a positive aspect of the nurses’ work; similar findings were reported by Breslin and Wood (2016) in their study of care workers.

As I have discussed earlier, in my interview with Sam, they reluctantly admitted to some degree of non-compliant behaviour to save time. However, this was minor and I never heard any of the nurses during my fieldwork, admitting to compromising their time with patients by non-compliant behaviours. I believe that they would have seen this as an illegitimate compromise of patient care; rather than legitimate worker resistance to the controls imposed on them by their employer, which is perhaps how a more orthodox view of LPT may be used to interpret any non-compliant behaviour. This is in contrast to other workers, who might see non-compliance as a legitimate way to ease the pressures on them, associated with chronic lack of time.

Spending time with patients is a significant, contributing factor in the satisfaction and dare I say, even joy that the nurses in the Team expressed in their work, where they felt that they had positively affected the life of a patient. This was evident from this extract from my interview with Chris:
Yea, it’s priceless that feeling…you might have 55 things to do and you’re at someone’s house, they’re really upset about whatever…And you have to…give them that time and attention. Because you might be the only person they see all day. You might talk nonsense with them about anything and everything – the price of chips, whatever. But it’s that, you give them that and that’s priceless… Chris, Interview

This positive view of their work was also echoed by Alex during a conversation I had with them, after they had visited a patient who lived in a nursing home:

Alex said they liked their job because they felt that they were making a contribution to improving people’s lives. Whereas working in a nursing home wasn’t going to contribute to an improvement in a patient’s condition; rather, a sometimes slow but inevitable decline. Field notes, 19th October 2016

Here Alex contrasts their impact and contribution to their patients’ wellbeing and recovery, with that of a nurse in a nursing home. It is clear that Alex felt that the work of a nurse in a nursing home was perceived by them as being less valuable, because of the type of patient they were caring for and the impact they could make on their future health and wellbeing.

As part of our interview, Chris reflected further on the impact they and the nurses in the Team had on their patients:

…patients have said, Oh, we’ll miss you all when you’re gone; when I’ve finished this treatment, I’ll miss you. And that’s quite priceless as well, but it’s also quite sad because then you think…who’s going to see them every day now? Chris, Interview

The joy of making a difference to their patients through their work, also forced Chris to reflect on the absence of that positive influence, once their patient’s treatment was completed:
…you know they’re not getting that contact every day and that, just that simple, someone coming to see them. Yeah, we’re there to do something else, but we’ll have a bit of a chat with them – especially if you’ve got an hour’s infusion. Chat about all sorts. I’ve had amazing conversations – you name it, I’ve talked about it to patients. Everything from birds to jobs they’ve done, places they’ve been – all sorts of things. Sometimes you just sit and watch TV with them. But that’s companionship for them and they quite like it. Chris, Interview

Here Chris seems to show joy at being able to positively impact a patient’s recovery and wellbeing, which is not directly related to the clinical treatment they are providing and yet this is also mixed with a slow awareness that their patients will miss them as people, as well as nurses. I sensed during the interview with Chris that this was tinged with some degree of sorrow for their patients. Yet this is a response that may be difficult to reconcile with a more orthodox view of LPT. Here there is an evident relationship between the nurse and their patient, which I want to suggest is not present between a worker who is confronted with a non-human product of their labour. The construct of craft is sometimes deployed to address the notion of job satisfaction derived by a worker, but this seems to me to go beyond this – in large part, due to the ‘humanness’ of the product.

However, the idea that employees are capable of actions that seem to be somewhat selfless is not new and has been highlighted by Bolton and Boyd (2003) and supported by Bolton (2000) who describes additional caring activities performed by nurses as ‘gifts’, which she believes are:

…a separate entity to ‘emotional labour’. (Bolton 2000:581)

This concept of a ‘gift’ is expanded by Bolton (2000) who argues that it is given freely and sometimes unconsciously. According to Bolton (2000), this gift is not ‘regulated’ by the labour process, a point for which she gives no adequate evidence to support her conclusion; except to say that the nurses in her study are not closely supervised in their emotional work and also, that they are not involved in producing a profitable product. I suggest
that this evidence does not provide a sufficient argument to suggest that emotional gift-giving is separate from the labour process. According to Bolton (2000), this emotional gift-giving includes ‘authentic’ caring and she goes on to suggest that nurses ‘care too much’ and this is an essential element of being a professional nurse. What Bolton (2000) seems to be suggesting is that emotional work is performed ‘outside’ of the labour process; it is not emotional labour and is therefore a ‘gift’. Indeed, Bolton and Boyd (2003) refer to this work as a ‘philanthropic gift’ and criticise Hochschild (2012) for arguing that emotional activity performed within a wage-labour agreement is emotional labour. However, Brook (2009) takes a different view and maintains that emotional labour includes all forms of waged-labour, which involves some form of emotion work.

I agree with Brook (2009) to the extent that all labour; whether mental, physical or emotional is waged-labour. However, I would also agree with Bolton (2000) that these selfless aspects of the labour process are not emotional labour, as theorised by Hochschild (2012). These are issues, which I will discuss and address in more detail, later in this thesis; along with the theoretical implications for LPT.

5.3.2 Mobility Power

All the nurses in the Team had moved to their current job in the community within the last 3 years. Some of the nurses had been in the Team for less than 12 months. I discussed this with them during my time with the Team; with some the issue came up naturally, as I sat with them in the car; for others, I raised the issue specifically with them at interview.

Without exception, all the nurses had chosen to work in the community because they had become – to a greater or lesser degree – disillusioned with their previous jobs. In the majority of cases, the nurses in the Team had previously worked in a hospital setting; although there was one nurse who had worked as a district nurse. Some of the nurses expressed to me their perception, that their current work was less frantic and less stressful
than their previous roles; they also saw the requirement not to work “nights” as a significant positive:

No nights is obviously [like] a big benefit for most people. In fact, I think that’s why most people in acute leave…Either that, or because they’re too stressed and over-worked. Sam, Interview

However, this same nurse admitted that they missed the greater professional challenge offered by work in a hospital setting:

…it certainly doesn’t feel like I’m making as much of a difference. I mean… I was literally saving lives every day…It was just, a more, I suppose it was in some ways it was more fulfilling. But you’ve got to balance that out with the stress of the job and also the shifts that you have to work. Sam, Interview

Sam’s perception of the work they used to do in a previous role was that they ‘made a difference’ and it seems that in some sense this contributed to their identity as a nurse. This seems to support the post-structuralists and their suggested link with worker subjectivity and identity. This quote from Sam is also not supportive of the view that I outlined in chapter two; that is, the suggestion that a post-structural perspective is not cognisant of labour as having interests in the employment relationship. However, these reflections by Sam of the satisfaction they derived from their work now, compared to their work in the past, appear to have less to do with the employment relationship itself and indeed more to do with worker concerns around identity. Perhaps Brook’s (2009) suggestion that workers’ consciousness are dynamic and at times contradictory has some relevance here.

Sam acknowledged during our interview that work/life balance was difficult to achieve in nursing, because as they put it:

…the nature of the job…People aren’t going to get poorly nine-to-five. Sam, Interview
The perception that their current job was less stressful than previous roles, was also supported by the nurse who had worked in district nursing. They disclosed to me – when we were on a shift together – that they were used to dealing with up to 20 patients on a shift. By way of contrast, the nurses in the Team usually had between 4-6 patients per shift. They also spoke about the nature of their current role:

As we sat in the car, they said they preferred the patients they treated in the Team, compared with those typically dealt with in district nursing. They explained this by saying that the patients in their current role were unwell and were being treated for a specific condition and then discharged; it was more satisfying. In district nursing, patients had a multiplicity of conditions and their ill health was being “managed”; in their view, this was less satisfying. Field notes, 11th August 2016.

This nurse’s perspective on their previous job as a district nurse, echoed the views expressed by Alex (in the previous section) in relation to the inherent value they attached to nursing in an environment where there were good prospects of the patient returning to full health.

Using a concept from within LPT, the nurses in the Team seem to have exercised their mobility power and consciously decided to change their employment from a hospital or district nursing setting, to working in the Team. I discussed the concept of mobility power in chapter two and it seems relevant to the nurses in my study. There does appear to be specific factors that were instrumental in the nurses’ decisions to leave their previous employment and join the Team. One of these factors was stress and the perception that they were overworked in their previous roles. During my time with the nurses, they often recalled their experiences of working in an acute setting and invariably their accounts were punctuated with words like “stress”, “over-worked”, “not enough staff” and “no time for patients”. The nurses in the Team who worked in a hospital setting, also suggested that the requirement to work night shifts contributed to their decision to leave their job in the hospital; a working condition that was not required in their current role in the Team.
The impact the nurses made in their previous and current roles is a conflicting one in terms of being a contributing factor for moving their employment. Some of the nurses seemed to suggest they received a sense of positive wellbeing from performing their current role and the contribution they felt they made to their patient’s recovery. Some of the nurses also expressed their satisfaction at being present with their patients and spending time getting to know them. However, this was in contrast to one of the nurses who felt that they were not making as big a clinical impact, as they did in their previous role; because in their present role they did not have the opportunity to treat and care for more seriously ill patients. There self-worth – in relation to their work - it seems, was tied to the degree of challenge associated with their patient’s condition. Yet by their own admission, their previous role was stressful and involved working nights; in this respect, Sam’s views concurred with their colleagues in the Team. Sam also told me that in the unit they worked in:

…50 percent of the patients didn’t make it…it takes its toll, but it’s kinda quite subtle and it happens over a long period of time…But to see people die in horrible ways, every week…I think it does have an effect, even for me…I was getting a bit fed up of it and a bit depressed. Sam, Interview

In this extract from my interview with Sam, they seemed to suggest that the absence of the kind of sorrow they experienced in their previous job; was in effect, a positive aspect of their current role.

The nurses in the Team for similar and different reasons, used their mobility power and consciously moved their offer of labour from one employer to another and the factors that I have discussed, relating to the nature of their previous employment are likely to have contributed to their decision to remove their labour. The decision by an employee to change their employer is a deliberate and usually positive choice; it is purposeful and can construct the impression that the employee is in control. However, the employee must also make their potential labour attractive to another employer; to such an extent that another employer will buy their labour
power. It is at that point when their labour is purchased – that precise moment – that the balance of control swings in favour of their employer once again.

Given the detailed description of the work and demands placed on the nurses in the Team – particularly those I discussed in chapter four; I was surprised that I did not observe the nurses in the Team resisting and generally complaining more vehemently about their work. I suggest that this may have been because the issues that the nurses were concerned about in their previous employment, were not present in their current community role and so the expected resistance and struggle was stifled. This is something that I have already hinted at earlier in this section, in relation to the absence of specific conditions being experienced by Sam, being seen as a positive aspect of their current role. It is an issue that I will return to again, in the next chapter.

The need for a worker to feel that they are doing a ‘proper job’ and one that a worker can take pride in, is highlighted by Delbridge (1998) in his ethnographic account of workers in the manufacturing sector. It seems that the nurses in the Team had become so frustrated with an inability to do a ‘proper job’ in their previous roles, that they had exercised their mobility power and transferred that labour power to another employer. It is Delbridge (1998) who regards this as a kind of conscientiousness and outlines the frustration workers feel when it is absent:

...a discarding of their own conscientious attitude to work. (Delbridge 1998:136)

This kind of conscientiousness was clearly present in the workers in Delbridge’s (1998) study; but it seems to me that conscientiousness and as I have discussed earlier, worker subjectivity and identity, emotional labour and emotional gifting are still a somewhat inadequate explanation for the levels of commitment I saw in the nurses I observed in the Team.
5.4 Summary

In this chapter, I have described some of the aspects of the work of the nurses in the Team, which seem to be "less of a fit" with a more orthodox interpretation of LPT. To begin the chapter, I looked at the invisible work carried out as part of the nurses' labour process. The work was invisible to the nurses' employer, because it was unacknowledged and was not subject to any formal process or guidance. The work was also invisible to the patients that the nurses treated and it was also largely invisible to the nurses themselves; until I pointed out this work to them, during the course of my time with the Team.

I continued the chapter by examining the nurses' use of discretion and the extent to which, it might be said that the nurses possessed a degree of autonomy. As part of my analysis of autonomy and discretion, I described both concepts and suggested that, whilst the nurses seemed to have opportunity to exercise some discretion, they did not (contrary to their own perceptions) have any significant autonomy. In this same section, I also looked at the extent to which the nurses in the Team were professionally vulnerable in the most part due to a lack of clinical support and how this lack of support seemed to be confused by them, for autonomy. I also highlighted the nurses' acceptance of boundaries on their responsibility to their patients, which seemed to suggest an acknowledgement of their professional limitations.

In the final section of the chapter, I looked at elements of the nurses' work that provided them with a source of joy and indeed also sorrow. The nurses' source of joy centred on their involvement with their patients and the positive impact they could make on their health and wellbeing. The sorrow I discussed in this chapter was an emotion I sensed some of the nurses felt, due to the transient nature of their involvement with their patients and the impact that the nurses' inevitable absence (once treatment was completed) was likely to have on their patients' ongoing wellbeing. I argued in this chapter that some aspects of the nurses' work was not necessarily
consistent with an orthodox interpretation of LPT, nor was it adequately explained by the concept of an emotional gift (Bolton 2000; Bolton & Boyd 2003), or indeed the theory around worker subjectivity and identity. I also looked at the mobility power possessed by the nurses in the Team and how this impacted on their choice of employer and their reasons for making that choice.

In the next chapter, I discuss the implications of both my findings chapters and continue to develop my suggestion that LPT explains some, but not all elements of the labour process of the nurses in the Team.
Chapter 6

Discussion
In this discussion chapter, I draw on the preceding two chapters (four & five) to form the central arguments of my thesis and outline the research contribution I have made, from this ethnographic study of community nurses in the NHS in England. This discussion chapter will draw on the comments, contradictions and discussion in chapters four and five and set my contribution within the contextual landscape of the literature review that I set out in chapter two.

As I have already outlined earlier in this thesis; my findings in chapter four are those which seem to conform to a more theoretically orthodox view of current LPT. Whereas, my findings in chapter five are those which are a more problematic, theoretical-fit with LPT and as such, may challenge or indeed extend current orthodoxy within LPT. I have separated my findings across the two chapters into these features and so given this structure, it seems sensible to split this (discussion) chapter into the same divisions.

In the first part of this chapter, I discuss my findings outlined in chapter four, where I develop my discussion using the tenets of LPT; that is, work, skill, control, compliance, consent and struggle. I argue that these aspects of LPT have been beneficial in my analysis of the labour process of the nurses in my study, because of the congruence between theory and those of some of my findings. In the second part of this chapter, I discuss the theoretical challenges to LPT orthodoxy, drawing from my findings in chapter five. In this second part of the chapter, I discuss the aspects of my findings that appear to be incongruent with some theoretical elements of current LPT. These are mainly focused on worker motivation for carrying out labour, where a worker appears to gain altruistic benefit from their work (rather than any economically rational advantage) and my suggestion that a relationship can sometimes exist between a worker and their ‘human’ product, which is not adequately theorised within LPT.
My discussion chapter will conclude with a final section, where I compare and contrast my findings from chapter four and five and draw more general, theoretical conclusions.

6.1 Labour Process Theory – An aid to analysis

In this section, I look at the elements of LPT, which have supported my analysis of the labour process of the workers in my study. In this section, I discuss in turn the nature of the work and how I believe the workers were controlled by their employer. I also discuss issues of compliance, consent and struggle within the nurses’ labour process.

6.1.1 Work & Control

A traditional Marxist view of profit under a capitalist system is that it is generated through the increase of unpaid labour, which can happen through one of two ways (Burawoy 1982). The first is through absolute terms, that is, extending the day and paying the worker the same amount of wage; this is also known within LPT as work extensification. The second is to increase relative surplus; that is, ensuring workers spend a reduced amount of their time during the day producing a wage equivalent; this is also known within LPT as work intensification. It is these two concepts that underpin the discussion in this section on the labour process of the community nurses in the Team. I am mindful however, that profit may not be a concept that sits comfortably within a study of public sector healthcare workers and I will therefore explain the relevance of work intensification and work extensification to the study of the labour process of workers, whose employer does not – nominally at least – have an interest in producing a profit.

Whilst public sector organisations in the UK do not have to produce a profit in the conventional way, that is demanded of a private sector organisation; these organisations are consistently expected to maintain the same levels
of quality, whilst facing increased demands for their services. This continuous demand for ‘surplus effort’ requires the same trick to be pulled on workers, that is demanded of private sector organisations when trying to produce a profit; that is, more effort power from labour for the same, or indeed less pay. This is a point highlighted by Allen (2015) in relation to the healthcare sector:

Contemporary healthcare systems face very real pressure to improve the safety, quality and efficiency of services in a context of unprecedented financial constraint. (Allen 2016:xiii)

In the last decade, since the financial crisis, public sector organisations have faced intense scrutiny of their costs and in all areas of public service, organisations have faced demands to cut running costs. In healthcare, the NHS Five Year Forward View suggests that the funding gap for the NHS is around £30 billion – with a significant proportion of this amount being ‘saved’ through “efficiency” (NHS England). Given this eco-political landscape in the UK, I argue that it is reasonable to assume, that whilst there is not a demand for profit – in the traditional sense – from organisations within the public sector; there is a demand to continually produce a ‘surplus’ of effort power from labour. All this is set against an operational backdrop, where these same public sector organisations face increasing demands for their services.

Public sector organisations (over the last decade or more) in the UK have been expected to produce a ‘surplus’ of effort power from their labour, year-on-year; this is a context, which pre-dated the financial crisis of 2008, but has been made significantly more challenging since that time. This demand for surplus must also be set within the context of several decades of NPM-inspired reform of public services (in many of the industrialised nations, including the UK), which I discussed at some length in chapter two. As I explained in that chapter, the ubiquitous influence of NPM ideology has pervaded the public sector reform agenda, since the 1970s and it is an ideology that includes, a focus on performance, quality and consistent standards; an emphasis on a ‘private-sector’ style of
management and a challenge to the dominance and control of professional groups. It is within this landscape that public sector organisations sit in the UK and as such, I suggest that a study that seeks to understand the work of nurses, through analysis based, at least in part on the concept of work intensification and work extensification is entirely justified.

As I outlined at the beginning of this chapter, work intensification happens when an employer increases unpaid labour, through intensifying the work undertaken by their employee. In LPT terms this means the employer extracts more effort power from their employee without any additional payment for this additional effort. In the case of my study, this manifested in feelings of stress as the nurse rushed between patients, assessing and then executing the best navigational routes to drive them to their next untreated patient – I outlined examples of this in chapter four. In a different organisational context, it is Delbridge (1998) who observes that control of effort power can sometimes be achieved through adjusting and increasing the “line speed”, which results in workers having to work faster; this is an example of work intensification in a manufacturing environment. This manufacturing example seems – superficially at least – unrelated to the nurses in the Team and yet I am suggesting that similar methods (resulting in work intensification and/or work extensification) can be used, as a means of control in a healthcare environment.

In the case of my study, the cause of work extensification varied, but all had a common theme of lack of time and delays; sometimes it was problems associated with traffic, at other times it was as a result of particular issues related to a specific patient, but crucially the impact was the same – reduced time available for the nurses to complete the same amount of work. In the case of the nurses in the Team, the workers – not their employers – owned the ‘time problem’; it was the nurses who ‘took the hit’ if there were problems associated with production and as such, this resulted in pressure on time and the ‘easy’ solution to this (as I discussed in chapter four) was to extend the hours they worked to compensate for
this reduction in time. The consequence of this work extensification was that their employer extracted more effort power from the nurses, without any additional payment for this work. As I mentioned earlier in this thesis, this mechanism of control and the subsequent manifestation of work extensification and intensification are similar to that described by Ackroyd and Bolton (1999). However, there are two key differences – I will highlight one now and the other later in this section. It is Ackroyd and Bolton (1999) who seem to suggest that the employer in their study created an environment in which nurses were forced to adjust the time taken to treat their patients – but as I have already stated in chapter four, this was not an option for the nurses in the Team, because much of the work with their patients had a fixed length and they were reluctant (for obvious patient safety reasons) to reduce infusion times by more than a few minutes. Therefore, their employer was creating an environment in which the only option available to the worker was to extend their working hours and in so doing, increase the unpaid labour extracted from them, by that same employer. There was also the additional burden associated with this extra effort power, because as I have outlined in chapter two nursing work is not just about clinical activity; it encompasses a variety of skills and knowledge that must be produced and reproduced in order for patients to be transformed into completed products.

The situation in relation to the nurses in the Team and the extraction of unpaid labour by their employer is one that is replicated across the public sector in the UK and has implications for employees (in particular, professionals) who work in other parts of the public sector and who deliver services directly (in one form or another) to vulnerable members of society. It is Ackroyd & Bolton (1999) who suggest that these kinds of employees are pressured to work harder, unless they are willing to renounce their own moral, ethical and (where appropriate) professional values around standards of service delivered to patients/clients/victims. My study seems to support this view, that public sector employers manage the amount of work an individual employee is confronted with, which enables them (amongst other things) to exert indirect, technical control on that
employees. Drawing on my previous discussion around observability, this type of control mechanism benefits the employer because it is technical, less cumbersome and removes the need to use costly, management resources who must know the precise detail of the labour process – thus avoiding the issues associated with lack of congruence between supervisor/subordinate skills and those associated with production-system insulation. This type of control mechanism also limits the impact of physical separation at the point of production and social insulation, because again, it does not rely on detailed knowledge of the work; instead it focuses on the product at the end of the labour process. What happens in the labour process to produce that product is of less concern to the employer, as long as the product is produced in a timely way and to the appropriate level of quality. In some senses, it is the antithesis of Braverman (1974) and the degradation of work and as Burawoy (1985) points out, instead of Braverman’s (1974) classic separation of conception and execution; it rather becomes a separation of the employer’s conception and knowledge, from their employees’ conception and knowledge. This mechanism of control also appears to work using a form of emotional blackmail – “clock off if you dare, but you’ll only be letting the vulnerable down if you do”.

This additional effort power extracted from workers is according to Bolton and Boyd (2003), a ‘philanthropic gift’ and they give an example, which relates to the behaviour of flight attendants:

…not ‘calling in sick’…when they are ill is because they do not want one of their colleagues to be called out from standby duty.

(Bolton & Boyd 2003:298)

Bolton and Boyd (2003) maintain that this behaviour is motivated by a commitment to colleagues, rather than a normative control regime instigated and managed by their employer. I would argue that this behaviour can be interpreted in another way; which is, that staffing levels were inadequate (which meant that colleagues were brought in to cover sickness) and this was a mechanism to exercise a form of indirect control by the flight attendants’ employer. I suggest that it is another example of
emotional blackmail – “call in sick if you dare, but you’ll only be letting your colleagues down if you do”. The flight attendant who is considering being absent from work due to sickness, knows the consequences of their actions for those who work with them on a regular basis. They feel some degree of responsibility to their colleagues and so come to work when they are not feeling well. This is a control mechanism by the employer (which uses an employee’s loyalty to their colleagues to maintain a form of indirect control), not an example of philanthropic emotional management by employees, as Bolton and Boyd (2003) would suggest. Whilst this is an example of a control mechanism in the private sector between employer and employee, a similar trick is pulled by exploiting the relationship between worker and human product in the public sector, to extract more effort power from employees. It is Burawoy (1982) who suggests that employers gain consent from their workers through game-playing. Many public sector workers in the UK are in a lose-lose game; let the vulnerable down and you go home on time with a nagging conscience; else carry out your duties and go home late. This is the reality of ‘surplus’ value for some workers in public sector organisations in a modern, industrialised economy.

The work allocation process was perceived by the nurses in my study to be unsystematic. The nurses were also of the view that their employer was unsympathetic to the time pressures they faced when carrying out their work with patients. This lack of understanding by employers, associated with the pressures of work is highlighted by Delbridge (1998) who suggests that – despite a management presence – workers felt that their problems were not sufficiently understood. I suggest that this perceived lack of appreciation of the demands of workers by their employer is symptomatic of a mechanism that uses work allocation as a technical method of control and an employer who (as I have highlighted already in this section) is not concerned about the precise details of their employees’ activity, so long as products are produced to the right quality and at the right time.
A community setting – by its very nature – is a geographically broad point of production, which may present a challenge to an employer in terms of effective control (Breslin & Wood 2016). I discussed in chapter four, Littler’s (1990) concept of observability and the factors that made observability more difficult for an employer, or a manager (acting as a proxy for the employer). The observability of the nurses in my study was limited to a greater or lesser extent by the factors highlighted by Littler (1990); namely, physical separation, congruence of manager/sub-ordinate skills, production-system insulation and social insulation. The most obvious impact on observability was physical separation and this will always present a control problem to any employer, because it rules out the most obvious method of monitoring the effort power of workers – visual surveillance. This type of surveillance enables an employer to immediately assess the work effort of an employee through visual inspection. The visuals may be collected through human interaction – via a manager, or employer; or can be achieved through means of technology, such as a camera, or in some dispersed workplaces, electronic monitoring of activity on keyboards. If the worker does not know when they are being watched, this type of control can also have the benefit to the employer of maintaining continuous levels of effort power in employees, a point illustrated by Foucault (2008) in his description of the panopticon. Many employees in the contemporary workplace must now contend with technological panopticons.

The extent to which an employer or manager has the necessary skills to assess the effort power being extracted from an employer depends – according to Littler (1990) – on the degree to which they possess the skills and knowledge required to undertake the work of their employee. The immediate supervisor of the nurses in my study was also a nurse, but their supervisor was not; rather they were a general manager and did not possess the necessary skills and knowledge to assess the work performance of their “grandchildren”; a point supported by Ackroyd & Bolton (1999), who state:
According to Ackroyd and Bolton (1999), the situation within the Team was not unusual within the NHS and as Littler (1990) suggests, this meant that there was a lack of congruence between supervisor/subordinate skills, which hampered observability.

My description of the elements of the nurses’ labour process in chapter four, highlights that there are significant elements of their work that were indeterminate. This is typical of a labour process that produces a service, like healthcare and is an example of what Littler (1990) refers to as the production-system insulation factor. This type of labour process is individualistic in nature, in the sense that the nurses in the Team tailored the production of their product to the patient and their specific needs and environment. This degree of indeterminacy creates a potential problem for employers, because it reduces the degree to which they can determine the precise elements of the labour process and therefore (again) reduces their level of observability.

The final factor that – according to Littler (1990) – determines observability is social insulation and is the degree to which an employee is free from interference by their employer, or manager. This is of particular relevance to workers who have obligations to the organisation who oversees the governance of their profession, as well as their own perceived ethical and moral obligations to their patients/clients. These obligations are aside from those imposed on them as an employee and as such, may act as ‘protection’ from access and obligation to their employer or manager – particularly where these elements conflict.

My study seems to confirm that observability is hampered, where professionals work in an environment where the opportunity for visual surveillance is limited and where an employer (or manager) does not necessarily share the same professional skills and knowledge as them.
My study also seems to confirm that observability is also hampered, where an employee’s labour process has a degree of both production-system and social insulation. This lack of observability is a problem for any employer, because it means that control of employees is more difficult; the employer cannot rely on the more obvious control mechanism of visual surveillance, or performance management based on congruent skills and knowledge; nor can they rely on the precision obtained through the application of a “scientific approach” to the management of a labour process, or direct access to their employees by virtue of their authority. The problem of control then requires a more indirect vector.

As I have argued earlier, it is my suggestion that the workers in my study were indirectly controlled, through the allocation of work; in the case of the nurses, it was through the allocation of untreated patients. This type of control uses the allocation of work to extract from workers the effort power required to produce and reproduce the products required by the employer. As I discussed earlier, a similar type of control mechanism is identified by Ackroyd and Bolton (1999), who suggest that control of nurses in their study was achieved through manipulation of patient throughput. This appears to be the mechanism used to control the nurses in the Team; however, the second key difference between my study and that one is that of environmental context – the nurses in Ackroyd & Bolton’s (1999) study worked in a hospital, whereas the nurses in my study worked in the community. A geographically dispersed point of production (such as community nursing), which affords little opportunity by an employer for visual inspection and one where workers do not always share congruent skills with their managers, possess a high degree of determinacy in their labour process and have obligations to masters, other than their employer. This type of environment requires an indirect, technical control method, such as the one I observed operating at NCHNT. A control method, which is unforgiving in work allocation and ‘off-loads’ production problems to workers – a description of the system, I am suggesting appeared to be in operation at NCHNT. However, what puzzled me, throughout my period of fieldwork was why the nurses in my study showed only limited signs of
worker resistance and struggle, given the conditions of their labour that I have detailed here. This is an issue that I will return to later in this chapter.

Finally, I want to briefly discuss the role of patients in the mechanism of control. As I have already discussed, problems in the process of production were routinely ‘off-loaded’ onto the workers in my study. This mechanism of control was unconsciously supported by patients and (possibly) consciously used by the nurses’ employer, through continued emphasis on the need to attend to patients at a scheduled time. A mechanism that effectively uses Friedman's (1977) concept of responsible autonomy as a device of control.

6.1.2 Compliance, Consent & Struggle

In this section I look at the concepts of compliance, consent and struggle in turn. I start with compliance and consent and then move on to the concept of struggle – including worker resistance.

Compliance & Consent

As I have already highlighted previously in this thesis, the Burawoyian concept of consent is a central theme of LPT. I highlighted in chapter four a number of examples of consent that I observed whilst undertaking my study of the nurses in the Team. However, the concept of consent and indeed compliance could become potentially problematic when applied to workers in the public sector, because it might become entangled by the idea of a ‘public service ethos’, which is also recognised as a concept amongst public sector employers:

…the embodiment of public sector ethos within the labour process is a defining feature of much public service work… (Mather et al. 2007:120)

This concept of ‘public service’ has the potential to be used by public service employers, in much the same way as the control mechanism I
discussed in the previous section; that is, it is wielded as a form of emotional blackmail by employers, to ensure they gain control, compliance and indeed consent from their employees.

As I have eluded to throughout this thesis, the concept of worker subjectivity within LPT has been an ongoing, theoretical discussion over several decades. Some authors criticise the “founding father” of LPT [Braverman] for neglecting the topic, whilst other authors defend him, suggesting that he deliberately ignored it, or at least implicitly referred to it in sufficient detail to make the criticisms unnecessary. Sometimes authors have taken, at times, both sides of the debate (Knights & Willmott 1990; Thompson 1990). What does seem to be clear however from Braverman’s (1974) analysis is that he assumed that the relationship between employers and employees was always antagonistic (Knights & Willmott 1990); a point which is contested by Burawoy (1985); who argues that Braverman (1974) ignored the day-to-day operation of employees and thus forfeited the opportunity to understand why employees routinely yielded to the organisation of their labour process by their employer – often to the detriment of their own happiness and comfort. In this study, I have endeavoured not to fall into the same trap that Burawoy (1985) accused Braverman (1974) of doing. My research method involved the observation, on a day-to-day basis of a group of workers and then the subsequent analysis and understanding of the nature and organisation of their labour process. As I have illustrated in chapters four and five, there are examples of workers yielding to the organisation of their labour process by their employer, as well as examples of where they have resisted, or where they have made it known that they were not happy with arrangements and pushed for change. In my study, the nurses often exhibited their unhappiness, resistance and struggle in the form of moaning, gossiping and oppositional rhetoric; manifestations that were highlighted by Mather et al. (2007) in their study of college lecturers. I observed that the majority of the nurses’ struggle was individual resistance and only on one occasion did I observe a suggestion that collective resistance should be organised.
Struggle

It is Burawoy (1982) who asserts that the state facilitates the disorganisation of the dominated classes by emphasising the rights of the individual. Given the obvious link between the state and the public sector, it seems reasonable to me, to assume that this emphasis on the individual is likely to permeate the many organisations who are charged with operationalising the policies that drive the state machinery. In this sense, it is therefore reasonable for me to assume that public sector organisations promote a sense of individualism amongst their employees.

As I have suggested earlier, what is noteworthy in the findings from my research, is the limited levels of resistance that occurred amongst this group of public sector employees; given the degree of work intensification and work extensification (already described in this thesis), that were an inherent part of the labour process of these workers. Throughout my period of observation, I saw only a fleeting suggestion of collective resistance amongst the nurses in the Team. This is something on which I have reflected, since leaving the field. Could this have been due to a lack of opportunity for collective resistance to flourish, possibly because there were only limited times when the nurses were together in one place? It was also an environment in which the world’s largest nursing trade union (Royal College of Nursing 2018) was viewed negatively by some workers and whilst it would be ridiculous to generalise based on the nurses’ views of their own trade union; coupled with the lack of opportunity for collective resistance, does this industrial environment point to a possible cause for the limited worker resistance I observed? A lack of resistance may also suggest the potential impact that professional status may have on a worker’s ability to resist; or indeed, the pressure on workers to comply and also consent to the demands of their public sector employers and their patients.
It seems then that some employees in the public sector may face a number of converging pressures to comply and consent to their employers wishes, these are; a pressure to show commitment – motivated by a ‘public service ethos’, a state-perpetuated culture of individualism, a lack of opportunity for collective resistance to develop, a commitment to values associated with their profession, as well as a perhaps keenly felt duty to their patients. A lack of resistance may be accounted for by my suggestion that public sector employees are perhaps under pressure to show commitment to their work – for all the reasons I have suggested in the previous section. However, I am not completely satisfied with this reasoning. Firstly, I am not convinced that the absence of employee resistance, necessarily indicates an environment that supports a tendency to comply and consent. Secondly, I believe that the gap in explanation for this absence of resistance is not theoretically satisfied within current, orthodox LPT and it is the theoretical implications of this gap that may begin to explain the lack of resistance amongst this group of healthcare workers. As a result, I believe that this gap includes some aspects of my findings that do not neatly conform to theorising informed by LPT.

It might also be suggested that this lack of resistance amongst the nurses who participated in my study is due to the work they do, which cannot all be defined as emotional labour and according to Bolton and Boyd (2003) could be seen as a philanthropic gift, not regulated by their labour process. This seems to me to be something of ‘cop out’, which avoids the work being part of the labour process, because it is theoretically problematic to include it. There is also the post-modernist interpretation of the nurses lack of resistance being as a result of the ontological limitations associated with the dualistic characterisation of control/resistance. It is these ‘non-conforming’ aspects of my findings that I will now turn my attention to, in the next section of this chapter.
6.2 Labour Process Theory – A challenge to theory

In this section, I discuss elements of my findings that provide some theoretical challenge to LPT and associated theories. I discuss these challenges in turn, beginning with some of the invisible work undertaken as part of the nurses’ labour process and then go on to discuss the exercising of discretion and the motivation for doing so. I also discuss the joy and sorrow experienced by the nurses and the exercising of their mobility power, through their choice of employer. In discussing these issues, I suggest that aspects of these elements of the nurses’ labour process are troubling in so far as they may suggest a theoretical gap in current LPT – particularly in relation to public sector workers whose labour process transforms human products of one sort or another. At the end of the chapter, I discuss the theoretical implications of a lack of expected levels of resistance amongst the nurses in my study.

6.2.1 Invisible Work

It is Allen (2015) who suggests that visible work is usually formal, authorised and documented and thus by contrast I want to suggest that invisible work is often informal, unauthorised and undocumented. In chapter five, I described in some detail, aspects of the nurses’ work in the Team that seemed to me to be ‘invisible’. In that chapter, I focused on three invisible aspects of the nurses’ labour process; environmental knowledge, informal assessment and social knowledge – all three aspects of the nurses’ work, fall within the counter-definition provided by Allen (2015). In this section, I look at these aspects of invisible work in the context of LPT and also discuss their wider theoretical implications.

As with much service-based work, the labour process of the nurses in the Team relied heavily on the effective processing of knowledge and information and these elements were also equally relied upon in the informal labour process, which contained the invisible work I highlighted in chapter five. To undertake this invisible work, the nurses depended on environmental knowledge they possessed – specifically traffic behaviour
and the geographical realities of their point of production. The nurses also relied on social knowledge, that is, knowledge about their patient, their patient's family and their patient's social context and family dynamics. They used this knowledge to determine the best time to visit patients and also used it – along with information they collected on their visits – to undertake, what I referred to in chapter five as an informal assessment of their patients on each and every visit. This was work and also knowledge that was not only unacknowledged by their employer but was also not usually acknowledged by the nurses themselves; until I highlighted it, as a point I was interested in, for my research. The lack of awareness by the nurses' employer of this work meant that a precise control of specific elements of that part of the labour process was either not deemed to be necessary; or their employer was unaware of the existence of that part of the labour process. This is true for many employees – the demands of any job are rarely known in their totality by employers, or those acting as a proxy for the employer. However, the lack of awareness by the nurses themselves of aspects of their labour process could suggest a form of unconscious consent and compliance; a form of consent that is so complete, as to blind the consenting to their own condition. This social blindness may be the result of the apparent inevitability of the social structures and systems under capitalism, which is referred to by Marx, as fetishism (Thompson 1989) and discussed more recently by Lloyd (2017) who states:

Capitalism structures our social relations and social reality and whilst we believe that we know about its exploitative conditions and oppressive practices, we wilfully participate as if we did not…” (Lloyd 2017:276)

The apparent inevitability of capitalism and its incumbent social structures may be an explanation for the near-unconscious consent that seemed to be present amongst the nurses in the Team, in relation to invisible work. As well as unconscious consent, there also seemed to be a conscious curtailment of work by the nurses in the Team. This restriction to the scope of their work and responsibilities, appeared to be in response to the
inevitable, practical limitations of their work – often in relation to limitations around time, which is a theme throughout this thesis. This is perhaps a resistance of sorts; one that acknowledges that their resources are finite and despite the potential to do more, the nurses individually constructed a boundary around their work – perhaps to counter, potential efforts by their employer, to prevent further exploitation.

I have suggested that the invisible work undertaken by the nurses was consenting in nature and I have also suggested that the limiting behaviour of the nurses in relation to some of their work, may have been a form of resistance. However, I remain somewhat concerned that aspects of the work of the nurses remains theoretically troubling; that is, I remain unconvinced that certain aspects of work within the public sector, fit (theoretically) neatly into a box marked “LPT”. It seems reasonable to me to assume, that in certain aspects of their motivation – public sector employees may be different from their counterparts in the private sector. It is also conceivable that their incentives for carrying out aspects of their work are not entirely motivated by a rationality, based on economics; but may have more to do with their social conscience and altruism. I suggest that this social motivation for work is more likely in public sector occupations, where workers have opportunities and responsibilities that involve dealing with vulnerable members of society – a point I referred to earlier in this chapter. This altruistic nature and developed social conscience are similar and possibly linked to the ‘public sector ethos’ that I mentioned earlier in this chapter and is no less likely than that, in its potential for being exploited by employers. This potential for exploitation, however, does not negate my suggestion that the concept in and of itself, presents something of a challenge to a more orthodox understanding of LPT. Rather, it may go some way to explaining why public sector workers undertake work that is unseen and unacknowledged by their employer and why they experience feelings of frustration, when they are unable to assist others in a more thorough and personally satisfying way. This seems to me to be a pattern of behaving that can only be partially explained as a form of consent and resistance and avoidance of further exploitation.
6.2.2 Discretion and Autonomy

In chapter five, I illustrated and discussed the nurses’ capacity to exercise discretion and possibly autonomy. The examples I described showed what some may argue to be violations of the ‘rules’; whilst others may suggest that the were merely examples of the nurses exercising their professional discretion and responsible autonomy, based on a more complete understanding of their patient’s circumstances and condition. I did suggest in chapter five, that the nurses had some capacity to exercise discretion and their motivation for doing this varied; sometimes it was for the benefit of the patient, sometimes it was for the benefit of the nurses themselves and sometimes it was for the benefit of their employer. Often it was a course of action that benefited a combination of these actors, but nonetheless all the examples could have been argued to be a violation of the ‘rules’; or as LPT might suggest a legitimate use of the tacit knowledge available to workers, which is an inevitable part of the informal elements of all labour processes.

It was my contention in chapter five, that the nurses in the Team were not able to exercise autonomy, because they lacked the capacity to determine the nature and pace of their own work. However, this was contrary to the nurses’ own perception of their level of autonomy, who believed that they possessed a high degree of autonomy in their job. As I argued in chapter five, the nurses may have mistaken their ability to work alone and without, direct visual surveillance, for autonomy. The nurses’ perception of their own ‘autonomy’ also varied with context and whilst it was seen as a favourable aspect of their job at some time; their perception of their own ‘autonomy’ was viewed more negatively, when it was seen as a possible source of professional vulnerability. I believe that the nurses were probably exposed to professional vulnerability, on some occasions; but I think that this was an inevitable consequence of an employer who had a very limited interest in the precise detail of the labour process of their employees – as I discussed earlier in this chapter. One of the nurses in the Team believed that this potential for professional vulnerability was at times so acute, that
it prevented an inexperienced nurse from effectively undertaking the work of the Team – without possibly putting their professional registration at risk. Again, this is perhaps an inevitable, but unintended consequence of an employer whose primary focus is on producing the appropriate number of products in the required time and is rather less concerned with controlling the minutiae of their workers’ labour process that produces the desired outcome. This kind of “flexibility” in the labour process, as Thompson and Smith (2010) suggest:

…systematically intensifies work by finding yet new ways to remove obstacles to the extract of effort. (Thompson & Smith 2010:16)

Unlike the problem of lack of professional support, which seems to me to be theoretically consist with LPT; I am again troubled by some aspects of the nurses’ work involving discretion and its implications for other public sector employees. There are elements of this work that I do not feel sits neatly into a theoretically orthodox view of LPT. My reasons are broadly the same as those I have already discussed in the previous section; namely an employee’s motivation to ‘go the extra mile’. A worker may exercise discretion to reduce costs borne by their employer; this is not an unreasonable and illogical course of action, because it is ultimately in the worker’s interest for their employer to remain financially sustainable. A worker may exercise discretion to benefit themselves and to make the performance of their own work a little easier, this is self-evidently logical. An employee may also work in a way that is consistent with profession values, because they wish to remain aligned with their profession and want to continue to be employed in their chosen field. What I find more difficult to reconcile with LPT is why an employee would use discretion to make their patient/client/customer’s situation better or easier, sometimes at the expense of their own comfort and ease – after all, are these people not just products, which they transform and are the outcome of their labour process? Is this not just the element of emotional labour, which forms part of the nurses existing labour process? I would argue that this is not emotional labour (Hochschild 2012), because the nurses were not obligated to perform it. A characteristic of emotional labour, according to
Hochschild (2012) is that the behaviour is induced or suppressed by individual workers and is not part of their 'true self'. I maintain (based on my direct observation of it) that this type of behaviour was part of these workers’ characters and was not an obligation placed upon them by their employer (or their employers' proxy). As in the previous section, I feel therefore, that I am forced to draw on the idea that this willingness on the part of a worker to 'bend the rules' and accommodate the needs and wishes of their patient/client/customer is less to do with consent or resistance in their social relations with their employer and more to do with their relationship with ‘the product'; that is, another human being.

What seems to be emerging then is the idea, that there exists (in some cases), a relationship at the point of production, which is not limited to the employer and the employed; but there is also (in certain production environments) a relationship, which is untainted by industrial antagonism and is between the product and the worker. This type of relationship between carer and cared for is also reported in Breslin and Wood's (2016) study of domiciliary care workers and it is a relationship that I suggest is not adequately recognised by LPT and whose actions are not fully explained by worker consent. In the next section, I want to illustrate in more detail, the nature of this relationship between worker and their product of production.

### 6.2.3 Joy, Sorrow and Mobility Power

In chapter five, I described how the relationship between the nurses in the Team was different to that which they themselves had experienced when previously working in a hospital-setting. I went on to describe how the nurses received a great sense of satisfaction from administering treatment to their patients, which contributed to their patient’s eventual, physical recovery. However, this sense of satisfaction was not limited to a realisation that they had supported their patient’s recovery; but it extended and included a sense of satisfaction gained from supporting their patients in less clinical ways. In chapter five, I illustrated this with an example,
where one of the nurses expressed concern – even regret – that the support they provided for their patient’s social welfare was to cease, once the patient’s treatment was completed. This social support was an acknowledged element of the nurses' labour process and another example of invisible work these workers performed, a theme I discussed earlier in this chapter. This sorrow felt by the nurses, at not being able to do more for their patients is also linked to the conscious boundaries that the nurses created around their work – which I also discussed earlier in this chapter. The implication of these feelings of joy and sorrow by these nurses, I suggest has theoretical implications, which may extend to other public sector workers; particularly those who work with ‘human’ products.

**Joy and Sorrow**

The joy and indeed sorrow experienced by the nurses in the Team, whilst dealing with their human products seems to me to lack an adequate explanation within LPT; because in common with the other issues I have discussed in this chapter, there seems to be an inadequate explanation for the motivation of an employee to behave in this nurturing way towards their patient – who according to LPT, is merely a product of their labour process, within a potentially antagonistic context. LPT is also similarly lacking in providing an explanation for the feelings an employee may experience towards their human product; that is, the happiness or joy they may feel from having helped their patient/client/customer and the sorrow and even feelings of regret, they may also experience at not being able to provide a better service to them. This seems to me to jar with LPT, which does not give an adequate theoretical insight into the reason a relationship would exist between product and worker; not least, one which seems to derive benefits to both human product and human worker. This seems to me to be an area of LPT – that is, the social relations between product and worker – that requires further, theoretical attention.
The obvious place to look for theoretical answers is perhaps the concept of emotional labour (Hochschild 2012) and it is Brook (2009) who suggests that Hochschild’s (2012) theorisation of emotional labour is perhaps suitable to be integrated with LPT:

Irrespective of Hochschild’s ambiguities and limitations in conceptualising agency and ultimately resistance, it is her theorisation of emotional labour…which more readily lends itself to theoretical integration with LPA [labour process analysis]. (Brook 2009:546)

However, in the context of nursing (where emotional labour is clearly a part of the labour process), the feelings and the behaviours of the nurses that I observed were not disingenuous; their concern and indeed willingness to go the ‘extra mile’ for their patients seemed to me to be ‘genuine’. It did not seem (as the concept of emotional labour dictates) to be an obligation that they felt had been forced upon them by their profession or engineered by their employer; nor did it feel something that they were doing to satisfy some self-regulated standards that they had set for themselves. It was a genuine action of concern and care generated from one human being and directed to another. At a human level, I felt like it should not be theorised, but rather left outside theory; else any attempt at analysis, would somehow start to destroy the essence of the thing itself. This is somewhat ‘unscientific’ and so as a social scientist, I argue that the temptation to label this activity as a ‘gift’, which is ‘unregulated’ by the labour process (Bolton 2000; Bolton & Boyd 2003) is I suggest (and I highlighted earlier in this chapter), a ‘cop-out’, which should be resisted.

**Mobility Power**

In chapter two and then later in more detail in chapter five, I discussed the two elements of labour power, that is, effort power and mobility power. In this section, I want to draw attention to the implications that mobility power appears to have had on the choices of employer, made by the nurses in the Team. I highlight how this supports the points I have been making.
throughout this chapter that, whilst LPT goes some way to explaining many of the observations I made about my time with the nurses in the Team; it may have exposed a theoretical gap in LPT, around worker motivations in the public sector. In particular, those public sector workers who produce a human product of one sort or another, as an outcome of their labour process. The satisfaction – professional, humanitarian and personal – gained from a different type of work, with a different employer – seems to have had some degree of motivating effect on these workers that appears outside of the current theoretical framework of LPT.

There also seems to be evidence to suggest from my observations, that some of the negative aspects of a previous role, when they are absent in the employee’s current role – generates a de facto sense of satisfaction. That is, the absence of negativity, generates an immediate positive perception of their current role. Something which may enhance the potency of mobility power, by making some work and by extension, some employers, more attractive to workers, than others.

### 6.2.4 Absence of Resistance

In chapter five, I suggested that given the amount of work and the mechanisms used to control workers, I was surprised by the lack of resistance I observed from the nurses in my study. As I suggested in that chapter, this may be related to the point I have made in the previous section of this chapter, that a job role looks more attractive (and therefore workers are less likely to show signs of resistance) where it does not possess the working conditions that made work more challenging in a previous role. However, I suspect that this is only part of a possible reason for the lack of resistance amongst the group of workers that I observed.

Throughout the second part of this chapter, I have suggested that the motivation of many public sector workers is something of an enigma and may not be fully explained by current LPT. I have suggested that this
motivation manifests itself, when workers routinely undertake additional work that is not remunerated or adequately acknowledged; when workers use their discretion and ‘bend the rules’ – without any obvious benefit to themselves; when workers experience a sense of joy and satisfaction of various kinds through their work and when workers’ choice of employer is influenced by the opportunities that an employer can provide for developing a relationship with the human product of their labours. All these factors seem to indicate, social relations in production, between the worker and their human product – a relationship that is quite distinct and separate from the social relations usually discussed within LPT. Might all these elements of the relations in production, be a possible reason for the lack of resistance at the point of production, by the nurses in my study and possibly in relation to public sector workers in similar roles, more generally?

6.3 Summary

In this chapter, I have argued that after analysing the labour process of the nurses in my study there are elements of the labour and nature of the production relationships, which present something of a theoretical challenge to an orthodox understanding of LPT and associated concepts.

I illustrate this challenge by asking whether it is reasonable for me, when using LPT as an aid to analysis to reduce the relationship between a nurse and their patient – or indeed any public sector worker who provides services to vulnerable people – to that of a worker producing a ‘product’? This is something that LPT demands of me to do and yet it seems to fall someway short in understanding the complex nature of the relationship between a public sector worker and the transformed (but human) object of their labour process.

It is Delbridge (1998) who argues that workers are committing to their own exploitation through the implication of uncertain global markets. Twenty years later, this same tactic is being used in the UK public sector; but the
uncertainty is generated through austerity and the threat of austerity measures, as well as the NPM-inspired pressures to improve efficiency and reduce costs. Despite this context and because of a moral commitment to the benefits of the services they provide to the vulnerable, public sector workers are at times, obligated to their own exploitation.

I suggest that more work is therefore needed to adapt LPT to the context of public sector workers who deliver services to the most vulnerable members of our society. I suggest that if this challenge is not taken up, the theoretical relevance of LPT may be limited to only certain workplace settings. It is Jaros (2001) who suggests that LPT has the potential to impact powerfully on the development of ideas and the political agenda. However, as a consequence of the potential limitation in LPT that I suggest have highlighted, researchers may be in danger of losing a very valuable and insightful analytical tool. A tool that will be indispensable in an eco-political environment, where analysis of the kind that can only be produced using LPT, is more relevant and necessary than perhaps ever before.
Chapter 7

Conclusion
7 Conclusion

In this concluding chapter, I summarise why this thesis is important and what contribution I believe that I have made to academic knowledge. This contribution is divided into analytical, theoretical, methodological and personal contributions. Also included in this final chapter is a section on what this thesis is not claiming – which I believe it is also important to discuss, in this the concluding part of the thesis. Within this chapter I will outline the limitations of this study and include what I believe are possible directions for further research. However, I begin by providing a summary of each chapter in turn.

7.1 Summary by Chapter

As is usual, my thesis began with an introductory chapter where I set out this research study in its context and explained why the research was necessary and also who might benefit from reading it. I also briefly outlined my personal motivations for undertaking this work and why I was drawn to this particular area of study in the first place.

The second chapter was a review of the literature relating to this study. The chapter included an overview of the emergence and characteristics of NPM and its impact (over several decades) on the traditional ethos of the public sector, as well as a brief discussion on the impact of NPM on the professional occupations within the public sector. I also looked in this chapter at the characteristics of professionals – in particular, the characteristic of autonomy. I then went on to look at healthcare professionals and in particular, nurses and the relationship between nursing and nurses as managers. Within the context of an acknowledged characteristic of NPM reforms, I looked at standardisation and specifically standardisation within healthcare. I then went on to develop this further and discussed how standardisation can be used, as a way to deskill and enable the delegation of work to less qualified workers, as well as being used as a method of control. At the end of the first part of this second
chapter, I looked at a number of different manifestations of non-compliance to standardised practice. In the second part of chapter two, I provided an overview of specific elements of LPT, which is the framework I subsequently used for my analysis of the data in this study. As part of this overview, I used the work of Braverman (1974) as an introductory framework to the central concepts of LPT and then went on to discuss labour and the labour process, the division of labour, management control and consent.

In chapter three, I provided a detailed account of the method and methodology I used to undertake my research. In this chapter, I discussed my ontological and epistemological position in relation to this research and also included the broad aims of my research. I also explained how my research design was deliberately developed to focus on the non-care giving elements of nurses' work, which was my primary research interest. I also discussed my research design in this chapter and highlighted that a feature of this design was that I did not observe the nurses when they were providing direct care to their patients but observed them at all other times. I explained how this gave me a unique ethnographical perspective on the nurses' non-care giving work. In the concluding part of this third chapter, I discussed the ethical considerations of my research and I framed this through the universalist and situationist views of ethics.

In chapters four and five, I discussed my findings and these chapters were broadly split between findings that I felt complied with current LPT (chapter four) and those, which left some analytical and theoretical questions remaining unanswered (chapter five). In chapter four, I outlined the labour process of the nurses in the Team. I described in some details the nature of their labour and I also discussed the nature of the nurses' point of production and how this was geographically dispersed, which meant visual surveillance of these workers – by their employer – was impossible. I provided analysis of the mechanism by which the nurses' employer extracted effort power from these workers using a technical mechanism of control and I described in some detail how the nature of the work and the
system of work allocation was used to facilitate this control. I also analysed the skills used by the nurses in the Team to undertake their work and used a framework developed by Apesoa-Varano (2016) to categorise their nursing skills. Towards the end of the chapter, I explored the LPT concepts of compliance, consent and struggle in relation to the nurses in the Team and analysed elements of the nurses’ labour process, based on these concepts.

In chapter five, I outlined some of the different forms of invisible work undertaken by the nurses in my study and to whom this work appeared invisible. I also discussed how the nurses exercised discretion within their labour process and I debated whether they were able to act autonomously, or whether this was actually a source of potential, professional vulnerability. In the final parts of this chapter I looked at the sources of joy and sorrow that the nurses experienced as they transformed untreated patients into treated ones. I also began to explore whether these aspects of their labour process were adequately explained by LPT. At the end of this chapter, I discussed mobility power and used the concept as an analytical device to understand the nurses’ motivations for choosing their current employer.

In chapter six, I drew broader conclusions from my findings and discussed in more detail a central contribution of this thesis; that is, the theoretical questions that I raised about the motivation of workers to “go the extra mile” and suggested that this is not fully explained within LPT. I also drew out the potential consequence of this possible theoretical gap and how this may have implications on the effectiveness of LPT as an analytical tool in particular contexts and the potential consequences this may have for future research efforts more generally.

In this chapter, I summarise my contribution in more detail, as well as outlining the limitations of this research and also suggest possible direction for further research.
7.2 Contribution

This thesis is about nurses and the valuable work they do, in particular it is about community nurses and the valuable work that they do outside the confines of an acute healthcare setting. As this study is ethnographic in nature, I hope that part of the contribution I have made in carrying out this research is to provide a glimpse of the day-to-day work and labours of a team of community nurses in a large, North of England city who work for and within the NHS. Moreover, I believe if that were my only contribution, it would have been worth my effort. However, I am conscious that the expected output from doctoral research is more exacting and I quite rightly have to be more innovative and novel about my contribution. Therefore, in this section, I outline what I believe are the other contributions I have made, as a result of this research study. At the end of this section, I also outline what I believe to be the things that I am not claiming, as a result of this research.

7.2.1 Analytical

I hope that throughout this thesis it is apparent that I have a high, academic regard for LPT. I trust that my readers are not labouring under any erroneous assumption, that my critique of this theory, means I do not have the upmost regard for it. Nothing could be further from the ‘truth’. Indeed, it was the relevance of LPT to my lived professional experience, that drew me to the ideas of resistance, consent and the nature of labour and work contained within LPT, in the first instance. It was also my understanding of their relevance to the public sector that eventually led me to undertake this research, as part of my doctoral studies and use LPT as the tool for my analysis. This leads me to the first element of my contribution and that is, I want to suggest that my successful application of LPT, to analyse the labour of workers in the public sector, adds to similar research previously undertaken in the sector and highlights how this versatile theory can be used to analyse and understand the labour process of different types of workers, working in different sectors. I also want to suggest that my study illustrates how LPT can be used to analyse the labour process of
‘professionals’ and in particular, professions working within a healthcare environment. Within my account of these workers’ labour process, I provided some detail of the nature of their labour and the mechanisms of management control undertaken by their employer. I also detailed how work extensification and work intensification were a feature of the nurses' labour process and I have suggested that these were features of the mechanism of control. I discussed some of the ways in which this group of workers complied and consented to their employer’s control and how this was at times entangled in their responsibilities to their profession and also to their patients. I also discussed how resistance and struggle (mostly individually, rather than collectively) was manifest in these workers.

7.2.2 Theoretical

As I have discussed in the previous section and suggested throughout this thesis; I have used LPT as an analytical tool to illuminate understanding of the labour process of the community nurses in my study, through recognised theoretical concepts within LPT. In this thesis, I believe that I have provided a useful account of the nature of the labour process of community nurses within the contemporary NHS.

In chapter five, I drew attention to the invisible elements of these workers’ labour process and began to hint that there may be theoretical limitations to LPT, when using it to support the analysis of public sector workers, such as the nurses in my study. I continued to develop this assertion, when I discussed whether I could reconcile LPT with the actions of public sector workers who intentionally used their discretion to benefit their patient/client/customer, with no simultaneous benefit to themselves; indeed, sometimes they exercised their discretion at the expense of their own comfort and ease. In trying to understand this behaviour, I suggested that it had less to do with consent in their social relations with their employer (which is a conclusion some would immediately suggest) and more to do with a worker’s relationship with the human product of their labour process. I also argued that this relationship between worker and
product was somewhat difficult to reconcile within LPT, which relies on an antagonistic model of control-resistance and worker-employer and has little room for any relationship that is not zero-sum.

I went on to support my argument of a relationship between worker and product by describing how the workers in my study experienced both joy and sorrow in their ‘relationship’ with their human product. The joy they experienced was satisfaction at contributing to their patient’s physical recovery; not just satisfaction at having done a good job. This was a type of satisfaction that they experienced almost viscerally. The opposite was also experienced by these workers when they felt sorrow at their omissions; that is, what they were unable to do for their patients, or what they would stop doing once their relationship with their human product came to a natural end.

In considering these theoretical issues, I also looked at the choice of employer made by the workers in my study using the concept of mobility power. I suggested that some of the positive aspects of the nurses’ role and the extent to which this allowed them to build a satisfactory relationship with their human product had a significant impact on their choice of employer. Here, I argued again that this is a concept that is difficult to reconcile within orthodox LPT, which largely relies on an antagonism within relationships of production. Again, I suggested that a relationship appeared to exist between worker and product, which was not obviously recognised by LPT and was not of an antagonistic nature.

In conclusion then, I want to reiterate that which I discussed in more detail in chapter six; that is, that the lack of resistance observed in the workers in my study, forced me to ask the question, why? It was from that question around lack of significant worker resistance that my argument and academic contribution in this thesis flowed. An argument that suggests that the lack of resistance observed is merely a symptom of underlying issues. A part of this lack of resistance might be explained by a lack of opportunity for workers to organise collective resistance, which I think may
be a reasonable counter-argument to my suggestions; that lack of resistance may also be in part as a result of the workers' professional responsibilities and values, that oblige them to act in a particular way, which are also likely to reduce the instances of resistance. Again, I think this may also be a reasonable counter-argument to explain my suggested lack of resistance amongst this group of nurses.

The LPT concept of mobility power helped me to analyse why the nurses in my study chose to work for their current employer, despite experiencing both work intensification and work extensification within their labour process. This I argued was possibly partly due to the points of resistance in their previous roles, not being present in their current role. However, what I believed to be more significant was that the nurses current role afforded them the opportunity to build and develop a relationship with their human product, which meant that they choose the work of their current employer, rather than another. This supports my suggestion of a relationship between worker and product (as I have already discussed) and is to some extent, theoretically problematic for conventional LPT. It is this theoretical concept that is at the crux of this thesis and it is this suggested relationship between worker and product which is influencing the exercising by these workers of their mobility power. What is this relationship between worker and human product? What is the nature of this relationship and how might LPT adapt to accommodate a theorising of such a relationship? I believe that these questions are worthy of consideration in further studies and as such, are a positive contribution to the ongoing debate within LPT and one that I will return to later in this chapter, when I discuss my suggestions for further research.

7.2.3 Methodological

I believe that the methodological approach to my research was both innovative and novel and in adopting it, I have made some contribution to the use of different methodological approaches within an ethnographic research context.
Earlier in this chapter, I outlined my suggestion that there is a theoretical gap in LPT, which does not recognise a relationship between worker and product. However, my research approach and method were firmly grounded in the idea that the worker should be the focus of any research that is to be informed by LPT. As a consequence, my research method (which I outlined in some detail in chapter three) was focused on the nurse; unfettered by any distractions from patients, or patients’ families. My approach meant that I was able to focus entirely on the worker and their environment and when the nurses discussed their patients, I saw these patients through the eyes (as it were) of the nurses. I received information about patients, by proxy through these workers; sometimes this was on a one-to-one basis with a nurse and at other times, it was as a result of a discussion about a patient, that was engaged in by a group of nurses.

My ethnographic method meant that I spent many hours sitting in a car; often accompanied by a nurse, but also on my own. This provided me with an opportunity not often afforded to an ethnographer (Emerson et al. 2011); that is, the time to write up detailed field notes, whilst I was still in the field. However, this particular method of ethnographic endeavour was not suitable (in the UK, at least) for fieldwork conducted in the winter months; as this ethnographical approach required reasonable light and moderately warm temperatures for it to be comfortable for the researcher. I am not however, suggesting that this particular method is not possible in the UK during winter months; merely that it would require the researcher to be sat in a car for many hours, in the dark and in winter temperatures.

My focus entirely on the nurse and their perspective, enabled me to bring into the light, aspects of a nurse’s labour process that is often ill-defined, or somewhat ‘invisible’; Allen (2015) outlines this approach:

…the aim…is to place direct patient care in the shadows in order to shine a light on nurses’ organising work. (Allen 2015:3)
I maintain that the research method I adopted was well suited to undertake the kind of work that Allen (2015) outlines and one that she believes is a neglected research area.

The idea for carrying out my research in this way came to me, in part, from a personal sense that sitting in a car with another person creates an immediate bond; a bond that I had experienced develop previously, during my professional life. Individuals seem to feel able and more willing to discuss openly their feelings and concerns when they are in the protected environment of a car; rather than the Orwellian confines of an organisation’s building.

I suggest that my methodological approach for this study was somewhat novel and also ideally suited to an ethnographic approach that is focused on the worker, the work and the lived experience of that worker, within the work environment.

7.2.4 Personal

I believe that a personal contribution from this thesis is the fulfilling of my commitment to the nurses who took part in my study. I promised to show through my research, the nature of their labour and the skill that is required to carry out their life-enhancing and life-preserving work. I also made a commitment to reflect the conditions in which they do this delicate work and the dedication that they show day-in and day-out to their patients.

There are many more field notes that never made it into this thesis. That is the nature of writing up doctoral research, the data has to support the argument. However, there is a feeling approaching regret, that I am not able to share with my readers some illustrations and incidents that show different aspects of the commitment and dedication of this group of nurses.
7.2.5 What I am not claiming in this thesis

In this section, I outline what I am not suggesting in this thesis, as I believe that clarity in this area is as important to state as those contributions that I am claiming have derived from this study.

As I hinted at earlier in this section, I believe that LPT is an incredibly valuable analytical tool, for the analysis of workers and their labour and I trust that I have gone some way to showing that this theory is both relevant and useful in the analysis of workers and their labour in the public sector. As a manager who had spent all my career in the public sector, it was the relevance of LPT to my experiences over the last three decades that drew me to the theory and to the field of industrial sociology in the first place. As such, one of the key points I want to discuss in this section is that, I am not claiming that LPT is unfit for purpose and unsuitable for the analysis of public sectors workers. I am actually claiming quite the reverse; that LPT is versatile and adaptable enough to analyse workers in the public sector, including those from a ‘professional’ background.

In this thesis however, I have suggested that there is a potential aspect of the labour of perhaps some public sector workers that seems to jar with conventional thinking within LPT, one which centres on the worker and the product of their labour process. This is a theoretical issue and one that I (obviously) believe to have some merit. However, it was not my intention in this thesis to create a straw man in the shape of LPT and then argue against it; rather, my motivations were to use LPT for analysis and were it did not quite provide a neat theoretical fit, to highlight this in order for others to comment on the validity of my argument and in due course may develop further theory. If others do not agree with my argument that is their prerogative and the theory is in no way poorer for the debate.

My other key point about that which I am not claiming is an obvious one (given my ontological and epistemological stance), albeit, one that I think requires clarification; that is, I am not making any claims about
generalisability, in relation to my observation of the nurses who participated in this study. This is a study about a group of nurses in a city in the North of England, at a specific time; it is unique and as I have discussed in chapter three, a socially constructed experience. What I am claiming however and something which is self-evident in this thesis is that my observations of these nurses may have highlighted a potential gap in the socially constructed theory that we refer to as LPT. In effect, I am highlighting a socially constructed gap, in a socially constructed theory, which I am suggesting may need to be filled with more socially constructed theory.

7.3 Limitations

Before I begin this section, I want to be clear that the limitations of my study, will not morph into a critique of the ethnographic approach to research, as a method – that would be rather self-defeating. I am assuming that given the methods widespread use over many years and in many different fields, it is accepted as a valid method to use for studying a group of workers, over a number of months, within their own workplace setting. An ethnographic approach is also entirely consistent with my ontological and epistemological position; indeed, many of the limitations levelled at an ethnographic method of research are neutralised when set in the appropriate ontological and epistemological context.

However, I do accept that a possible limitation of this study may have been the amount of time I spent in the field. In total, I was in the field for 140 hours and this was over an elapsed period from the 25th July 2016 to the 23rd November 2016. Whilst I believe this was enough observational hours to draw conclusions about the characteristics of the nurses’ labour process and also draw the theoretical implications that I have outlined in this thesis; it is also likely that my understanding of the nurses’ labour process would have become deeper and broader, following a more prolonged period of time in the field. Some ethnographers suggest a minimal time to be spent
in the field; I do not accept this reductionist approach to ethnographic research. I also believe that in some quarters, there is an unnecessary focus on the number of hours spent in the field, which at times borders on the obsessional. In my study, a prolonged period of time in the field was not possible, largely due to the limitations of time associated with undertaking primary research, as part of a doctoral studies programme. Whilst I believe it was enough time to draw the conclusions and arguments in this thesis, I accept that my understanding of the nurses’ labour process would have likely deepened had I spent longer with them.

As I have inferred already in this chapter, the design of my research study lent itself to observation during warmer months. The need for me to spend long periods on my own in a car – without heating – meant that my particular ethnographic approach was only (comfortably) feasible between the calendar months of April and October. Indeed, the period of time I spent in the car during November (2016) was the most uncomfortable of my whole fieldwork experience. I include this personal inconvenience, only because it illustrates another limitation of my research; that is, that I did not observe the nurses during prolonged periods of adverse weather and as such I have no detailed understanding of the impact bad weather could have on their labour process during the winter months. How did weather impact on the nurses’ view of their patients? Did the nurses relate to their work and their patients in the same ways as I had observed, during my time with them? How did adverse weather conditions affect the labour process of the nurses? Did adverse weather result in further work extensification and work intensification? I experienced only one period of snowy weather, during my fieldwork with the Team and this resulted in both work extensification and work intensification; but I did not produce enough data to draw any meaningful conclusions about the impact of poor weather. What impact did adverse weather have on the nature of the mechanisms of management control? How did the weather affect the logistical elements of the nurses’ work and how did they react to this? Did delays due to the geographical environment increase during the winter months? If so, how did this affect the nurses’ relationship to their work,
their employer and also their attitude to their patients’ needs? I am unable to answer any of these questions because, during the period of my fieldwork I did not experience any prolonged periods of adverse weather; they just did not occur. All these questions remain unexplored in my study and given that adverse weather could impact significantly on the nurses’ point of production, this is a limitation and perhaps does add some weight to the argument that a longer period in the field (say 12 months), may have helped to address some of these questions and potential omissions.

7.4 Further Research

In comparison with research undertaken in a hospital setting, there seems to be a lack of research of nurses within a community setting. As I discussed in my introduction, this is a gap in knowledge that is particularly important given the emphasis on community healthcare in NHS England’s Five Year Forward View (NHS England 2014), where treatment in the community seems to be the “direction of travel” for the NHS. The reasons for this are many and are beyond the scope of this conclusion, but what is clear is that in the future there is likely to be an increase in the provision of care delivered outside traditional healthcare settings. What is also clear from the NHS England’s own research plan (NHS England 2017) is that there is a commitment to:

Alignment of research assets to support delivery and increasing capacity and capability in the use of evidence and knowledge exchange (NHS England 2017:16)

Of course, this means research is likely to be undertaken in the areas highlighted in the research plan (NHS England 2017); such as, technology development and service transformations that according to NHS England should improve outcomes and reduce costs; evidence, incidentally, should more be required (in the last chapter of this thesis) of the pervading influence of NPM. However, what I suggest is also needed, is more research within the community healthcare setting generally, as treating
patients in their own home and communities is a unique context and one that throws up different challenges for workers and their potential to be exploited and for employers and their need to maintain management control – compared with other more traditional healthcare settings.

Specifically, in relation to my own study, I would like to see further research on healthcare professionals working in a community setting and in particular nurses and the impact this may have on the nature and characteristics of their labour process. Will a greater reliance on community-based services lead to increases in work intensification and work extensification for nurses? How will organisations change the way they manage and control their employers who work in these healthcare setting, where the point of production is likely to be more geographically widespread? What challenges do these potential changes to control mechanisms have on nurses’ ability to both individually, collectively and professionally resist the demands of their employers?

In relation to the theoretical challenge that I have suggested is highlighted when using LPT to analyse aspects of the nurses’ labour process; that is, the relationship between the worker and their human product. I suggest that this potential theoretical gap in LPT would benefit from further investigation. Therefore, as such, I believe more research is needed on the depth and extent that similar studies highlight this potential, theoretical relationship between worker and product. I think it would be academically prudent for future research studies to look further at a lack of resistance amongst workers in different healthcare settings, as well as research that looks at this type of worker behaviour amongst other healthcare professionals. In production as well as service-based occupations, I am aware (and I have discussed it earlier in this thesis) that this type of behaviour may be attributed to Burawoy’s (1982) concept of consent or a worker’s subjective concerns over identity. Therefore, more research may be needed to analyse whether similar behaviour is attributed to consent and/or issues relating to worker identity; or indeed, could be constructed as having different theoretical significance. This research would be
academically worthwhile, because it would indicate whether this behaviour is observed only where the product of the labour process is the ‘transformation’ of a fellow human being, which is my suggestion in this thesis; or whether it is behaviour that is not limited to human products. If this behaviour is observed in labour processes that do not have a human-related product, it would make my suggestion of the significance of the human product, open to further analysis. I also believe that it would be worthwhile to focus some research on the exercising of mobility power amongst workers, whose labour process is the ‘transformation’ of another human being and how this mobility power may be wielded to increase the worker’s opportunity of developing a relationship with their human product.
7.5 **Final Summary**

In this final chapter of my thesis, I have briefly summarised the contents of each chapter and then gone on to synopsise the contribution that I believe I have made within this thesis; a contribution that I have divided into four parts – analytical, theoretical, methodological and personal. I have also included a section, which outlines and explicitly states what I am not claiming within this thesis.

As part of this chapter, I have also highlighted the limitations of this study; all were methodological limitations with implications for findings. In the final section of this chapter, I discussed what I believe to be areas of further research that have been prompted by the work I have undertaken in this study.

It is Thompson (2009) who suggests that the central task of LPT is:

> …to develop a credible account of the relationships between capitalist political economy, work systems and the strategies and practices of actors in the employment relationship. (Thompson 2009:108)

I am now at my journey’s end. I hope I have gone some way towards developing a ‘credible account’ of the nurses who participated in my study and I trust that this chapter is a fitting conclusion to my several years of labour on this research. My work is now done – it is for the reader to decide if it was all worth it.

There is nothing better for a man, than that he should eat and drink, and that he should make his soul enjoy good in his labour. This also I saw, that it was from the hand of GOD.

Ecclesiastes 2:24 (The Holy Bible)
References


