Cardiff School of Social Sciences Working Paper Series

www.cardiff.ac.uk/socsi/research/publications/

Working Paper 131: Feminisation/defeminisation: identity-work; dilemmas in primary school teaching and nursing

Author: Joanna Latimer (Cardiff) and Jenny Ozga (Edinburgh)

ISBN 978-1-904815-94-5

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Feminisation/defeminisation:
identity-work dilemmas in primary school teaching and nursing

Joanna Latimer (Cardiff University) and Jenny Ozga (Edinburgh University)

> Nevertheless if we proclaim that technology in general more often symbolizes masculinity than it symbolizes femininity, I think few lay people and few scholars would raise any objection. (Melström 2002: 461)

Abstract

The article revisits research in the sociology of health and education undertaken during the nineteen- nineties and the intensification of managerial change agendas. We explore how gendered relations enable the accomplishment of new political economies in education and health. Since the early nineteen-nineties both spheres of work have been subject to increasing managerial scrutiny and professionalising agendas. We explore the effects of these agendas on the redistribution and reprofessionalisation of work in primary schools, hospitals and clinics. We consider the significance of these redistributions for practitioners of nursing and primary teaching. Specifically, both nurses and teachers are pressed to scientise and technologise their discourse and practice in response to managerial imperatives. Science and technology as cultural domains are both strongly associated with *the masculine*. Yet the masculinisation of nursing and primary teaching has not necessarily led to the elevation of nurses' and primary teachers' status. Drawing together two analytical frameworks (labour process and post-structuralism), the paper presents and examines this anomaly.

Addresses for correspondence:
Professor JE Latimer
School of Social Science
Cardiff University
The Glamorgan Building
King Edward V11 Avenue
Cardiff
CF10
latimerje@cardiff.ac.uk

Professor J. Ozga
Centre for Educational Sociology
Moray House school of Education
University of Edinburgh
St John's Land
Holyrood Road, Edinburgh, EH8 8AQ
Jenny.Ozga@ed.ac.uk

Feminisation/defeminisation: identity-work dilemmas in primary school teaching and nursing.

Introduction

Education and health are fields of practice in which work is distributed in ways that connect to the gendering of particular attributes and practices (e.g. Davies 1995.) In addition, both fields have been, and continue to be subject to managerial scrutiny and professionalising agendas. The article re-examines the ways in which modernising agendas in education and health in the UK during the nineteen-nineties mobilised gendered relations of ordering to produce new economies of health and education work.

In reconsidering the consequences of attempts to modernise health care and education, we examine how managerialism and professionalisation have led to the 'masculinisation' of nursing and primary school teaching. We argue, however, that, *despite* the masculinisation of work previously associated with the feminine in teaching and nursing, there has not yet been a marked increase in the social status of primary teachers or nurses. In addressing this puzzle we are driven towards complexity.

Our analysis draws on aspects of labour process theory to review shifts in the representations of primary school teaching and nursing as *traditionally* feminine kinds of work. We record the loss of traditional skills and independent, practice-based judgement, and the reassertion of management controls (Smyth and Shacklock 1998, Apple 1996, Blackmore 1999). We identify the fragmentation of professional identity that follows from women primary teachers' attempts to maintain the social aspects of their practice while demonstrating their capacity as modernised, accountable professionals (Menter et al 1997). We suggest that a parallel history may be identified in nursing.

We illuminate how the relations of ordering which underpin the distribution of work in health care are gendered, and how these relations are being re-accomplished despite the masculinasation of nursing. We show how nurses are enrolled in particular kinds of discursive practices that re-turn them to gendered and asymmetrical power/knowledge relations. Here we are drawing on arguments derived from contemporary anthropology (Strathern 1988, 1995, 1997), that suggest that the relations of ordering which underpin society are gendered. Specifically, the gendering of different kinds of attributes, practices and roles is a cultural effect. For example, as the introductory quotation from Melström suggests, technology is usually associated with masculinity. Indeed, as Flax (1992) has argued, knowledge itself is differentiated and hierarchised through the gendering of different kinds of knowledge and knowledge practices. We are not intending to suggest any essential relationship between the male or female and particular practices and attributes. On the contrary, we are relying on an understanding that the gendering of pratices and attributes is a cultural effect but one which is critical to the *assymetrical* ordering of social relations.

The division of health care labour has been altered, with some aspects of traditional medical work (such as diagnosis in Primary Care) appearing to be devolved to nurses, while aspects of traditional nursing work, such as bedside care, are being devolved to unqualified care-givers (Gregor 1997). At the same time, in attempting to make the purpose and efficacy of their work visible and distinct, nurses have increasingly made their knowledge base explicit (Porter 1992) and technologised their practices (Latimer 1995). Even where nurses are attempting to show 'caring' as the basis of nursing (e.g. Benner and Wrubel 1989) they enrol knowledge practices traditionally characterised as masculine, such as the empiricist tradition in science.

In education work, traditional caring practices in the primary school have been marginalised by an emphasis on testing and results, accompanied by apparent improvement in the knowledge base and more scientific pedagogy (Jeffrey and Woods 1998, Pollard et al 1994). Teachers are required to 'scientise' their practice by changing processes of professional formation and regulation (TTA 2001) and are encouraged to distance themselves from traditional mothering classroom tasks, which are now to be carried out by classroom assistants and volunteers (DfEE 1998). At the same time, primary teachers, like nurses, are taking on more and more management work that is concerned with making the education process transparent through practices that *show* that input is being standardised at the same time as outcomes are measured (Ozga, 2000, Gewirtz 2002)

The changes in nursing and primary teaching work suggest a symbolic defeminisation of nursing and primary education. But the attempted masculinisation of nursing and primary teaching is not accompanied by significant evidence of attempts to elevate the status of nurses and primary teachers[1]. This anomaly raises a number of questions:

- How is devaluation accomplished where women take on more and more work previously associated with the masculine?
- What is the significance of the defeminisation of primary teaching and nursing practitioners?

The paper begins by exploring how primary school teaching and nursing are distinguished from other occupational groups and from ordinary life, through discourses which have figured them both as involving distinctly *feminine* kinds of knowledges and practices. We show how 'primary' and 'nursing' identities have depended to a large extent upon systems of distinction that articulate these as feminine forms of work, but in ways that stress that women need to be more than natural to do them. We go on to discuss how policy in health and education, emanating from governments and from within the professional bodies, is re-forming the spaces in which primary school teachers and nurses practice. We suggest that these reforms stress the need for the modernisation of health and education by technologies and evidence-based interventions. At the same time as these reforms attempt to extend responsibility and individuate accountability, they delimit autonomy, centralise discretion and standardise content and procedures. These new spaces of work proliferate new possible subjects, such as 'expert practitioners', and 'practitioner-managers', whose autonomy and discretion are more apparent than real. Nurses and primary school teachers are refigured as subjects who follow orders, multi-task, as well as implement instructions and procedures decided far from the classroom or the bedside.

We end by suggesting that both these effects are helping to deliver new political economies of health and education.

The politics of gendered knowledges

The production and reproduction of a hierarchical distribution of work can be understood as dependent upon the gendering of knowledge practices (cf. Rafferty 1996.) Strathern (1995, 1997) and others have distinguished the ways in which personal attributes as well as knowledge and social practices are gendered. Different kinds of work are gendered in relation to the kinds of knowledge that underpin them, or are made to seem to underpin them. As Flax (1990) has argued, the gendering of knowledge practices is critical to the production and reproduction not just of epistemic differentiation, but to the hierarchising of social identities.

[1] For example, nurse clinicians in primary care may earn up to about £30,000 pa, while general practitioners earn on average £50,000 pa.

Gendered work and knowledges cannot be understood merely in terms of divisions: there is not simply a gendered *division* of labour. On the contrary, in a Euro-American tradition the gendering of parts and practices is based upon a relation between what is characterised as masculine and what is characterised as feminine. As Davies puts it:

> ..the cultural baggage of gender, to the content of masculinity and femininity, each as a partial expression of human qualities and experience, the two as locked together in ways that can demean and sometimes altogether erase the qualities associated with femininity. (Davies 1995: 180)

Strathern (1997) has helped to elucidate how the asymmetry of this relation is accomplished. Specifically, 'the masculine' forms the basis of *comparison*, it is the point of reference against which other forms and practices are measured. Through processes of comparison, 'the feminine' is rendered both 'less than' and, frequently, supplementary to, those practices and attributes characterised as masculine. For example, knowledges characterised as subjective and intuitive are made to seem, through comparison, partial, provisional *and* feminine. The point of comparison for such knowledges is those objective and scientific practices that give positive knowledge of the social or natural world. These knowledges derive from practices characterised as objective and rational, and are associated with the masculine. In comparison feminine knowledges are rendered less valuable than and (where they are allowed to be knowledges at all) supplementary to masculine knowledges. In addition the subjects (or objects) of these knowledge practices (for example elderly patients and very young children) are by association also downgraded, and therefore potentially 'devalued'. Thus the question arises: what happens in occupations where the significance of work practices, such as nursing and primary teaching, once accomplished through association with the feminine, is now being displaced by masculinised knowledge practices. This is the situation that we explore in our two examples, education and health care.

Education and health care: gendered domains

There are two different ways in which primary teaching and nursing are traditionally associated with the feminine. First, the kinds of things nurses and primary school teachers do can be figured as feminine kinds of practices, to do with nurture and care. Second, their feminine character derives from the fact that it is often women who carry out these practices. However, this is to oversimplify the gendered relations that help order education and health care work.

Education and health care are two fields of practice in which work is distributed in ways that connect to the gendering of particular kinds of attributes and knowledges (e.g. Acker 1994; Blackmore 1999 Davies 1995; Gamarnikow 1991; Grumet 1988 Rafferty 1996; Rafferty et al 1997). This is not a simple *division of labour*, because the work, and the kinds of attributes necessary to complete it, are not valued equally. Doctors are paid more and have a higher status than nurses, nurses are paid more and have greater status than care assistants, and many informal carers are paid nothing at all and their status is deeply affected by their caring work (Okely 1999). As people get paid less and less for the nursing they give to the ill and disabled (either as formal or informal carers), the work is increasingly associated with women, and work associated with women, or 'feminised practices', is consistently downgraded. The same story has been told in teaching (Widdowson 1980, Kean 1990, Blackmore 1999). Valuation has depended on a gendered distribution of mental and manual work that needs to be revisited in the light of our understanding that the definition of mental labour is itself masculine.

Distribution and gender

Education is distributed among the primary, secondary, further and higher sectors. Within each of these there are further distributions - between, for example, graduate teaching assistants and professors in higher education, and heads, deputies and teachers of different grades in primary and secondary education. Across the education sectors and within them the distribution of work is graded and hierarchised. The basis of these gradings and hierarchies is (supposedly) objective, and invokes experience, levels of education and training, and knowledge, legitimated by qualifications and formalised promotion/recognition procedures. Across the education sectors and within them there is a gendered distribution of status. There are many more women at the bottom of the status hierarchy in school education and in higher education (as classroom teachers and contract researchers), and there is a disproportionate number of men in higher positions.

Within medicine there are parallel distributions, and there are added complications. First, medical work is distributed across a number of disciplines - nurses and doctors, the professions allied to medicine, care assistants and technicians as well as informal carers all contribute to medical work. Second, there are different locations of work which affect the distribution of health care work as well as patterns of care. For example, within hospitals doctors nurses and others work closely together some of the time and alone at other times, while in primary care practitioners work alone much of the time. In this article we confine our focus to nurses, and the distribution of work between nurses and doctors and within nursing. There are 385,000 registered nurses in England alone. 92% of qualified nurses in the UK are women, and yet approximately 52% of the 'top jobs' in nursing (e.g. top level jobs in administration and education, such as directors of nursing and academic chairs) are occupied by men (cf The Wanless Report, 2000). Figures are comparable in other countries**.** Nursing is therefore undoubtedly a woman's occupation, but the kinds of work nurses do is varied and hierarchised. Put simply, the more mental the labour can be made to appear the more men seem to be doing it[2].

Patterns of work

An essential feature of primary schoolwork that has remained constant over a considerable period of time is that one woman stays in one classroom for the entire school day with the same group of children. As Steedman makes clear, she is everything to them; model, mentor, companion, guide. The costs for the woman may be high: Steedman describes classrooms as 'prisonhouses' (Steedman 1987). That woman is alone with 'her' class, teaching them everything in a more or less integrated school day. Modernisation of teaching (DfEE 1997) brings a layering or redistribution of responsibilities. Primary teachers are now figured as professionals trained to deliver more scientifically-based, subject or skill specific (and centrally designed) education, and as part of a teaching team (Alexander 1992, Menter et al 1997, Woods and Wenham 1994). Classroom assistants and volunteers are increasingly employed to practice the (relatively unskilled/natural) so-called mothering tasks, enabling the professionals to get on with delivery of education (for example the literacy or numeracy hours).

Nursing (within hospitals) is organised in relation to wards or clinics: nurses therefore tend to work in groups, as part of a ward or clinic based team. Work used to be organised by 'task allocation', where tasks are hierarchised in line with grade. For example, fluid balance charts and the administration of fluids to all patients on a ward might be the task of a junior student nurse for a shift, while medicine rounds would be the task of a qualified or 'staff nurse'. Work

[2] With Davies (1995) we would guess that the elevation of men to top jobs in nursing is accomplished through an organisation logic which recognises and privileges educational attainment and career trajectories which are in themselves associated with male rather then female practitioners.

was co-ordinated by a ward sister or if they were male, a charge nurse. Increasingly nurses have attempted to redistribute responsibility so that nurses have 'their own' group of patients for whom they are entirely responsible, this form of organisation is called primary or team nursing. There has been an increasing individuation of accountability in nursing at the same time as patterns of care are represented as concerning nurses with the nurse-patient relationship.

The Construction of Primary Identities

In the relatively sparse literature that considers women teachers, there are gendered assumptions about their commitment to a service ethic, that may fail to make connections to the origins of the profession and its feminised nature[3]. Primary teaching has been traditionally constructed as women's work, and has been feminised since the First World War (Widdowson, 1980). Good mothering (i.e. middle class mothering) provided the model (albeit a very idealised one) for primary teaching; philosophers of primary education (for example Froebel, Pestalozzi, Montessori) constructed systems of educational provision that privileged imagined or idealised female patterns of relationship with their children.

Attention, empathy, watchfulness and a kind of enforced companionship became, as Steedman (1987) puts it, dimensions of a job of work that were seen as 'natural'. The process worked in two directions; the elevation of the ideal practices of motherhood as a model for the schoolroom created new forms of motherhood as well as new practices of schooling. Thus from the point of origin of mass primary provision the identities of mother and schoolteacher are interwoven.

The point here is to emphasise the conscious design of primary teaching, in the past as well as in the present. These discourses helped to distinguish primary school teaching from other kinds of educational work: they represented a 'policy choice' to feminise the emergent profession, and to promote respectability, conscientiousness and duty as its distinctive features (Weiler 1997, Prentice and Theobald 1991, Casey 1993). Yet while primary teaching identity is distinctively feminine it is also classroom-bound. This poses several problems: the workings inside the classroom are difficult to 'see' and, because education at this level is rooted in emotional relations of proximity, it is also potentially difficult to regulate. Indeed the search for a means of regulation of the social relations of education is, we suggest, a powerful factor in scientising primary teaching (Ozga 2000). But this organisation of primary school work also has consequences for practitioners, in that it elicits a particular performance of femininity (Walkerdine 1993). Indeed, Steedman suggests that such is the intensity of the emotional labour requires that it equates to a performance of motherhood, that simultaneously denies the primary teacher full adulthood:

> I never left them: they occupied the night times, all my dreams. I was very tired, bone-achingly tired all the time. I was unknowingly, covertly expected to become a mother, and I unknowingly became one, pausing only in the cracks of the dark night to ask: 'what is happening to me?.
>
> Children make you retreat behind the glass, lose yourself in the loving mutual gaze. The sensuality of their presence prevents the larger pleasures: the company of children keeps you a child. (Steedman, 1987:118/119)

---

[3] Feminisation of teaching is a process that ebbs and flows depending on many external factors, including the model of the teacher being promulgated by policy makers at any given time. Our concern is to highlight the ways in which feminisation of elementary/primary teaching has been encouraged by the state in different periods and constructed in relation to qualities of 'naturalness' and 'goodness' that were then required of women teachers. Some commentators have read the process in reverse-that is they have assumed that the 'natural' qualities associated with femininity have constructed the profession in a particular way (and one that they generally find inadequate).

The performance of good motherhood required that the authority of women teachers was premised on their morality and propriety, as well as their naturalness; femininity as a source of authority was constructed apart from 'public' authority (Blackmore 1999).

The Construction of nursing identities

Nursing has also been figured as an occupation which entails 'lower order' work (Dunlop 1986) traditionally associated with women, such as domestic duties (bed-making, serving meals) and intimate care of bodily functions (cf.Lawler 1991.) Since the nineteenth century it has also been emphasised that women have needed to be *trained* to do nursing properly. Nurses were not initially educated. Nor can nursing simply be understood as an apprenticeship. Rather, nurse training was figured as a total embodiment of sets of moral principles as well as highly disciplined practices, which reflected 'essentialist notions of femininity' (Rafferty 1996:5). Critically, nurses were trained, not to be emotionally engaged with their patients, but to implement orders and *administer* treatment regimes decided elsewhere (Olson 1997). As Florence Nightingale put it, without a systematic approach to building nurses' character nurse probationers would degenerate into:

> conceited ward drudges...that potter and cobble about their patients, and make not much progress in real nursing, that is obeying the physician's and doctors orders intelligently and perfectly' (Nightingale cited in Rafferty 1996:34.)

Thus, according to Nightingale, there is a need to discipline women in very particular ways for them to be able to undertake the tasks of the nurse and contribute to the enlightenment project of progress. The natural and unrefined woman would not make a good nurse. So while nurse theorists such as Nightingale undoubtedly saw nursing as one of the ways in which women could contribute to society outside of the home, the pay back was that the forms of work in which nurses were to be engaged reflected wider cultural preoccupations with the distribution of feminine and masculine attributes and relations: nurses' (women's) work was figured by its relation as supplement to doctors' (men's) work. Nurses took their status from their association with doctors.

The work of nursing is being distinguished then as characteristically feminine, but women need to be disciplined to undertake it: the raw stuff of womanhood needs to be recast in a moral mould. Morality is connected to specific feminine attributes valued at the time: the capacity to *follow* orders perfectly and intelligently, a disciplined and suitable conduct and demeanour, a central concern with literal and symbolic hygiene. Nurses were not figured as having autonomy or as taking initiative, and critically they were not to express emotion in all that they witnessed or undertook (Lawler 1991). Lyth (1960), in her study exploring the reasons for such a high fall-out rate in nursing, suggests that these forms of social distance, instituted in patterns of care, were repressive and infantalised nurses, inhibiting their development and job satisfaction.

New formations of teaching and nursing work

The most recent wave of reformation of nursing and primary education through new technologies began in the 1980s when the *process* of both nursing and primary education came under scrutiny from policy makers as key aspects of education and health that required scientisation in order to be modernised/managerialised..

Nursing processes began to be articulated and developed in the 1970s. New technologies where adopted from the US, such as holistic or comprehensive patient assessment, and planned care (Roper et al 1980, 1981). These technologies helped rewrite nursing as much more than domestic work, but they also enrolled nurses in masculine notions of rationality. As a twin technology the nursing process, for example, mimicked medicine because it involves nurses in

history taking at the same time as it incorporates nurses into aspects of a fashionable management science: they are to organise nursing work in relation to problem-identification, objectives and evaluation. Within these new processes of nursing, patients, like pupils, were also increasingly pyschologised and ideas about a nurse-patient relationship mobilised (May 1992). At the same time nurses have struggled to construct the knowledge base of nursing as a discipline in its own right.

Nursing theorists such as Patricia Benner, Jean Watson and Marilyn Leininger, in their articulations of nursing as a discipline in its own right, have helped to associate caring, and thereby women, with thinking as well as feeling and doing. Dunlop (1986) argues that the recognition and expression of nursing skill and knowledge can be linked with the broader feminist struggle for making visible the ways in which 'women function intelligently in the world' (p.661). But there is a dilemma in attempting to make the rationality of caring visible (e.g. Daniels 1987). Nurses in attempting to articulate their distinctive occupational identity have centralised caring at the same time as they have enrolled the traditional tools of professionalisation (theory-building, decision-making, a knowledge-base) to make nursing visible as expertise. These 'tools' are traditionally associated with the masculine, they are in a Euro-American context, distinctly 'male parts' (Strathern 1997).

In education, the story of the first wave of change in the 1980s was one of masculinisation through the market - as neo-liberal principles became the principles of ordering of educational provision. Schools, including primary schools, became increasingly corporatised as they competed for clients and developed management cadres. Feminised practices and sources of authority in primary education were labelled as ‘progressive’ and the ideas of progressivism were labelled unscientific (Menter et al 1997). They were said to be responsible for educational underperfomance. An increasingly classified subject-based curriculum was introduced (Pollard et al 1994), with a strong emphasis on immediate measurable performance outcomes. This formal rationality appeared to demonstrate effectiveness and efficiency, and constituted a remaking of hegemonic masculinity as flexible, entrepreneurial management, sharply contrasted with emotional, intuitive and apparently inefficient feminised performances of teaching (Blackmore 1999, Yeatman 1994)

The second wave sees the growth of even more explicit management in education and medicine - at the level of the system, the institution and the individual. It has been suggested that the impact of managerialism represents a further 'masculinization' of the health services (Webb, 1985) and of education (Whitehead and Moodley 1999, Shain 2000). Nurses and teachers have been both sucked into work which *implements* the new management at the same time as these very management technologies enrol them in more and more technologising/scientising of their teaching and nursing practices. These processes and shifts are now discussed in detail.

Making health and education transparent

Giddens (1991) argues that modernity is distinguished by increasing emphasis on rational organisation, technology and accountability of individuals. Managerialisation of the public sector has involved "examination" of services by accountants and managers (Dingwall *et al*, 1988; Broadbent *et al*, 1991). This examination is marked by a move to "rationalise" resources and an outcomes approach to evaluation of service provision drawing on an economics based model. Transformation of the organisational forms of public service provision and control has relied heavily on extension of the role of audit. Organisations must, accordingly, produce auditable information about their activities, and this process, in turn, comes to colonize definitions of ‘knowledge’ ‘excellence’ and ‘quality’.

There is a shift away from process, to a focus on inputs and outputs. The content of care or education (input) is increasingly prescribed, by, for example, evidence-based medicine and nursing, or evidence of 'what works' in education. At the same time success or failure of process (refigured as delivery or implementation) is measured solely in relation to outcomes. Outcomes are limited to those things that can be measured, such as morbidity and mortality rates, throughput rates, and patient satisfaction in health, and examination results, truancy rates and levels of literacy and numeracy in education. Auditing these outcomes calls for more technologies - technologies that can measure morbidity, mortality, satisfaction, attainment, wastage, labour market outcomes attendance, etc. In addition each segment of health and education must institute contracts and business plans - so that efficiency as well as efficacy are visible.

At one level these factors constitute a pressure for health and education workers to conduct themselves in relation to more explicit accountability. This means that in a sense everything comes up for grabs, as this example from health shows**:**

> What's a doctor, what's a nurse? There's work to be done, you get the work done by the people who are best qualified to do it *...hands-on care is below nurses' level of competence.* A higher quality, cheaper service, with a competitive edge, will be achieved by those who *make the most improvement in their labour costs* (Eric Caines in an Interview with Naish 1990, cited by Allen and Lyne 1997: 133, emphasis added).

However the *visibility* of work - its purposefulness and effectiveness - is not so easily accomplished for many traditional nursing and teaching tasks. For example, what is the 'health gain' of making patients comfortable? Or how can the health gain of nursing care aimed at prevention be demonstrated in the rationalist world of evidence-based medicine? The answer is 'not easily'. Similar difficulties are encountered in demonstrating 'what works' in teaching. Teachers develop capacity in their pupils through negotiation, dialogue and co-operation, what Connell (1995) calls the 'socially-sustained capacity to acquire learning strategies'. These processes and their effects are not easily measurable and demonstrable. Frequently the research methodologies which might help to illuminate these issues are themselves downgraded as producing only partial and relative knowledge that does not count as evidence. Thus 'reliable' research on education and health fails to see or cannot account for the unmeasurable or invisible rationality and effectiveness of that work, and thus contributes to legitimation of the redistribution of health and education work.

Nurses have attempted to make their work visible as rational and effective and thus raise their profile, either by attempting to further scientise/technologise their practices or by taking on work which already has a higher status. Nurses have taken on more and more doctor's work as well as aspects of work associated with the new management. The same is broadly true of teachers, who have divested themselves of much 'dirty work' to classroom assistants, and who spend increasing amounts of time on paperwork and record-keeping.

New nurses?

Nurses have been called upon to make visible that they are indeed professionals and that what they do cannot be done by ordinary women or even semi-skilled women: while moral skills are important, they cannot form the basis of a profession. Instead, nurses are compelled to show that their practices are rational and purposeful and necessary. They are doing this through three strategies, which each involve 'masculinising' (in the metaphoric sense) nurses' practices. Yet how is it that nurses are 'adding on male parts' but not succeeding in raising their status?

The first way nurses are raising their profile is by ‘showing’ that their work is knowledge-based. One effect then of managerialisation of the medical domain is for nurses to increasingly adopt a scientific and technical discourse in a way that mimics medicine (Rafferty 1996). So that 'care' cannot be left to the vicissitudes of the individual patient: care is now to be made visible as technologically sound, effective and evidence-based.

At the same time nurses attempt to distinguish their practices from doctors and others by stressing the relational and relative aspects of their knowledge practices. For example, at the same time as nurses are competent and knowledgeable, they do more than simply apply science:

> In the context of generous knowledgeable caring practices that are finely tuned by one's own sentient and skilled embodiment, the level of mutual respect and knowledge of the other will allow for more than mere rights and justice. The language of cost-benefit analysis and other forms of rational calculation will seem like impoverished 'outside-in-accounts' that miss the human connection and community and particular human concerns in the situation. (Benner et al, 1996: 253).

or..

> ....the point has perhaps been made that reducing the nurses' function to an analytical, more or less objective process divorces it from the intuitive, subjective response. (Henderson 76, p.108).

At the same time as nurses make visible the knowledgeability and expertise of nursing, they ‘refeminise’ their identity by drawing on a knowledge discourse which stresses the relative and subjective. So that nurses, particularly new nurses (Savage 1995), stress the embodied and subjective aspects of their knowledge practices, embedded in a relation to the other. Refeminising their knowledge and practice in these ways returns nursing to the relations of ordering in which the feminine, in comparison with masculine knowledges and practices (object, positive), supplements.

Second, nurses maintain their visibility through taking on more and more of the work of the new management. Wards and clinics are no longer organised by nursing Sisters, or charge nurses, rather many nurses are giving up organising wards and clinics for the ‘management of transparency’. Nurses who want to rise above the level of staff nurse, have to increasingly become the conduits of the new forms of management. Nurses have been enrolled in audits, business plans, constructing standards, and the endless production of accounts. As one ward manager put it to me: ‘I am more in the office doing all this (waving a hand at a filing cabinet) than out there (waving at the door into the ward)’.

Third, nurses are maintaining their visibility as engaged in important work through taking on more and more work previously associated with doctors (cf. Hunt and Wainwright 1994)[4]. In the past nurses have gained status from their association with medicine (Melia 1987). Much of this work includes technical tasks which merely expand nurses responsibilities, for example

[4] This has been legitimated by the professional body governing nursing and by nurses themselves as ways forward to enhance health care. Other commentators are more sceptical. The problem facing the DoH was whether nurses could take on more doctors work, in ways which would help reduce the cost of the NHS. Recent studies in general practice suggest that interest in nurses expanding their roles has been generated more as an aspect of workload issues in general practice (e.g. Bond et al 1998) than as an ideological concern for more choice for patients or for filling gaps in the service. As Jenkins-Clarke et al put it: “The Medical Manpower Standing Advisory Committee made its first report ’Planning the Medical Workforce’ to the Secretary of State in December 1992 recommending that research should be undertaken to quantify the manpower effects of skill mix initiatives. These issues are being raised against a background of changing roles under the GP contract, manpower shortages and boundary definitions and enhanced roles for nursing staff as well as shifts at the primary/secondary care interface and by other initiatives such as growth of day surgery and early discharge from hospital." (1997:1).

taking bloods ordered by a doctor. This means that nurses have less time to do other nursing work more readily associated with nursing, such as bed-bathing or walking patients (Latimer and Rafferty 1998). These kinds of tasks can be left to un- or semi-qualified nursing assistants. So that tasks previously associated with medicine may help keep nurses visible as doing important technical work, but they do not elevate nurses status because they do not extend nurses' authority - nurses do not appear to have autonomy or discretion over when the tasks are to be carried out (cf. Allen et al 1997; Last and Self 1994). So this is still 'women's work', even if it appears to 'upskill' nurses because it is more obviously technical than the work of cleaning and nurturing the sick body.

But there is proliferation of new positions in nursing, with titles such as clinical nurse specialist and nurse practitioner, which explicitly involve nurses in discretionary aspects of medicine. Some of these new positions involve nurses in the discretionary aspects of medicine through which doctors perform and maintain their authority and professional status, such as diagnosis, referral and prescription (e.g. Bond et al 1998). These emergent roles in nursing seem to be shifting some of the discretionary aspects of medicine so that nurses' privileges are being redrawn (Latimer and Rafferty 1998). But nurses in these new roles are not being paid like doctors did before them: how can this be justified? We want to suggest that obviation of the need to pay nurses more for taking on doctors work is being accomplished in a number of ways:

Firstly, the content of the work that these nurses are taking on is being systematically downgraded. Nurse practitioners in general practice, for example, are taking responsibility for 'delivering primary health care and other *basic* health services'. They are to work with people presenting with *minor* acute illness. Thus the work and the type of patient nurses are taking off doctors is being classified in ways which minimalise its value.

Second, these nurses' practices are described and evaluated by processes of *comparison* with doctors practices (e.g. Touche Ross 1994). For example, Jones (1997) compares nurse practitioners in primary care with doctors, and suggests that nurse practitioners:

* are more able to deal with uncertainty
* order less tests
* refer for less hospitalisation
* are less expensive to train and pay
* give greater patient satisfaction

So that nurse practitioners are distinguished by comparison in ways which refeminise them - they refer less, use less medicines, cost less, they don't make a radical difference to measurable health outcomes (morality and morbidity), but they do give greater satisfaction. This association with the mundane and the everyday refeminises their work and permits their downgrading.

Third, nurses' new roles are emergent in the context of protocols and guidelines of diagnosis, investigation and treatment, aimed at reducing the discretionary power of individuals, to standardise responses, and obviate or hide the interpretative aspects of medical diagnosis and treatment. So that nurses who substitute for doctors are being more and more regulated (in theory any way) by technologies which allow managerial action/discretion at a distance (such as decision-making trees, critical pathways, evidence-based protocols, and managed care packages.) These technologies decouple discretion from tasks. In these ways nurses are refigured as skilled but not completely professional, where skilled work can be defined as: "'knowledgeable practice' within 'elements of control'" (Thompson 1989 p.92, drawing on the Council for Science and Society, 1981:23)

Emergent roles in nursing are emerging in the context of new forms of regulatory control of medical and nursing practice. So that nurses are refigured as those kinds of women who can, in Nightingale's words, follow orders, intelligently. In supporting these shifts doctors are able to devolve those aspects of their work which undermine their performance of autonomy and discretion, the marks of the professional, not the skilled worker. So it seems then that nurses are caught in gendered relations of ordering. We now turn to discuss the effects of the new management in primary teaching.

New teachers ?

Like nurses, new model primary teachers are called upon to demonstrate their difference from ordinary women, and to acquire and display expertise that goes beyond conscious motherhood (Steedman 1988). The new model primary teacher has been released from the constraints of classroom-bound identity but at the same time is very heavily constrained by global discourses of economy and effectiveness that rework her status as expert provider. Her responsibilities are now without limit, as is her capacity to improve performance. She is at once more constrained (in terms of support and opportunities) and more extended (in terms of responsibilities). Primary teachers' work, and primary teachers' identities are being changed. As Smyth puts it:

> 'the view that schools should be more autonomous and more responsive to local needs is being promulgated at the very time that they are being told in no uncertain terms what their outcomes 'must be' and how they 'must strive' to meet national priorities and enhance international competitiveness. Teachers, therefore, are supposedly being given more autonomy at the local school level at precisely the same time as the parameters within which they are being expected to work and against which they will be evaluated are being tightened and made more constraining' (Smyth, 1991: 324-325)

Modernisation of primary schooling thus privileges technical and managerial skills and promotes competition and the measurement of outputs. Status is achieved not through teaching but through management; progression through the performance hurdles that chart the new teaching career is tied to achievement of those outputs. Developmental skills that draw on capacities for care and nurturance are not just devalued by current policy ensembles, but are seen to be a drag on moves to modernise. Thus women teachers are:

> 'no longer given credit for being skilled at all, as the very definition of what counts as a skill is further altered to include only that which is technical and based on a process which places emphasis on performance, monitoring and subject-centred instruction' (Apple and Jungck 1992: 26)

Primary teachers, like nurses, are expected to be self-regulating within a highly designed and structured framework of control and accountability (Menter et al 1997). Again, like nursing, tensions with management are produced. Enhanced managerialism has accompanied apparent devolution of control to schools; devolution of financial management installed surveillance of the teaching work-force at the level of the institution, rather than any intermediate arena, such as the LEA. As well as the formal mechanisms of inspection, assessment and appraisal, there is a whole repertoire of assumptions and relationships that seek to change the nature of primary teaching. The discourse of decentralisation and devolution apparently promoted lay influence but actually promoted a male management cadre that took responsibility for the schools performance against externally-published targets. In a variety of ways, teachers' work has become much more strongly subjected to control from, and influence by, the school manager, who in turn became an agent of accountability to the central department. The practices of

active management by head teachers produce substantial changes in work practices in teaching, and a major shift towards team membership, good organisation and effective co-ordination as the manifestation of successfully re-professionalised teacher identity. There are many examples of the colonization of teachers' lives and work by managerialism; and the private and informal areas of teachers' working lives are converted into public, formal and measurable spaces (Hargreaves 1994). Technical rationality, as the basis for the organisation, planning and management of work produces what one teacher (In Jeffrey and Woods 1998) called 'teaching for others:

> You're forever looking over your shoulder, filling in a form or flicking through the National Curriculum to see which bit this lesson pertains to. Teaching has always been an never-ending job, you could fill 24 hours a day doing it, but in the past you were doing it for love of doing it, because you wanted to do it to improve the children. Now you are doing it because somebody is saying 'Have you filled in this record card, what position or level is this child at? What assessment are you going to do to show me the evidence? Where is your evidence?' (Jefffrey and Woods 1998: 99-100)

Case studies of two primary schools that formed part of a wider study of markets and competition in primary provision found that changes were most marked in the diminishing of individual, personal autonomy in the classroom (Menter et al 1997:100). However in addition to the pressures of individual accountability, the constant pressure to be a 'performing' member of the group and a responsible member of the team had changed social relations among teachers. Interdependent work relations were experienced in some primary schools as coercive rather than collegiate (Menter et al 1997).There was also a very marked increase in stress related to workload. Primary teachers did not abandon their established practices in developing and determining their own teaching styles, nor were they entirely changing the form of their relationships with children. Instead they were continuing old and new practices side by side; adopting newer practices of monitoring and assessment, alongside maintenance of their preferred teaching styles, and their close social relations with the children. This produced considerable tension and feelings of inadequacy, as the framework of accountability created dissonance between their emotional labour and the need to assess, grade and give an account of individual pupils and their status in relation to one another, and as the size of the task became unmanageable.

The knowledge that primary teachers drew on (i.e. knowledge in practice) and the context in which they imparted it (embedded in social relationships and social practices) were both devalued by the new work practices. They struggled to continue to work with them, alongside the new forms. This led to their also producing two distinct discourses in response to external requirements; a public response that supported the reform process and defended it in relation to the interests of children and parents, and a private discourse of anger and frustration. The consequence for some primary teachers is *a fragmentation* of professional identity in which there is a gap between:

> ...the responsible, accountable professional on public display, and the private experience of bitterness, anxiety and overload. This is also indicative of the covert coercion of the new management. It is significant that these teachers should internalise their responses to that coercion, and thus live out the consequences of change in terms of fractured and fragmented identities. (Menter et al 1997: 115).

The sense of fractured and fragmented identities is also expressed by nurses (cf Traynor 1999).

New formations of nursing and teaching: dilemmas of identity and dilemmas of interpretation.

In the paper we have explored how the professions of primary school teaching and nursing are distinguished from other occupational groups and from ordinary life and work through a discourse which has figured these as involving distinctly *feminine* kinds of knowledges and practices. We have shown how 'primary' and 'nursing' identities have depended to a large extent upon systems of distinction which articulate these as feminine forms of work, but in ways which stress that women need to be more than natural to do them. We have suggested that it is the very discourse of femininity used as a resource to distinguish these practices which allows for their denigration and devaluing as supplement to more 'elevated' forms of knowledge and practice. We then discussed how policy in health and education, from governments and from within the professional bodies, is re-forming the spaces in which primary school teachers and nurses practice. We have suggested that these reforms stress the need for the modernisation of medicine and education by technologies and evidence-based interventions. At the same time as these reforms attempt to extend responsibility and individuate accountability, they delimit autonomy, centralise discretion and standardise content and procedures. These new spaces of work proliferate new possible subjects, such as 'expert practitioners', and 'practitioner-managers', but autonomy and discretion are more apparent than real, and lie far from the classroom or the bedside. Nurses and primary school teachers are refigured as subjects who follow orders, multi-task, implement instructions and procedures decided elsewhere.

Critically, however, we have shown a redistribution of work as an effect of these reforms. Nurses and primary teachers emerge as taking on more and more work (aspects of management, aspects of doctors' work) which are associated with the masculine, as at the same time as they abandon those kinds of work previously seen as traditionally feminine to other unqualified or semi-qualified women. However, the apparent masculinisation of teaching and nursing has not led to the elevation of nurses and primary teachers' status. In the context of nursing, we have explored how the absence of elevation and status is accomplished to reproduce a particular kind of gendered politics of knowledge and resources. And in the context of primary teaching we have discussed the effects on teachers and their practices.

There are, then, two theoretical voices speaking throughout this paper; the clipped accents of Labour process theory, and the more nuanced discourse of post-structuralism. Is this a productive conversation, or do we end up with two very different accounts and interpretations that cannot speak to each other?

Labour process theory has shaped the discussion of women primary teachers, and their responses to managerial strategies that seek to control their work, and to alter its nature. That this is a gendered process is significant: this positioning of women creates dilemmas for teachers as it is a gender identity which has traditionally sustained primary schoolwork; in changed economic circumstances that particular gender identity is not seen as an appropriate resource for the effective performance of primary teaching. Labour process theory has produced the focus on the design and redesign of the state profession of teaching; on the impact of the material conditions of labour on the work and on the people who do it, and on the significance of management as a process of control of that labour. The application of labour process theory to teaching is unusual but not unprecedented (Apple 1988, Dreeben 1988, Ozga and Lawn 1988). It is also not unproblematic, and, of course deeply unfashionable. There are problems with the concept and with its application to particular forms and processes of work. Indeed it is often equated with 'work' and associated with key concepts (deskilling, reskilling, fragmentation and intensification) that are themselves imprecise and contested, and certainly gendered (Braverman 1974, Thompson 1990).

One of the reasons that Labour process theory has fallen out of favour is that it has been taken as understanding the subjective as a state of consciousness that follows from the objective conditions of work. This would produce an account of changes in teachers work that left them regulated, de-skilled and deprived of agency. However it is possible to think of consciousness and ideology as implicated in the 'process of struggle in which the so-called 'objective' contents of class, including forms of management control, are shaped and reproduced' (Knights and Willmott 1990:10). Thus the relations of production are influenced by all the players and there is no binary opposition of the subjectivity of free workers on the one hand and oppressive objective structures on the other (Knights 1990).

It is freely acknowledged that a purely structural labour process analysis that focuses on the traditional elements of that approach - work design, formal authority, technology, monitoring and management - is deterministic and provides no space for dynamic negotiation, accommodation and resistance. On the other hand, labour process theory has to hold on to a relationship of interdependence between subjectivities and structures that both create and are created by subjects. So while accepting the criticism of the idealism of orthodox Marxism, this approach to labour process theory is taking issue with the :

> 'tendency of some post-modernists and post-structuralists to see any focus on political economy and class relations to be somehow reductive, to analyse the state as if it floats in thin air…to expand the linguistic turn until it encompasses everything and to embrace overly-relativistic epistemological assumptions.' (Apple 1996: 130)

In contrast, the post-structural analysis of nurses identity dilemmas offered here does take account of and has attempted to explain how the devaluation of nurses helps accomplish a particular political economy. It has helped to show how old stabilities get produced and reproduced despite the gender complexity and heterogeneity of nurses' practices and discourses. But rather than simply figure nurses as victims it as helped to show how they are both positioned and (unwittingly) position themselves in ways which allow their degradation. And this is connected to the discourses which are enrolled to categorise and classify their knowledge and the kinds of work they do. The implicit dilemma is that illuminating these asymmetries reiterates the very hierarchies which we would like to undermine.

The difficulty in bringing these two approaches together from a post-structural and post feminist perspective is that labour process theory relies on a key assumption that helps reproduce asymmetries in power relations. Specifically, labour process constitutes *classes of attributes*. The very notion of deskilling and upskilling reproduces the hierarchies which underpin the asymmetrical values attributed to different kinds of practices and understandings. For example, labour process rests upon a notion of centred subjects, embedded in a preoccupation with emancipating persons so that they each can 'have autonomy' or 'make decisions'. Anything less is figured as a state of subjection. A post-structural and post-feminist reading is also concerned with subjectivity, but upsets notions of subjects as centered: rather subjectivities are elicited and subjects are located. In this reading, the very notion of an autonomous and decision-making subject could be understood as a masculine project. A post-structuralist perspective seeks to explain *how* some groups seem to have more authority and status than others (and get paid a lot more). Within this view authority and status has to be accomplished - it is not a given - and it is accomplished through performance and moves (Lyotard 1984). We have shown how performance is elicited and moves made in ways which enrol nurses and teachers in particular kinds of discursive practices which return them to the gendered relations of ordering. Critically, the resources for helping to elevate identity status seem to be attributes and discourses associated with the masculine.

As Strathern (1997) has emphasised, Euro-American relations are ordered in ways which depend upon the comparison of gendered attributes and practices, including knowledge. Through processes of comparison in which the point of reference is prefigured masculine, attributes and practices with feminine associations are constituted as supplementary and hence can be devalued. Professions traditionally dominated by women are caught in relations of ordering which return the feminine to supplement. Where practitioners distinguish their identity as more than ordinary people, they may draw on discourses which keep in play feminine/masculine notions and risk reproducing the very relations of asymmetry which permit the devaluing of their work. If they do not do this overtly, they draw on these discourses to sustain their continuing practice, but in a context that privileges the rational and technical. However we recognise that attempting to withdraw from these gendered discourses is also deeply problematic because organisations are constituted so that certain kinds of discursive grounds have 'more' visibility and greater value than others. The new managerialism allied to evidence-based practice elicit an endless preoccupation with the management of transparency and incites nurses and primary teachers alike to continuously attempt to show what and who they are. There is another effect: the fetishistic obsession with transparency takes attention and energy away from the hybrid, interdependent and complex interactive aspects of how education and medicine get organised.

We do not think there is a feminisation of professional work. On the contrary we think that the inexpressible and the invisible are becoming harder to defend. Women, as they enter the language game set by managerial agendas, enrol and become enrolled in modes of ordering which are normally understood as masculine. Primary teachers in one study experience this as a fragmentation and fracturing of identity. Nurses, attempting to maintain their gendered identity, deploy discursive practices associated with the feminine, and leave themselves open to down-grading. Both of these contexts are helping to deliver new political economies of health and education by sedimenting the gendered relations of ordering through which particular forms of knowledge and practice can be marginalised or down-graded.

Bibliography

Acker, S (1994) *Gendered Education* Buckingham Open University Press

Alexander, R (1992) *Policy and Practice in Primary Education.* London, Routledge

Allen E., Annandale E, and Clark J. (1997) *New roles, new responsibilities: Skill mixes and their implementation in medicine and nursing.* Poster presentation at ENRIP database launch, Royal Society of Architects.

Allen D and Lynne P. (1997) Nurses' flexible working practices: some ethnographic insights into clinical effectiveness. *Clinical Effectiveness in Nursing,* 1:131-140.

Apple, M (1988) 'Work, Class and Teaching' in Ozga, J (ed) *Schoolwork: Approaches to the Labour Process of Teaching.* Buckingham, Open University Press

Apple, M (1996) *Cultural Politics and Education* Buckingham, Open University Press

Apple, M and Jungck, S (1992) 'You don't have to be a teacher to teach this unit: Teaching, Teachnology and Control in the Classroom' in Hargreaves, A and Fullan, M. (eds.) *Understanding Teacher Development*. New York, Teachers College Press

Benner P. (1984) *From Novice to Expert. Excellence and Power in Clinical Nursing Practice.* California: Addison-Wesley.

Benner P, Tanner C and Chesla CA. (1996) The Primacy of Caring and the Role of Experience, Narrative and Community in Clinical And Ethical Expertise. In: Benner P,

Tanner C ad Chesla CA. *Expertise in Nursing Practice. Caring, Clinical Judgement and Ethics.* New York: Springer Publishing Company.
Benner P and Tanner C. (1987) How Expert Nurses Use Intuition. *American Journal of Nursing*, 87: 23-31.
Benner P and Wrubel J. 1989. *The Primacy of Caring. Stress and Coping in Health and Illness.* California: Addison-Wesley.
Blackmore, J (1999) *Troubling Women: feminism, leadership and Educational Change* Buckingham: Open University Press
Bond S, Cunningham B, Beck S, Derrick S, Healy B, Holdsworth S, Lawson J, Rawes G and Sargent J. 1998. *Evaluation of Nurse Practitioners in General Practice in Northumberland. The EROS project 1 and 2.* University of Newcastle: Centre for Health Services Research.
Braverman, H (1974) *Labour and Monopoly Capital* London, Monthly Review press
Broadbent J, Laughlin R and Read S. 1991. Recent Financial and Administrative Changes in the NHS: A Critical Theory Analysis. *Critical Perspectives on Accounting*. 2(1): 1-30.
Casey, K (1993) *I Answer With My Life.* New York, Routledge
Daniels AK. 1987. Invisible work, *Social Problems,* 34(5): 403-13.
Davies C. 1995. *Gender and the Professional Predicament of Nursing.* Buckingham: Open University Press.
Department for Education and Employment (DfEE) (1998) *Teachers meeting the challenge of change London*, The Stationery Office.
Dingwall R, Rafferty AM and Webster C. 1988. *An Introduction to The Social History of Nursing.* Routledge, London.
Dreeben, R (1988) 'The School as a Workplace'. In Ozga, J (ed.) op. cit.
Dunlop MJ. 1986. Is a science of caring possible? *Journal of Advanced Nursing*. 11: 661-670.
Flax J. 1990. Post-modernism and gender relations in feminist theory. In: Nicholson L.J. (ed.) Feminism/Post-modernism. New York: Routledge
Garmanikow E. 1991. Nurse or woman. In: Holden P and Littlewood J (eds.). *Anthropology and Nursing,* London: Routledge.
Giddens A. 1991. *Modernity and Self-Identity*. Cambridge: Polity Press.
Gregor F. 1997. From women to women: nurses, informal caregivers and the gender dimension of health care reform. *Health and Social Care in the Community* 5(1) 30-36.
Grumet, M. (1988) *Bitter Milk* Albany: State University of New York Press
Henderson V. 1981. The nursing process - is the title right? *Journal of Advanced Nursing*, 7, 103-109.
Hunt G. and Wainwright P. (eds.) 1994. *Expanding the role of the nurse. The scope of professional practice.* Oxford: Blackwell Science.
Jeffrey, B and Woods, P (1998) *Testing Teachers*. London, Falmer Press
Jenkins-Clarke S, Carr-Hill R, Dixon P and Pringle M. 1997. *Skill Mix in primary care. A study of the interface between the general practitioner and other members of the Primary Health Care Team. Executive Summary.* York: University of York Centre for Health Economics.
Jones G. 1994. Accident and Emergency and the nurse practitioner. In: Hunt G and Wainwright P. (eds.) *Expanding The Role Of The Nurse. The Scope Of Professional Practice.* Oxford: Blackwell Scientific.
Kean, H (1990) *Deeds Not Words* London, Pluto Press
Knights, D (1990) 'Subjectivity, Power and the Labour Process' in Knights, D and Willmot, H (Eds.) *Labour Process Theory.* London Macmillan
Knights, D and Willmott, H (1990) 'Labour Process Theory' in Knights, D and Willmot, H (Eds.) *Labour Process Theory*. London Macmillan

Last T and Self N. 1994. The expanded role of the nurse in intensive care: a national survey. In Hunt G. and Wainwright P. (eds.) *Expanding the role of the nurse. The scope of professional practice.* Oxford: Blackwell Science.

Latimer J. 1995. The Nursing Process Re-examined: Diffusion or translation? *Journal of Advanced Nursing*, 22: 213-220.

Latimer J and Rafferty A-M. 1998. *Extension and Expansion: Emergent Roles in Nursing and Health Visiting* (with Ann Marie Rafferty) Research Report. NHSE/ Department Of Health. Keele: Keele University.

Latimer J. 2000. *The Conduct of Care: Understanding Nursing Practice.* Oxford: Blackwell Science.

Lawler J. 1991. *Behind the Screens. Nursing, Somology, and the Problem of the Body*. Edinburgh: Churchill Livingstone.

Lyotard J.F. 1984 *The Post-modern Condition: A Report on Knowledge*. Manchester: Manchester University Press.

Lyth I M. 1990 (1960). Social Systems as a Defence Against Anxiety. An Empirical Study of the Nursing Service of a General Hospital. In: Trist E and Murray H (eds.). 1990. *The Social Engagement of Social Science. Volume 1. The Socio-psychological Perspective.* London: Free Association Books.

May C. 1992. Individual Care? Power and Subjectivity in Therapeutic Relationships. *Sociology*, 26(4):589-602.

Melia K. 1987. *Learning and working.: the Occupational Socialisation of Nurses.* London: Tavistock.

Melström U. 2002. Patriarchal machines and masculine embodiment. *Science, Technology and Human Values*, 27(4): 460-478.

Menter, I. Muschamp, Y. Nicholls, P., and Ozga, J. with Pollard, A (1997) Work and Identity in the Primary School: a post-fordist analysis_Buckingham, Open University Press

Okely J. (1999) Love, care and diagnosis. In: Tamara Kohn and Rosemary McKechnie (eds.) Extending the Boundaries of Care: Medical Ethics and Caring Practices. Cross-Cultural Perspectives on Women. Oxford/New York: Berg.

Olson T. 1997. Ordered to care?: professionalisation, gender and the language f training, 1915-1937. In: Rafferty A-M, Robinson J and Elkan R. (eds.) *Nursing History an the Politics of Welfare.* London: Routledge. pp150-163.

Ozga, J (2000) 'New labour, New Teachers?' in , J, McLoughlin, E and Gewirtz, S (eds.) *New managerialism, New Welfare?* London, Sage

Ozga, J and Lawn, M (1988) *Teachers, Professionalism and Class*. London, Falmer

Porter 1992. The poverty of professionalisation: a critical analysis of strategies for the occupational advancement of nursing. *Journal of Advanced Nursing,* 17 (6) 720-726.

Prentice, A and Theobald, M (1991) *Women who Taught* Toronto, University of Toronto Press

Pollard, A Broadfoot, P Croll, P, Osborn, M,Abbot, D (1994) *Changing English Primary Schools* London, Cassell.

Rafferty A-M. 1996. *The Politics of Nursing Knowledge.* London: Routledge.

Rafferty A-M, Robinson J and Elkan R. 1997. Introduction in: Rafferty A-M, Robinson J and Elkan R. (eds.) *Nursing History an the Politics of Welfare.* London: Routledge.pp.1-9.

Roper N, Logan W and Tierney A. 1980. *The Elements of Nursing*. Edinburgh: Churchill Livingstone.

Roper N, Logan W and Tierney A. 1981. *Learning to Use the Nursing Process*. Edinburgh: Churchill Livingstone.

Shain, F (2000)

Salisbury SJ. and Tettersell MJ. 1988. Comparison of the work of a nurse practitioner with that of a general practitioner. *Journal of the Royal College of General Practitioners* . 38, July: 314-316.

Savage J. 1995. *Nursing Intimacy. An Ethnographic Approach to Nurse-patient Interaction.* London: Scutari Press.
Smyth, J (1991) 'International perspectives on Teacher Collegiality; a labour process discussion on the concept of teachers' work' *British Journal of the Sociology of Education* 1293) 323-346
Smyth, J and Shacklock, G (1998) *Remaking Teaching: Ideology, Policy and Practice* London, Routledge
Steedman, C (1987) 'The Mother made Conscious' in Lawn, M and Grace, G (eds.) *Teachers: The Culture and Politics of Work.* London, Falmer Press
Strathern M. 1997. Gender: Division or Comparison? In K. Hetherington and R. Munro (eds.) *Ideas of Difference: Social Spaces and the Labour of Division.* Sociological Review Monograph. Oxford: Blackwell Publishers.
Touche Ross. 1994. *Evaluation of Nurse Practitioner Pilot Projects.* London: South Thames Regional Health Authority/NHSE South Thames.
Teacher Training Agency (TTA) (2001) *Handbook to accompany Standards for the Award of Qualified Teacher Status* London, TTA
Thompson P. 1989. *The Nature of Work. An Introduction to debates on the Labour process.* Basingstoke, Hampshire: Macmillan.
Thompson, P (1990) 'Crawling from the Wreckage: The labour process and the Politics of production' in Knights, D and Willmot, H (eds.) *Labour Process Theory*. London Macmillan
Traynor, M. (1999). Managerialism and Nursing: beyond profession and oppression. London, Routledge.
Walkerdine, V (1993) 'Femininity as performance' *Oxford Review of Education* 15 (3) 267-279
Waerness K. 1992. On the rationality of caring. in Showstack Sassoon A. (ed.) *Women and the state.* London: Routledge.
Widdowson, F (1980) *Going up into the Next Class: women and elementary teacher training 1840-1914*. London, Women's Research and Resources Centre
Weiler, K (1997) 'Reflections on writing a History of Women teachers' *Harvard Educational Review* 67 (4) 635-657
Whitehead, S and Moodley, R (1999) *Transforming Managers: Gendering Change in the Public Sector* London, UCL Press
Woods, P and Wenham, P. (1994) 'Politics and pedagogy: a case study in appropriation' *Journal of Education Policy* 10 (2) 119-143
Yeatman, A (1994) *Post-modern Revisionings of the Political* New York, Routledge