Where are the Nurses?: An ethnographic study of nurses - Seeking an explanation into their failure to redress chronic disparities in the late 1990's

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Background of the study: Nurses confronting disparities

Nurses have disappeared from the protest arena. Not so long ago, in the wake of Mandela's return to the visible terrain of activism, they launched a series of strategies to resolve the arduous conditions they had long been actively resisting. Of these strategies, two stand out as being most distinct. The first was an initiative to unify the many nursing associations formed in response to National Party segregationist policies. Implementing these policies in 1983, the South African Nurses Association expelled black members and directed them to form homeland associations, which many of them did, subsequently to be organised by the League of Nurses of South Africa (LONASA), a body founded by SANA . In the context of a seriously eroded socio-economic landscape, the consequences of expelling nurses hasn't yet been fully analysed, however it is clear that the fledgling homeland associations operated with fewer resources, yet were accountable to a constituency situated within the most disadvantaged health care sectors constructed through apartheid.

In 1992, the Concerned Nurses of South Africa (CONSA), a national grouping of nurses bearing strong links to liberation structures, called a National Consultative Forum, spear-heading the unification initiative. Their mandate was focussed: unifying the divided nursing bodies was necessary to strengthen the seriously fragmented and inequitous profession. To them, doing so required the installation of nurses in policy-making positions at a national level, where their absence from active participation had been historical. A second mandate was concerned with redressing chronic institutional disparities experienced by nurses, particularly in the public sector; generated from inequalities that meted extensive consequences resonating within their personal

domains. These stances were rooted in challenges to some of the main practices constraining nurses in their work; practices which are embodied in notions of 'care', within professional relations and found in hierarchical arrangements.

There were many agendas brought to the process, yet I have argued[i] that two fundamental discourses, both framed as 'transformation', permeated approaches; one based on the imperatives of the initial platform, which embraced goals for the alteration of professional structures; the second, aimed for a merger, thus retaining the essence of the powerful SANA. Failure of the nursing leadership to address the discursive incongruities directly resulted in considerable tensions and distrust. Although the Constitutional Congress held in January, 1995 successfully formed the Democratic Nursing Association of South Africa (DENOSA) with all associations agreeing to dissolve in order to affiliate, it took two more years to negotiate 'a merger'[ii] with SANA and launch the new 'unified' organisation.

The second event was the national labour unrest which rippled through the public health-care system throughout South Africa between 1994 and 1996. It was not the first time nurses took to the streets to protest poor salaries, difficult conditions of work and chronic disparities within their work places which, for years, frustrated their capacities to 'care'. However, this episode stood apart.

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[i] In a paper "*The Transformation of Nursing In South Africa: Reality or Rhetoric*" delivered to the Critical and Feminist Perspectives in Nursing Conference, Vancouver, 1997.

[ii] SANA entered the final rounds of mediation with this new discourse which set them apart from other associations who found mechanisms for dissolution and unification with DENOSA. They argued the term was necessitated by the legal process of bringing two constitutionalised bodies together yet exemplified the resistance within SANA to concede to unification.

Firstly, the labour unrest occurred within the context of political transition when the new government needed to project images of stability and control. Nurses' failure to succeed might be viewed as a compromise based on privileging success for the new non-racial democracy. Some writers have posited this moment of struggle as a clash of two moral economies[iii] reflecting the tension between growing expectations of the workforce coming up against priorities of the RDP. The dimensions of issues underpinning the labour unrest resulted from the inequities of apartheid-capitalist dictates. Notwithstanding this, black nurses were essentially rebuffed by the new leadership for leaving the bedside and regularly issued with threats of dismissal[iv] thereby diminishing the flames of equity and fanning those of capitalist and patriarchal relations of power.

Secondly, the strikes were not a coherent attempt to resist oppressive forces, as research[v] has shown that many nurses were divided while many were threatened and coerced into leaving the bedside. The many anecdotes by nurses who told of hiding in cupboards, locking themselves into offices and taking leave to evade abuse by male workers illustrated the considerable threats to nurses' safety and the neglect of rights to choose. In addition to this, nurses lacked tacit support from the public at large during the labour unrest, as was evident by the attacks directed at nurses' 'immoral', 'unethical' behaviours launched by the popular

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[iii] See D.Bonin, T.Gwagwa and A.Sitas. 1994. "Strikes and worker expectations in KwaZulu Natal" in SA Labour Bulletin. Vol 18 No5.

[iv] See for example, "Govt's threat to rebel nurses" in Cape Times. 29.9.95; "Angry nurses boo Zuma" in Sowetan, 19.9.95; "Florence Nightingale turns in her grave" in Mail and Guardian, 8.9.95.

[v] For further literature see the work of Phumele, Kunene (1995. *Strikes by Nursing Personnel: A Challenge for Nurse Managers in KwaZulu-Natal Province*. Unpublished MA: University of the Witswatersrand.); and Sitas, Ari., Burns, Catherine, Webber, June & Phillips, Gary. (1998. *A National Survey of South African Nurses*. Unpublished survey commissioned by DENOSA)

press, a reaction common to protesting nurses internationally, notwithstanding the nature of their issues[vi]. The strikes fizzled out following the formation of work-place forums and a nominal increase in wages.

The outcomes of both these efforts is debatable, but when viewed within the framework of effectively altering constraining and often contradictory practices within their work sites, nurses' general circumstances are unchanged. There is considerable evidence to show that difficult conditions continue to challenge capacities to deliver acceptable levels of nursing care. Government priorities of setting the district health care systems in motion has translated into substantially decreased funding to public tertiary facilities over the past five years, aggravating shortages of staff and resources.

Adding to this are the deeply rooted perceptions of nurses that permeate societal discourses. To work as a black nurse in a society rife with less than favourable anecdotes about nurses, compounds harsh realities already experienced by black women. Broadly disseminated attitudes forwarded by doctors, patients, the media and the public that the images projected by, and the care given by SA nurses, is highly divergent to those inherent to classical Nightingalism - essentially embodied in images of capes, caps and continuous care. Indeed, nurses are often spoken of as being 'lazy' and indifferent, they 'take far too many coffee breaks', are only concerned with their 'status', their 'authority', as is evident through disclosures about how 'bossy' and 'negligent' they can be[vii]. For many of their critics, this was most evident in their 'moral

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[vi.]This literature is quite substantial, generally rooted in feminist aims to understanding women's, specifically nurses', enforced subjugation within the workplace. For example, see Garmanikow, E. "Sexual Division of Labour: the Case of Nursing" in Kuhn and Wolpe (eds) 1978 *Feminism and Materialism: Women and Modes of Production.* London: Boston and Henley.; Witz, Anne 1992. *Professions and Patriarchy.* London: Routledge; and, Bowden, Peta. 1997. *Caring: Gender-Sensitive Ethics.* London: Routledge.

[vii.]These observations result from informal conversations with doctors at KEH, 1996 - 1999, generally discussion were initiated by doctors inquiring into my

abdication' from the bedside during the labour unrest that threatened to, and indeed at times, brought the SA health care system to a stand-still between 1994 and 1996. Consequently, it is within these realities that black nurses have disappeared from the protest arena highly disillusioned, demoralised and devalued. Indeed, nurses, if not nursing, is in crisis as this country enters its second term of democratic governance.

Research problem, methodology and theoretical approaches
This paper describes research conducted between 1996 and 1999 within the public hospital system. The research was driven by an interest in understanding how nurses have failed in altering their circumstances in an environment of considerable social and political transformation. Responding to this question is of tremendous value to nurses, patients and the transforming health care system, for a number of reasons. Firstly, nurses form the backbone of health care systems globally and are essential to their operation. As such, I argue that for this transforming health care system to gain momentum and strength, nurses must be enabled to develop the stamina and capacity necessary to contribute, which calls for the resolution of the issues at the centre of their frustrations. This is all the more urgent in order for nurses to participate in building a constructive response to the HIV / AIDS pandemic, now reaching devastating proportions in South Africa.

In South Africa, nurses are a highly diverse arrangement of primarily women who cannot be reduced to one unified category, type, or ideological orientation. They become closest to representing a unified type in that most share similar locations of disadvantage. Numbering well over 150,000, they comprise the largest part of the health-care sector, and a formidable constituent of women within the work-force.

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presence in clinical areas; from narratives of nurses, based on personal experiences.

Thus, the correlation between occupational sex-segregation and constrained class location is an important parameter of this study. This statement was reinforced in a national survey of nurses[viii] conducted in 1997 which illuminated features of nurses within the sphere of work, profession and home. It showed that nurses are mainly women who fall into all categories of work, from professional to semi-skilled workers. The majority have undergone a four year training programme to earn the qualification of registered nurse; as such, the average gross salary is R3,600. Although 52.6% report they are in a full time marital relationship, 82.3% are mothers. The majority (67.2%) live in households comprised of 3-6 people, with close to 15% living in larger households. Of these two groupings, over 30% of nurses are the single wage earners.

Secondly, by virtue of education, experience and location within the health care system, nursing has the potential for playing a pivotal role in leading the primary health care initiative and in informing policy decisions. Nursing education of the 1990's is underpinned by psycho-socio-biological theories which aim to develop strong assessment, planning and intervention capabilities. Within supportive health care environments, these theories are potentially honed through practice, thus cultivating competent and skilled practitioners who have much to contribute to PHC initiatives and policy development. The absence of nurses from these arenas points to the legitimacy and credibility that has yet to be forged for nurses as professionals.

Thirdly, a search of the literature revealed considerable research that highlighted issues confronting nursing and nurses within the context of the profession and work environments. Valuable contributions to issues such as burn-out, stress, absenteeism, recruitment and retention have

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[viii.]This study "A National Survey of South African Nurses" was undertaken by a multi-disciplinary team of researchers at the University of Natal Durban, commissioned by the Democratic Nursing Organisation of South Africa. It is available from DENOSA.

contributed to knowledge within these terrains. I have approached the study with a view to explore nurses beyond the usual boundaries of their occupation and work-place to include the historical and social spheres of their realities. This approach embraces feminist methods that highlight the importance of theoretically synthesising difference and disadvantage[ix], thereby enhancing insights into notions of identity, difference, cultural cleavages while noting the economic features of inequality. It also contributes to this growing literature on South African nurses marked by the works of Shula Marks, Laetitia Rispel, Jacqueline Mybhurg, Liz Walker, and others[x].

Lastly, South African nurses are often portrayed as inactive and docile participants or victims of their grim social and work-related

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[ix.]Jacqueline Cock and Alison Bernstein effectively argued for this theoretical 'fusion' in a paper presented at SASA, 1998. "Diversity and Disadvantage: Perspectives from the USA and South Africa".

[x.]Shula Marks has a number of publications that critically analyse the history of nursing in SA. The most comprehensive is her book Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession. Johannesburg: Ravan University Press. 1994. In addition: Marks, S. 1993. "The nursing Profession and the Making of Apartheid" in Bonner, P., Delius, P. and Posel, D. Apartheid's Genesis: 1935-1962. Johannesburg: Ravan Press; Rispel, L. 1990. Nurses' Attitudes to Different Organisations: Policy Implications. MA Thesis: University of the Witswatersrand; Rispel,L. 1995 "Challenges Facing Nursing in the RSA" in Image: Journal of Nursing Scholarship. 27:3; Rispel, L. and Schneider, H. 1989. "Professionalisation of SA nursing: Who Benefits? In Rispel, L (Ed) Nursing at the Crossroads: Organisation, Professionalsiation and Politicisation. Johannesburg: CSHP.; Myburgh, J. 1990. Unionism and Collective Bargaining in the Nursing Profession. MBA, University of the Witswatersrand.; Walker, L. 1993. The Responses and Understandings of a Group of Primary Health Care Nurses, Based in Soweto, to the Issue of Abortion. MA: University of the Witswatersrand.; Walker, L. 1996. "My work is tot help the woman who wants to have a child, not the woman who wants to have an abortion: Discourses of Patriarchy and Power among African Nurses in SA" African Studies. 55:2.; Webber, J. 1994. The Concerned Nurses of SA and the Transition f Nursing Organisations in SA: 1994. BsocSci (Hons) Thesis: UND.; Webber. J. 1997. "The Transformation of Nursing in SA: Reality or Rhetoric" Unpublished paper presented at the Critical and Feminist Perspectives Conference. Vancouver.

circumstances. I believe this to be highly inaccurate, albeit a useful tool for the reinforcement of their subjugation. Nurses continue to operate with a strong moral ethic and commitment to their patients. History has shown that nurses were not only central to forging a strong professional body with high standards and a strong, international reputation, they remain the most accessible care-providers within health-care environments. In South Africa, nurses have been active participants in political resistance throughout apartheid, from the earliest days when the government used nursing bodies as the vehicles for issuing passes to black women, to the more recent periods of mass action[xi] . Nurses need to be recognised as active players whose involvements are among those structuring, reinforcing or resisting their current realities.

Methodologically, this study was undertaken using ethnographic approaches of participant observation and semi-structured interviews. The sample involved 26 black female nurses, drawn from different occupational categories and hierarchical locations, in order to gain a representative sample throughout the institutional hierarchy. Although the sample was purposive, nurses were selected randomly by a senior supervisor, based on availability. Interestingly, all the nurses were initially educated within a college-based programme, their experience within the field spanning 30 years. While the older nurses of a professional category were more inclined to have pursued university degrees and maintain affiliation to a professional association, the younger nurses were generally not.

The semi-structured interview aimed at gaining testimonies of the many contexts experienced, starting with descriptions from childhood and home, to the current moment within society, institution, community and home. This approach aimed for an understanding of nurses' diverse locations as women, in relationships and structures of their homes,

[xi]See Cherryl Walker. 1982. Women and Resistance in South Africa. London: Onyx Press; Critical Health, "Special issue on nursing" No 24, October, 1988; Shula Marks, 1994, Ibid.

communities and work environments during the various stages of apartheid and post-apartheid; it sought explanations for decisions to enter nursing and, delved into descriptions of practical experiences within the occupational setting, for example conditions of work, interpersonal relations, rewards, frustrations. Further, I pursued insights into their knowledge of and responses to unification of nursing organisations and labour unrest between 1994 - 1998.

The primary site of research, King Edward VIII Hospital (KEH), the second largest hospital in sub-Saharan Africa, was selected as it presented a single site offering a number of sub-sites within its parameters. The hospital was built in 1936 on a lip of industrial land in Durban to respond to an acute shortage of hospital beds for the massive influx of African and Indian labourers and indigent. From the outset, it was beset by a lack of resources and equipment for patient care that was to endure through 60 years of operation. The Race Relations Survey[xii] compared funding of Groote Schuur Hospital and KEH showing the gross disparities manifested through apartheid policies. KEH operated on half the budgetary allocation, 33% more beds and 132% fewer staff than Groote Schuur. In addition, since the hospital expanded to its current 2,000 bed capacity, records showed a continuous over-occupancy, resulting in an average of 150 patients cared for on floor mattresses or double-occupancy in beds in the case of children, a root cause for cross infection. Additionally, the nursing staff, predominately black, located in stark contrast to the medical and administrative staff primarily of Indian and Caucasian origins, presented the potential for complex work relations, considering their historically disadvantaged location as black women. Finally, KEH was a site of labour unrest between 1994 and 1996, a social event central to this inquiry.

[xii.]See the 1993/1994 version, Johannesburg: South African Institute of Race Relations.

The study found nurses isolated and quite exposed within chaotic institutional relations, leaving them fragmented as a work-force. This finding contributes to feelings of frustration, disillusionment and demoralisation, a finding which explains their inability to remain in the protest arena. On the other hand, the study also found nurses to be assuming divergent and disparate forms of defiance and resistance within the public and private spheres. Nurses seem to negotiate the contradictory terrain of resistance and acquiescence to their own subordination, a process somewhat dialectical in nature that operates to retain women within constraining relations.[xiii]

The analysis of women within the context of apartheid relations has been taken up extensively by SA scholarship. Building upon a socialist-humanist Marxian foundation to examine women and protest, Belinda Bozzoli argued that women's struggles could be categorised according to two types, she developed through concepts of internal and external domestic struggle. The former refers to women's issues fought on the home front in relation to labour, income and property issues; the latter incorporates domestic issues women negotiate within the broader capitalist sphere. Bozzoli's work helps in analysing how women contest and accommodate broader material constraints, positing the concept of a patchwork quilt of patriarchies[xiv] as embodiment of the notion that there is no single logic to these struggles.

Whereas Bozzoli's work extends analysis beyond unitary

[xiii.]Cherryl Walker (1990) takes this point up in *Women and Resistance in South Africa*. Deborah Posel (1992) elaborates it in her own theoretical formulation in "Women's powers, men's authority: Rethinking patriarchy" paper presented at Women and Gender in Southern Africa Conference, Durban.

[xiv.]This oft quoted concept originated with Belinda Bozzoli, 1983 "Marxism, Feminism and South African Society" in Radical History Review, 46/7; it has been employed here following further reference by Cherryl Walker and Deborah Posel.

conceptualisations of patriarchal power relations, Posel argues that power, domination and patriarchy require theoretical tools that enable the exploration of the "contradictory nature of urban African gender relations"[xv]. She suggests the need to establish the difference within and between domestic struggles by elaborating the existing tensions between challenges to extend power and the consequent challenges to men's positions of authority. Here, she draws on Barrington Moore's work to argue that relations of authority tolerate degrees of resistance in that

> the exercise of authority is not based on coercion alone [but rather] is grounded in some degree of consent on the part of the subject of that authority [xvi]

This approach is instructive when trying to understand the historical and contemporary responses to nurses' resistance. Yet the limitations of these frameworks exists, not so much in the way that these struggles are interpreted, but notably by the unilateral focus on patriarchal relations of power that do not easily allow identification nor analysis of dynamics not strictly divided along patriarchal lines.

Posel suggests there are two different forms of domestic struggles: women's challenges to extend power which do not challenge the position of authority held by men, and women's direct challenges to male authority. Whereas the latter involves some degree of rejection of patriarchal norms, the former struggle occurs within the boundaries of accepted patriarchal norms. Clearly, the 1994-1996 labour unrest and initial mandate by progressive groupings to unify nursing aimed at the resolution of disparities and extension of power of nurses, but in no way presented a challenge to patriarchal relations.

Importantly, the key to explaining nurses' failure to alter their disparate

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[xv.] Ibid, p.10.

[xvi.] Deborah Posel,1992:13
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conditions lies in understanding the relationships and connections experienced within the various terrains nurses navigate and in determining how relations of power operate to constitute nurses as subjects. Further, explanations of their fragmentation exist in identifying and exploring the diverse forms of normative and disciplinary discourses and practices and the contradictions dissecting various spheres of their lives. Discourses and practices operate to subject nurses to a number of divergent locations within institutional relations of power, and as women, within organisational and patriarchal relations of power. Many of these practices operate in contradictory ways, intensifying their isolation and vulnerability through the various relational spheres they negotiate. With this in mind, I elected a feminist, post-structuralist theoretical approach which centralised the concepts of subject and subjectivity signifying a break from humanist traditions' orientation to abstractions of the individual or to an essentialised identity[xvii].

Post-structuralism proposes subjectivity as multiple, precarious, contradictory and continually in the process of discursive formation[xviii]. The central operative question posited by Foucault[xix] is not so much why

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[xvii] Humanist discourses are varied yet clearly essentialise the individual as 'unique, fixed and coherent'. For example, Chris Weedon (in Feminist Practice and Post Structuralist Theory, Cambridge: Blackwell. 1987) explores this focus within humanist Marxism, which she suggests, posits women as a unified grouping alienated by capitalism.

[xviii] See for example Michel Foucault. 1986. "The Subject and Power" in H. Dreyfus and P. Rabinow. *Michel Foucault: Beyond Structuralism and Hermeneutics*. Susses: Harvester Press.; Chris Weedon, 1987; Jana Sawicki. 1991. *Disciplining Foucault: Feminism, Power and the Body*. London: Routledge; and, Amena Mama. 1995. *Beyond the Masks: Race, Gender and Subjectivity*. London: Routledge.

[xix] In his paper "The Subject and Power" in H. Dreyfuss and P. Rabinow. 1986. *Michel Foucault: Beyond Structuralism and Hermeneutics*. Sussex: Harvester Press.

domination occurs, but rather how power, knowledge and discourses operate through practices and relations to constitute subjects. He writes[xx]:

> . . . let us ask . . . how things work at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours, etc . . . we should try to discover *how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts*, etc. We should try to grasp subjection in its material instance as a constitution of subjects. (my italics)

This approach focusses upon exploring relations of power wherein power is viewed as a central feature of every social relation, intersecting all levels of interactions as a productive, multi-directional dynamic that is inherently linked to the production of knowledge. Foucault's work brings these two concepts together in dynamic unity which together catalyse, producing truths that span and alter social relations. In his work, discourse is conceptualised in tactical terms, as the vehicle mobilising regimes of truth that constitute and forge social reality and the subjects within. Subjects within this formulation are constructed through multiple, dispersed and, often, contradictory discourses.

Exploring different aspects of nurses personal, occupational and professional relations provided insights into the nexus of practices, experiences and relationships that shape different subject-locations, the relations which constrain or alter them in their different locations, and the forms resistance assumes in either rejecting or contesting their realities. Employing Foucault's approach to power, knowledge and discourse is useful in determining how particular knowledge claims and practices are employed throughout societal relations, as apparatuses to constitute, regulate, control and discipline.

[xx.]In *Power / Knowledge: Selected Interviews and Other Writings 1972 - 1977.* London: ;Harvester Press. 1980.

Care, Professions, Hierarchies: Conceptual considerations
In the initial stages of this research I considered a number of discourses and practices likely to influence nurses' attitudes and experiences within their occupational and personal realities. The ethics of care, professional discourses and hierarchical practices stood out most clearly within their occupational lives. Intersecting their occupational and personal lives is their gendered societal location, challenged and, to some extent, compromised within a context of social instability, change and transition.

Care is the core nursing modality projected by nursing theorists. As an attribute, there is no doubt that caring is ethically important. In the most generalised sense, it expresses the way we matter to one another, yet it's moral core is perceived in many ways and assumes a variety of forms. A number of feminist writers have attempted to theoretically engage the practice of care in an attempt to develop an understanding of its ethical parameters while heightening sensitivity to the tendencies of essentialising care as a womanly trait.

Carol Gilligan[xxi] shifted approaches to caring by noting gendered differences between what she terms the *justice voice*, noted for inherent moral principles and rules, contrasted by the *voice of care* which implies a broader understanding of moral agency situated within diverse moral contexts. For example, nurses describing what caring meant within the context of nursing, genuinely articulated the depth of concern linked with care. At the same time, the legalistic parameters of caring displaced capacities for concern. This excerpt works well to describe what I mean:

> Caring is looking after someone wholeheartedly, not just because you are
> going to be rewarded, but because you have feelings for someone and
> because you want to care for someone. It has to be from deep down in
> your heart. . .[but] if you really follow the nursing process you care for
> the patient according the patients' problems. . . you have to plan, you
> have to put it down. /after writing it down you go and do the nursing

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[xxi] I refer here to her 1982 work: *In a Different Voice*. Cambridge: Harvard University Press.

> interventions, and once you have the results, you go and write it down.
> [But] what we do mostly is look at Mrs. so-and-so and her problem at
> that particular time; and you just don't plan on the paper; you just look
> at the problem and you solve the problem. You have no time to write on
> paper. After two or three minutes you just go and check what the
> outcome is. But if anything goes wrong, as long as it is not written on
> paper, you didn't do it. (6 12/2)

Gilligan's theoretical shift clearly contributes to the possibility of
extending notions of care, or the ethic of care, beyond the realm of being
strictly a womanly attribute, or duty, to the broader socio-political
context. In this way, contextualising care, lends itself to taking into
account the oppressive conditions in which many practices of caring
occur. Taking this debate further, Peta Bowden[xxii] writes that

> . . .caring is perceived as an innate characteristic of women
> and therefore a natural determinate of women's social
> possibilities and roles. Correlatively, the absence of caring
> attributes is used to castigate and denigrate women. . .
> celebrations of caring reduce and simplify the range of
> women's moral possibilities those displayed in practices of
> care. . .[consequentially] the enormous diversity of women's
> ethical experiences and the wide range of caring practices,
> tend to become ossified in abstracted and prejudiced
> models of femininity and care. On this basis, the ethic is
> impotent in face of gendered, social inequalities.

Within the context of highly structured nursing relations, notions of
caring and the appropriations of caring practices stand in sharp contrast
to those with the 'characteristic freedom that mark the possibilities of
caring in friendship'[xxiii] or maternal relationships. Although there are
overlaps between the values inherent to maternal care and those taken
up in nursing practice, the context of nursing care is more formally

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[xxii] See her introduction to *Caring: Gender Sensitive Ethics.* London:
Routledge.1997: 6-12.

[xxiii] Ibid., p.101.

regulated by external forces displacing notions of free-will to care with the responsibility to care within the reality of formal organisation and public accountability.

In an effort to strengthen the professional terrain for nurses, nursing theorists have constructed scientific discourses of care as a central feature to expertise in nursing practice. Perhaps the best example can be found in Patricia Benner's[xxiv] writing, in which she illustrates how nurses navigate theory and practice to implement appropriate care through discourses of 'embodied intelligence' wherein expert nurses are posited as having the knowledge and capacity for quick response and seemingly automatic, perhaps mechanical, extension of suitable care; 'distance', a term used to denote the means for keeping feelings separate in clinical practice; and 'unidirectional focus of caring', which suggests reciprocity as an unnecessary parameter for reward . As noted by Bowden[xxv], these works aim for increasing professional credibility while enhancing the value and worth of the work nurses do. However, the approach is problematic on two main counts. Firstly, these concepts contribute to the objectification of nurses, to the depersonalisation of nursing interventions, while enhancing the isolation of nurses in the work they do. Secondly, these approaches fundamentally disregard the immense complexity and disempowering practices of structural relations within institutional settings, not to mention further gender and class constraints imposed through broader social relations.

[xxiv] Specifically, in her 1984 work *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. California: Addison Wesley Publishing Company; more recently in Madeleine Leininger and Jean Watson (Eds.) 1990. *The Caring Imperative in Education*. New York: National League for Nursing; and, P. Benner, C. Tanner, C. Chesla (Eds.). 1996. *Expertise in Nursing Practice: Caring, Clinical Judgement and Ethics*. New York: Springer Publishing Company.

[xxv] Op cit., p. 108-124.

Professional discourses and practices have been a source of considerable tension and divisions since the turn of the century when Mrs. Bedford-Fenwick, the editor of the British Journal of Nursing and ex-Matron of St. Batholomew's Hospital, successfully launched the campaign to professionalise nursing in England, much to the chagrin of Florence Nightingale. Although it was a while ago, these two orientations set apart by divergent discourses, still permeate nursing . While Nightingale's reforms altered the role of hospital matrons from that of domestic managers to managers of a body of nursing staff, it upheld themes of gender, subservience, vocation, discipline and morality that located woman as cheap labour solely within hospital hierarchies. Bedford-Fenwick's lobby for professionalisation shifted the locus of control from hospital authorities to a supra-institutional level, creating yet another hierarchy to which nurses were accountable, while instituting means of social closure[xxvi] through setting educational standards and compulsory registration to an autonomous nursing association.

Writing about professions and patriarchy, Anne Witz maintains that the professional project within nursing has failed, primarily for its inability to usurp the control of hospitals and doctors in determining nursing relations. For example, nurses within South Africa continue to be trained within authoritarian college programmes situated in hospitals. Noted by Rispel and Schneider[xxvii] as the apprenticeship system of training, their

[xxvi.] In her analysis of the politics of nursing registration in England, Anne Witz (1992. *Professions and Patriarchy*. London: Routledge) states there were three key exclusionary aspects to the dual closure strategy of nurses pursuing registration: to form a centralised system of control, self-governing and self-regulatory capacity, and a single point of entry into nursing. She asserts that credentialist and legalistic tactics featured wherein uniformity and standards provided through education, and a legal, compulsory system of registration.

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In "professionalisation of south African Nursing: Who Benefits?" .in L. Rispel. (Ed.) 1989. *Nursing at the Crossroads: Organisation, Professionalisation and Politicisation*. Johannesburg: The Centre for the Study of Health Policy.

subservience within the male medical model is entrenched, assigning little in the way of autonomy or recognition of the status earned through professional registration, nor capacity to challenge the conditions within which they work. The apprenticeship programme at the heart of nursing's professional status promotes the womanly duty to care, "turning it into obedience to external authority"[xxviii]. As Bowden[xxix] explains, the apprenticeship programme

> . . . ensured a ready supply of low-cost and disciplined young labourers who were eager to offer their services in exchange for the professional training offered. . .the needs of caring for increasing numbers of acutely ill patients and financial pressures on the institutions rapidly compromised education in favour of long and heavy hours of mindless, repetitive work on the wards. Emphasis on womanliness as the most important factor in successful nursing, stressing its meanings in terms of submission and self sacrifice, obedience to orders and unswerving loyalty to doctors rather than initiative, innovation and advocacy, gave ideological justification for this abuse.

Bolstered by university and research programmes, nursing has become increasingly qualified and acknowledged for articulating theory suitable to the changing health terrain; theories and findings which, to some degree, have filtered into the discourses of tertiary-based college programmes. Unchallenged, are the gendered practices holding nurses within proletarian institutional relations, fundamentally reinforcing working experience for many which continues to run counter to professional discourses and undermining capacities to satisfactorily provide nursing interventions. This statement is supported by the recent UND study, which showed high levels of frustration amongst nurses particularly related to staff shortages, working conditions, shortage of equipment, non-supportive management structures and poor remuneration. The inconsistencies between professional discourses and

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[xxviii.] Bowen, 1997:130.

[xxix.] Ibid., p. 130.

proletarian practices are divisive within the workplace, again as the UND study illustrated, resulting in a strong correlation between level of study / location within the nursing structure and link to professional / proletarian identity.

Witz[xxx] also suggested that although Nightingale lost the battle over registration, her reforms left a huge mark on the role and institutional position of nurses, in particular matrons. The managerial role of matron was to result in the formation of a female hierarchy within the existing institutional hierarchy, which for the most part in South Africa remains in the domain of medicine. Stratified from the outset between two main categories of nurses, the lady nurses, that is those whose qualifications allow hierarchical mobility, and regular nurses, those used for the mundane, household tasks, the nursing hierarchical relations have been the conduit for channelling the "discipline and obedience associated with the professionalisation of nursing."[xxxi]

These discourses and practices found within the ethics of care, professionalisation and hierarchical structures, underpinning the essence of nursing globally, do much to reinforce unequal power arrangements detrimental to the women who nurse. Within South Africa the further dimension of racial inequity inherent within society, and upheld through nursing practices, meted material inequities to black nurses in the forms of segregated training facilities, lower salaries, poor working conditions, and less authority within hierarchical structures. The organisations that regulated and monitored professional practice, SANC and SANA, succeeded in forging a profession with an international reputation for high standards, although falling short of upholding the universalism of the nursing ethos through the dark days of apartheid. Workplace settings and professional organisations mirrored the policies

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[xxx.]   Ibid., p. 139.

[xxxi.]   Bowden, 1997:130

emanating from the State, marginalising black nurses materially and professionally until the late 1980's when active co-optation to the ranks of the profession was in keeping with the imperatives of the State.

Through social relations denoted by class, race and gender, an arsenal of strategies have underpinned the discrimination women face in many spheres of their experience. Access to equity and choice in employment, education, reproduction and marriage has been severely hampered by various forms of control, implicit in legislative practice and within tacit understandings. African women's realities attest to this. Although the number of women entering the labour force has increased substantially since the 1940s[xxxii], African women earn the least and represent the highest category of uneducated,[xxxiii] unemployed,[xxxiv]. Not only has women's subjugation been enforced, but the location of African women as the most economically marginalised signifies vast cleavages between unemployed and employed African women, potentially subjecting the latter to powerful insights into their own comparable advantages, notwithstanding the chronic remunerative shortcomings they endure.

Gender relations, across time and space and within all cultural and ethnic groups, have been skewed by patriarchy's uncompromising persistence in constructing women's social role in domestic terms, that of nurturers, care-givers and, in the case of rural South African women, producers. Across racial and ethnic boundaries the gendered realities of women have offered some common discursive space for women, for example in the spaces shared within nursing and motherhood, or in

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[xxxii] Noted, amongst others, by J. Cock. 1990. *Colonels and Cadres: War and Gender in south Africa.* Cape Town: Oxford University Press.; and, D. Budlender. (Ed.), 1996. *The Women's Budget.* IDASA.

[xxxiii]   Ibid.

[xxxiv]   I. Valodia, "Work" in D. Budlender (Ed.) 1996. *The Women's Budget.* IDASA.

common forms of discrimination (most poignantly found in the experiences of violence against women and sexually skewed laws). These commonalities have been generally obscured by racial ideologies central to colonial discourse, particularly in their propensity for historically intersecting with patriarchy and class-based differences.

Theorising How Nurses are made subjects

Analysis and interpretation of the narratives involved determining social relationships most dominant within these experiences, primarily the levels upon which institutional and professional connections operated. Approaching the narratives in this way provided the opportunity for exploring some of the ways in which private experience, public roles, organisation and accountability directly influence meaning, the nature of caring directed to patients, and the ethical possibilities challenging care in forms of resistance.

This feminist post-structuralist approach focusses on social and institutional contexts where power relations of everyday life reside and intersect to reinforce the subjugation of women. Weedon[xxxv] writes

> . . . social meanings are produced within social institutions
> and practices in which individuals, who are shaped by
> these institutions, are agents of change . . .change which
> may either serve hegemonic interests or challenge existing
> power relations.

Three main relations of power dominate the realities of these women, and serve separately yet in an interconnected way to shape their subjectivities. Patriarchal, institutional and organisational relations of power are immediate forces through which a regime of micro regulations and disciplines operate to instill, manouevre and regulate a complex web of subject locations.

Striking illustrations of patriarchal power and dynamics surfaced

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[xxxv.]   Op cit, 1987:25

throughout this study. The narrations have posited numerous examples of the ways women's interests have been subordinated to those of men by illustrating the gendered role of women within family relationships, the contained opportunities appointed to women, and the constraints of customary law. Further, patriarchal relations of power are projected and buttressed through a number of sites, specifically through capitalist and racialised power dynamics and their interconnections. Much of the evidence for these claims has been evinced through the literature exploring South Africa's historical evolution, linking the success of capitalism to racial policies, from segregationist policies of colonial powers, through years of apartheid which succeeded in entrenching an ideological racism that will challenge social and political transformation into the next millennium. Many of the testimonies resonated with this history, revealing experiences of economic marginalisation and frank racial subjugation. Some examples emerged as the respondents cited exposure to segregation practices and to removals in their social spheres, or institutionally, subjection to laws prohibiting supervision of white subordinate staff by experienced black nurses. These illustrated, not only subjection to racialised relations of power, but the interconnectedness of racialised, capitalist and patriarchal relations of power serving the interest of a racially specific, and for the most part, male elite.

Institutional relations of power refer to the dynamics creating, guiding and reproducing tertiary relations. For the most part, they emanate from patriarchal, racialised and capitalist forces in that many of these relations serve to buttress a male-dominant, racially-stratified and materially-differentiated order. Institutional relations denote a series of practices and discourses that function to maintain order, in so doing, to sustain and reproduce power dynamics, particularly those of a hierarchical nature within the hospital setting.

Working in tandem with institutional and patriarchal relations of power are organisational relations of power. Organisational relations of power issue the professional discourses and practices that subjugate nurse to particular roles, images, codes, 'scopes of practices'. I perceive these to

be located between patriarchal and institutional relations in that, although somewhat distinct in their discourses and practices, they serve to sustain both of these forces.

Foucault[xxxvi] argued that there is no one discourse of power, rather discourses are tactical elements that operate in the field of force relations. Weedon and Turner[xxxvii] elaborate this point when they assert the importance of examining discourses within a specific historical context in order to determine the process of subjection and the interests being served at particular times. Guided by this, I approached the range of perceptions, experiences and conditions embodied by the narrators previous to their entry to nursing, and which frequently contributed to their entry to nursing, as one relational mosaic, which I called constitutive practices. Constitutive practices pointed to the different and often fragmented locations these women occupy, their private and public social contexts, and their roles within a society contesting relations of power; all commanding forces influencing the subjugation of women, the perceptions of location and attempts to negotiate one's location.

The landscape of constitutive practices bears some fairly uniform strokes, for example, all of these women were born and raised in areas that fell within politically prescribed and approved settlements according to apartheid, with a vast array of experiences related to the unfolding of segregationist legislation. For the majority their day-to-day lives were compromised economically, for many, intensified by the absence of one parent. Despite their ages, all of these nurses shared testimonies of harsh confrontations throughout their lives related to racial, class and

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[xxxvi] In "The subject and power", Dreyfus, H. and Rabinow, P. 1986. Michel Foucault: Beyond Structuralism and Hermeneutics. Sussex: Harvester Press.

[xxxvii] Op cit, 1987:111; and Brian Turner in A. Perterson and R. Bunton. 1997. *Foucault: Health and Medicine.* London: Routledge.

gendered subject locations.[xxxviii]

> Families moved into the area so we had smaller plots to farm. People were too close. Our animals were lost, sold and vanished... (3 2/5)

> My brother was stabbed to death at home . . . Well, as I say, there was a lot of unrest... (7 21/5)

> I was born in KwaMashu. . .It was affected by riots. . .You would have to belong to certain political organisations and if you didn't your life was in danger. . .The police used to come and they would throw tear gas at us and rubber bullets... (2 28/7)

> We had a local teacher and we did not like him at all. . . if you were to look down, he would say, "animal! Are you admiring your hoofs?" When there was the Sharpeville shooting, he said "we shot the animals in Sharpville because they were too clever!" (7 1/8)

For the majority of respondents, entry to nursing was a consequence related to the interconnections of their gendered, racial and economic locations. When asked about the reasons for entering nursing, the responses illustrated the tremendous impact of social context upon choice, and the range of intervening discourses framing perceptions. Whereas professional and sub-professional nurses trained prior to 1986 stated their entry was based upon having few options, restricted to teaching or nursing, women who registered over the past ten years generally submitted that they could not afford other alternatives, and viewed the apprenticeship salary as a tremendous benefit.

Though none of the respondents described a nursing career in vocational terms, most of their testimonies entailed acceptance of their decisions, either through their own senses of self or through encouragement from

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[xxxviii] I have drawn in a few concise quotations in order to demonstrate some of the points. In the original text they are cited more fully.

others, buttressed by caring motifs. These generally assumed two forms. For some, nursing became acceptable when it responded to the characteristic exemplified by Carol Gilligan's reference to 'voice of care'. That is, a strong sense of morality and concern informed their caring perspective which translated into gendered roles and responsibilities. Interestingly, these were often sentiments embodied in idealised renditions of images of nurses in pristine uniforms, recurrent to the point of my referring to them as 'icons of care' . However, descriptions extended beyond linking uniform, cape and caps with womanly traits of nurturing and care to an explicit aim for attaining a sense of control, certainty, confidence and self direction.

> I liked the way nurses dressed. With cap, they walked straight. [Their] way of walking: slender, sure-footed and kind. Talking softly. (3 2/5)

> . . . what I admired of nurses was the uniform, cleanliness. I used to tell myself that when I was a nurse, I would have my own monies . . .dreaming of having all of the things . . . (3 5/9)

The relations instrumental to constituting subject locations in regard to gender, class and race underpinned many of the explanations around why these women entered nursing. Being a woman, being African, being poor worked separately and together in influencing their entry into the profession, while informing aspirations of the profession as a choice. For some it was the hopes of escaping poverty and improving their life chances within a 'dignified' profession; for others, their gender and racial location precluded other choices; for still others, the salaried training programme was the only way of combining training with meeting their financial obligations. In many cases these three factors intertwined to influence their choice.

From the point of entry, the college-based educational programme and clinical experience was characterised a range of practices directed toward developing practitioners, as well as, achieving conformity. I termed these regulating practices, as reference to them illustrated that they were continuously at play to engender 'truths', adapt bodies, maintain

compliance despite the duplicity of the tertiary conditions.

Specific forms of power call for detailed formulations of knowledge from which mechanisms for regulating and controlling populations are dispersed. Hospital nursing programmes, and hospital environments and the relationships within, manifest elaborations of knowledge and discourses to buttress institutional relations of power. Parallels drawn between hospitals and factories, have a particular resonance within this institution. Monolithic in size and design, the discourses which served the prime demonstrations of power at this setting, served to maintain a racial rationality and order, which by their very nature contradicted central tenets of the universal ethos of health care.

The narratives emitted evidence of discourses that worked in normative and disciplinary ways, separately and in unison, in the everyday lives of nurses. Normative practices were manifest in a number of sites: through training in the form of scientific theories, ethical codes, specialised knowledge, professional competencies; all issuing boundaries within which nurses should practice. Add to this the fortifying impact of professional discourse, citing a unitary body that appropriates status, inclusivity and dignity as inherent parts of the nursing order. The inscription of these features in the icon-like symbols of white uniforms represent a discourse of their own.

Disciplinary practices operate as a prevalent means of constraining individuals and populations, operationalised through normalising strategies and techniques like surveillance. These practices function to maintain useful and manageable bodies while maintaining widespread visibility. This was most clearly displayed in the 'apparatus of allocation', a hospital rendition of the panoptical gaze. 'Allocation' is a surveillance system that is set to monitor every level of movement, recording details of attendance, patient transfer, aberrant incidents, systems failures, absences and usual or unusual events transpiring within the corridors.

Although disciplinary practices frequently illustrated contradictions to discourses of caring, their ultimate purpose was legitimised in nurses' descriptions. For example, testimonies often normalised harsh treatment during training as a function of transforming the initiate - in one woman's terms, to 'civilise' students - thus contributing to self-subjection and normalising practices. Another function of the disciplinary practices was to disable agency, obstruct autonomies and weaken capacities by linking with other practices to reinforce subjugation to institutional relations of power.

> [The matron] was teaching all the new nurses. She was teaching us ethics of nursing. She was a very good teacher. She was very strict, so I could say my foundation is very, very good. [Through her training] we know who we were, where we were going. She taught us manners, ethics, [that] we must do away with 'evil'. . . And she was in place of our parents, because when the kids are away from home they start doing nasty things and we were working for the community and not for money. (7 21/5)

> The lecturers were too harsh to us. When it was a school day, you were scared of going to the college. They were very harsh with us. They were black SA nurses at this time. For instance, if you did something wrong they used to tease you in front of the patients. The patients would think you were a fool now, the patients would mistrust you. Because the tutors scolded you in front of her. (4 6/9)

> . . . on my first day, when I was a student [registered nurse] in the ward . . . the nurse just gave me the valuables and said, "we've got a dead lady here. A corpse. Here are the valuables" . . .I was so shocked - standing there - holding these valuables in my hand. I didn't know where to start and what to do. . . I can say the frustrating thing I observed in nursing is this thing of seniority, and that when we are new nurses, we are all being ill-treated. And in nursing, there was [this] thing of having to revenge; saying that when I am senior I will do the same things to my junior. (6 2/2)

Regulating practices were intense in their capacity to isolate nurses to varied locations according to category and rank. For example, isolating practices central to apprenticeship programmes, served to remove young women from the broader discourses in society, focussing them on the enclosed terrain of hierarchical practices. They worked to maximise the

integration of women within systems of efficient controls, in Foucault's terms [xxxix] , to create useful and docile bodies. In the most debilitating way, they predisposed nurses to difficult conditions with little effective recourse.

> When I was trained it was tough. What can I say, the way we were treated. . . by the seniors. You can feel that you are a junior nurses. . .an African nurse. You can feel it; sometimes you cry. They ill treat you. . .sometimes the sister in charge won't like you. I had one sister in charge, an African sister, who used to hate me. . .she made me work harder. She used to allocate me every day to nurse the 'typhoids'. . . she used to give me bad off-duties. I enjoyed nursing the 'typhoids' but, you know, she was supposed to change me after a week. It was very hard work. (4 6/9)

> . . .you had to stand waiting for your seniors to go inside the entrance. . . she used to tell us that seniors are seniors, and we are nothing. We must know that we are nothing. We are just like dust. (3 2/5)

The outcomes, which distinctly emerged through the narratives, are nurses, acutely aware of their location of subservience or position of authority and regulated by hierarchical practices denoted through category and rank, and until recently, closely aligned with racial practices. The frequency with which nurses noted, with disdain or frustration, their subjugation to authoritarian and hierarchical locations, was a feature of the testimonies. So too was their inclination to reproduce these characteristics in their everyday interactions and relationships: unsympathetic matrons, bullying sisters and frustrated nurses, issued patterns of authoritarian behaviour displayed in interactions with doctors and patients, where struggles for power were frequently depicted.

Not only do nurses occupy a multiplicity of subject locations, they were situated within an interplay of discursive arrangements and practices that serve to isolate, normalise and discipline. Additionally, they are bombarded by a range of discursive contradictions that I have denoted as enervating, or weakening practices. These practices represent the raw

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[xxxix.]   See Discipline and Punish. 1975:135.

edge of relations of power through which inconsistencies and contradictions to the ethos of care are sustained. While these serve to frustrate the sensibilities of nurses and catalyse dominant power relations, they present the potential for creating and widening a discursive gap, the space created by displacing interests in attaining a subject position and predisposing institutional relations of power to resistance.

In analysing this work it became necessary to separate the ambiguities permeating nurses' experiences. Discourses and practices of caring, profession and hierarchy suffused by imperatives of class, race and gender, exaggerated within the context of the apartheid era, were most frequently contained, within relations at the level of occupational category and rank. Practices that worked to isolate nurses within institutional relations interacted with discourses mobilised for a variety of ends, in incoherent and fragmenting ways. For example, discourses of profession (professionalism; professionalisation), which serve regulatory purposes, proved to be the hook that nurses hung perceptions of status and pride upon. Caring was projected as the main ingredient of the unitary practice of the profession. Most nurses genuinely elaborated the meaning of caring within the context of the nurse-patient relationship, explanations that were saturated with altruistic sentiments. However, elaborations of the nature of their social and work place environments detracted from the possibilities of maintaining caring and professional aspirations for a number of reasons. Most difficult were the material ambiguities within the work site. Chronic shortages of staff, consistent problems with supplies and resources compounded by high and often acute patient loads confounded capacities to care, and to do so professionally. Respondents consistently expressed frustration with the lack of support from nursing and institutional hierarchies regarding these constraints. The testimonies of nurses working at the bedside, supervisors and doctors illustrate isolation practices whereby each carries on quite separately, fulfilling occupational roles. These tensions were passionately articulated in a number of testimonies of bedside nurses , pointing to the persistent reluctance by those with most power

to acknowledge material constraints.

> If we have shortages here we just admit and people end up having to
> sleep on the floor, on floor beds, under the beds. Only to find that even
> the food that they are eating, its not satisfactory. We end up frustrated,
> not having enough linen to give these people to wear. You know you
> dehumanise people, and depersonalise them, because an old man . . . is
> still respected at home. When he comes . . . we give him shorts, and
> that's the only attire . . .that can't even cover his stomach. . .that
> accumulates in that person and causes friction now between you and
> that man because here in the hospital they don't respect people. So all
> those things you are being confronted with, like the staff shortage and
> you are trying to do your best but there are barriers between you and
> this person and there are things that you can't go beyond to help this
> person. At the end, you yourself, when you are working hard, people
> never appreciate it. All our frustrations, we just swallow them. (6 2/2)

Middle managers, the matrons sandwiched between accountability to
doctors and senior administrators and the function of overseeing wards,
managed the tensions through disregard of the constraints and
adherence to discourses of caring and discipline.

> . . . nurses should be caring and compassionate. There should be
> emphasis on better selection, looking at the academic abilities. . . I would
> like nursing to be a profession. With the attitude nurses have now, I can't
> see it as a profession. (8 ½)

> How can we improve the profession. We need to do nursing for the true
> reason. We must be realistic when asking for salary increases. (8 1/12)

> I'll be confronted by problems where I will use my psychology. . . I let
> people know what I want because I don't want if from them. It's the
> patient that is demanding. . . I am supervising patient care and I made it
> clear, if only I could chop off their hands and look after their hands, I'll
> be the happiest woman. (8 1/9)

Although doctors did not feature in this research, a couple of senior
medical staff, curious with my presence, volunteered attitudes which
highlighted my views regarding isolation practices. They commented
about their disappointment with nursing care; nurses' failure to respond
to patients' needs; professionalism as a big mistake for nursing; the need
for more discipline; and, their sense that there is a cultural difference in

the way people care. These comments were particularly rich, used ironically, as they were shared in a nursing station, overlooking a busy 30 patient acute-care ward serviced by two professional nurses, one staff nurse, and three general assistants. There was no accounting for the work-load, lack of supplies in their brief disclosures. In addition, the comments reinforce the need to explore the perceptions of doctors towards nurses, as a rich source of data into the depth of divisions separating these health-care team members.

The challenge of caring seems to remain with individual nurses, rather than emanating from a coherent response by all care providers. Enervating practices intersect the outstanding features of functional expectations and hierarchical ranking with sex-defined roles and racial stereotyping. These operate within a context where the enormous structural challenges are ignored. Nursing's main ethos continues to operate within strictly isolated terms. Arguably, these practices endorse and encourage the exploitation of nurses' , their capacities to provide effective care, while holding them personally responsible for the failures of nursing care with the ultimate consequence, as has been the case in South Africa, of discrediting them.

> We cover most of the body of the health team. We frequently perform tasks we are not trained to carry out. If all goes well, great! If disaster comes, doctors put all the blame on nurses. Nurses hold the blame. (6 12/2)

> This frustration goes on and on. We don't ever have somebody specifically for nurses where we have to go there and say "I've got this problem." So I have to bear my frustration. Do a good job, work hard, nobody praises you, but at the end, you are accused: "why are you not doing this!" "But you can see I have done this"; "Write it down!" All those things makes people frustrated and angry. . .all these things make us fight with one another, amongst ourselves. As a nurse you must have a clean environment. Clean the patient with clean water, not with dirty water. So now if you don't have enough general assistants, you have to, as a sister, do the job. All that makes us unhappy and whatever you complain to management about, no answers. It's always that they can't do anything, no money, nothing...nothing. All these things are boiling to nurses. At the end of the day, we go on strike. (6 2/2)

Women and Resistance

Despite the significant and frequency of contradictions displacing discursive unity within these women's experiences, the general day-to-day operation of this hospital remained intact. While nurses were intent on maintaining order, their choice to cling to these difficult jobs were complex. Subjugation is highly compatible with strict, established hierarchies of power relations when the main interests of individuals are met within the subject position. For nurses at this hospital, social constraints and disadvantage pressurised most of these women to safeguard their employment security, while the status gleaned from their subject location as nurses – especially as professional nurses – served to displace their compromised location as women.

However, many separate and compound discursive contradictions increasingly eroded the unity within various discourses – those of care, of profession, of morality. Alain Touraine[xl] contended that heightened tension between forces of domination and resistance is incited when agents of social and cultural control are caught within contradictory practices. To Chris Weedon[xli] these contradictions create a gap or space between the subject position and their interests, predisposing situations to resistance. Nurses' testimonies cited prevalent forms of defiance and resistance undertaken by many of the narrators during the course of their careers: resistance to subject locations as subservient women in relationships resulting in a subject preference for professional discourses; resistance to professional complicity by SANA with forces of apartheid withstood through partial, and subsequently full, withdrawal as members; resistance to subservience to imperatives of race by forming alternative support networks and through vigorous efforts toward educational upgrading. Resistance to the strict and authoritarian

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[xl] In *Return of the Actor*. Minneapolis: University of Minnesota Press. 1988.

[xli] Op cit, 1987:112.

hierarchies emerged repeatedly within the testimonies; however, the cleavages at every level of the hierarchies sustained each level and category at a distinct and separate focus of contention. Resistance to broader grievances was in many ways turned inward, directed toward hierarchical relations, presenting little coherence for challenging broader institutional relations of power. Thus, resistance strategies, although prevalent, were for the most part disparate and taken up in isolation to others with similar grievances.

During the early 1990s a destabilising ripple moved through KEH, when opportunities began to emerge to challenge problematic contradictions in the wake of the social transition toward democracy. The 1994-6 labour unrest affected everyone within the corridors of KEH. Most nurses interviewed criticised the strike on moral and ethical grounds. Although evidence showed broad agreement about disparities related to conditions of work, the use of strikes was considered inappropriate by the narrators because it compromised patient care. Although nurses justified their opposition through discourses of caring, I believe the consequences of resistance resonated more powerfully in the aftermath. Women who protest are frequently framed discursively within their location as women and mothers, a reality which often confines the rationale for protest to these arenas. Whereas this has at times legitimised women's location within the protest arena, in this context nurses were severely chastised for betraying the moral discourses of caring, a strategy which successfully detracted from the grievances motivating protest action.

Additionally, the strike leadership failed to achieve a coherently collective response to the grievances. Testimonies exposed criticism for disorganisation and for the failure to unify divergent grievances. However, the most serious damage was done through the use of coercive, threatening and violent interventions to pull nurses into the protest arena. Not only did these women feel highly vulnerable within KEH, their sense of insecurity within unstable communities and home environments and their worries about financial security were heightened by the uncertainty of retribution within and away from the work site.

The labour unrest at KEH damaged the tenuous hold most of these women had on the fragments of dignity and self-respect gained through their affiliation to this profession. The narratives illustrated a consistent perception that few positive outcomes were achieved. Despite the victory of professional nurses to wear uniforms traditionally worn by their seniors', the larger battle for altering dominant power relations was lost. Through the analysis, however, a small shift in orientation to authority and discipline seemed to dawn. The labour unrest did force the administrative powers to divert from hierarchical reporting structures, and to set up a 'forum' where nurses could meet with them directly. Although this small shift seems placatory as a means of retrieving stability, it holds possibilities for reflection and scrutiny over the exaggerated use of authority and rigid hierarchies that constrain and demean nurses.

The unification process was a form of resistance that was, in many ways, inaccessible to nurses at KEH. The process was protracted due to internal tensions, which I have argued were based on confusion surrounding discourses of reform versus those of transformation. To those who hoped for coherence and support through unification, the failure to unify was very disheartening.

The research found that although most nurses were critical of SANA's failure to represent their interests through the apartheid era, they remained affiliated to the association until its dissolution (or the merger). Part of this is explained by the indemnity coverage gained as members, a mandatory prerequisite issued by employers. Additionally, for many, affiliation to SANA earned status within their homes and communities. Conversely, affiliation to the new unified structure was initially rejected by most professional nurses. Concerns regarding it's ethnic composition and the elite backgrounds of the black leadership, underpinned these comments.

The most visible DENOSA leadership within KwaZulu Natal came from

two principal backgrounds. As previously mentioned, the main transformational thrust within the organisation was spearheaded by Durban-based nurses of CONSA, many of whom were university and college-based nurses who held political pedigrees for their contributions to the liberation struggle . In addition to these, the first president of DENOSA was a university professor from a KwaZulu Nurses Association background, – an organisation historically linked to the IFP. So the cynicism articulated regarding the highly educated, elite composition of DENOSA displaced the efforts made unifying nurses. Further, and paradoxically, similar skepticism was not raised as an issue concerning the white, university-based leadership of SANA. Explanation might lie in the political context of KwaZulu Natal during the mid 1990's. The unification process was undertaken during a period of heightened, politically-motivated violence, particularly within KwaZulu Natal where the tensions between the IFP and ANC introduced considerable insecurities in many black communities. The reactions of nurses were possibly rooted in their sense of insecurity and vulnerability resulting from the ethnicity-based, political tensions and violence.

However, this explanation introduces an interesting paradox that emerges within the nurses' own narratives as to why nurses privileged affiliation to SANA rather than DENOSA. After all, the historical dominance of white nurses is central to these nurses' critiques of SANA as elitist, as historically linked to the apartheid regime, as non-representative racially, and as an organisation which had never effectively addressed the chronic issues plaguing the profession and the nurses within. Perhaps the distance between the strategies and outcomes of apartheid, as a system whose strategies filtered throughout society, and the immediate insecurities of the 'black-on-black violence' contributes to the explanation. As one nurse cited, "better the devil you know, than the devil you don't" (8 1/9).

Conclusion
The failure of nurses to successfully contest their persistent disparities within an environment of social and political transformation in South

Africa is rooted in these explanations. Nurses are actively subjugated by dominant patriarchal, institutional and organisational relations of power. The discourses and practices emanating from these sites, separately and jointly, dominate the realities of these women in all spheres of their day-to-day activities. They shape subject positions with a range of conditions, some of which serve the interests of nurses. In keeping with post-structuralist propositions, these testimonies have illustrated certain key points. Firstly, nurses actively negotiate a multiplicity of subject locations constructed and influenced by the many spheres upon which power relations operate, further dissected by a range of contextual conditions, parameters of difference and disadvantage, and the particular intersection of historicity mediating this landscape.

Secondly, nursing subjectivities are often privileged for their capacity to displace the subjugation nurses claim within their social, cultural and material experiences as women. Having said this, nurses are entrenched within institutional relations operating to maintain order within this distinct tertiary setting. The evidence depicted through constituent, regulating and enervating practices provides frank illustrations of the diversity of power relations operating at a range of levels, to both entice nurses to their occupation while confounding capacities to realise preferred outcomes. Discourses and practices emitted through motifs of care, hierarchies and organisation introduce a range of converging scenarios that frequently contradict the general tenets central to the universal ethos of health care.

Notwithstanding this, discourses elicited through motifs of caring and dignity are upheld by nurses within the varied nursing subject positions. Despite the challenges to the provision of adequate care, they serve to preserve the essence of their roles within the occupation, to some extent bolstering resistance to the many contradictions inherent in their work environment.

The issues compounding capacities to care extend beyond the sphere of nursing, particularly resonating from South Africa's particular socio-

political history. Nevertheless, nurses habitually became, and continue to be, the main targets of denigration and blame for the shortage of material and personal resources which seriously constrain capacities to care. The frustrations they experience and display impairs legitimacy, continually eroded through these scenarios and in their relations with medical staff, patients and the public. Isolating practices, evidenced in this research, reinforced nurses susceptibility to these conditions, and served as persistent obstacle to nurses working more coherently. As a consequence of their subjugation within organisational, institutional and patriarchal relations, through which the imperatives of capital and racialism have been met, their subject locations are diverse, divergent, fragmented and vulnerable.

Throughout this transitional moment in South Africa, nursing as an occupation, and nurses specifically, at KEH are undergoing a crisis of meaning . Their multiple subject positions are interwoven such that the capacity of nurses to contest their tertiary subject positions is acutely impaired. Contradictions dominate their various spheres, often multiple and compound in their manifestation. The vulnerability nurses experience within many subject-positions, and their fragmentation as a workforce – sustained through rigid hierarchical arrangements – reinforce their isolation, incapacity and unwillingness to present a challenge to the relations which dominate them.

Endnotes: