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Will graduate entry free nursing from the shackles of class and gender oppression?

Nursing often faces criticisms such as being 'too posh to wash'. It is the profession's oppressed position that leads to negativity regarding educational achievement

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Debates in nursing focus on the provision of good nursing care and its relation to academic status. For example, are nurses "too posh to wash" if they believe entry to the profession should require a degree, or is this a case of them having pretensions "above their station"? This article discusses the nature of oppression and its relationship to hierarchy, and concludes that nurses are oppressed through gender and socioeconomic class. It also examines the profession's social position, arguing that the majority of nurses identify with the most oppressed social class.

KEY POINTS

- Nursing is a culturally oppressed profession and this has implications for practice and delivery of patient care.
- It is nurses' oppressed position that leads to criticisms of academic achievement.
- Nurses should feel comfortable with educational attainment alongside their role as caregivers.
- The more equal social position that nurses can claim should enhance rather than detract from the quality of patient care.

INTRODUCTION

The recent public debate about nursing becoming a degree entry profession has rekindled worries about its focus as a profession. The concerns of the public, patients, fellow professionals and, most importantly, of nurses themselves have repeatedly centred on their ability and willingness to provide direct patient care. The debate over whether nurses have become "too posh to wash" is well rehearsed. Why is this?

In contrast, the medical profession has always required university education but it has never appeared to be concerned that its members may not wish to perform intimate investigations or learn clinical skills. The basic academic level of achievement for medical staff in the UK is equivalent to two undergraduate degrees, yet clinical practice and direct patient treatment retain their primary status for medics. So why are there concerns that requiring nurses to study to degree level will remove us from the bedside altogether? Perhaps this has more to do with our historical and current position within British society than with any academic incompatibility with providing care.

This article argues that nurses are an oppressed group on at least two fronts – sex and class – and have been so from their inception as a professional or vocational group. This is important as it highlights one of the central social debates within nursing.

On the one hand, nurses are a powerful, numerically impressive grouping, with the trappings of a legislatively accepted position in the social order; on the other, however, they have long been seen, and often behaved collectively as, victims of circumstances rather than proactive agents of policymaking (Tschudin 1999; Menzies, 1960). The source of this situation is gender and unequal social class relationships, and the oppressive nature of these.

THE NATURE OF OPPRESSION

What is oppression? Traditionally, it refers to the unfair use of power by a ruling group over another group within a social situation. There are several theories of oppression. Many feminist theories deal with unfair sexual discrimination, while Marx has been the dominant figure in the understanding of the oppressive nature of social and economic class hierarchy. The theories addressed in this article focus on the unjust treatment of individual members of these groups, and the piece argues that the nature of hierarchy within social relationships inevitably leads to oppression.

This is a controversial position in a liberal democracy such as the UK in the early 21st century. The mainstream view of power differences within a democratic society can be summed up as meritocracy. In a meritocratic society, some groups gain more power because they have gained dominance due to harder work, education or intelligence. In this view of the world, hierarchy is a necessary and justifiable aspect of social relationships. However, this cannot be said for group identities imposed upon us by circumstances outside of our individual control, including gender and social class. These social groups are strongly entwined with the concept of nursing.

SEXUAL DISCRIMINATION

Nurses are, and always have been, mainly women. The public sees them as female and nurses themselves often describe an unnamed individual nurse as "she".

While there have always been men in nursing, there has been little percentage increase in the number entering the profession in recent years. The UK nursing workforce is 10.73% male, an increase of 2.36% of the total since 1990 (Nursing and Midwifery Council, 2007). If the trend continues at the current rate, it will take a further 300 years to achieve numerical gender equality in the profession.

Men are, however, over represented in particular parts of the profession and feature disproportionately in management and other senior positions (Lane, 1998); they also make up 50% or more of mental health and learning disability nurses. Consequently, the number of women in "adult branch" nursing is more than would appear to be the case from the headline figures.

From this analysis, it can be claimed that nurses are likely to face a similar set of prejudices and injustices as those facing women within society.

SOCIOECONOMIC CLASS

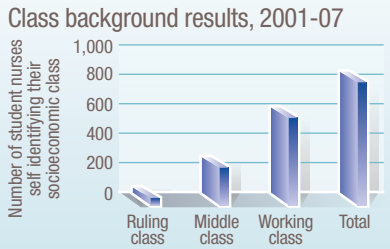
In a recent survey, nurses were asked whether they identified their class background as working class, middle class or ruling class. Fig 1 shows that a large majority identified it as working class (this data comes from my own unpublished research).

This self identification requires examination from a variety of viewpoints. Looking at social position and class from the perspective of oppression requires consideration of the Marxist argument, which remains the pivotal critical theory in relation to economic repression.

From a Marxist perspective, as employed paid workers, nurses are working class. However, this classical definition also includes all other staff in NHS hospitals, including senior managers and medical staff. This creates an analytical problem when proposing subjection of one part of the same group (nurses) by the other (managers and medical staff). Nevertheless, Marx (1976) differentiated between waged workers on the grounds of "badly paid" and "best paid".

Later Marxist theorists, such as Marcuse (1964), expanded politicoeconomic oppression to the bureaucratic modern capitalist state. In this case, it is more useful to consider social class as one of many oppressions affecting suppressed socially determined groups. This theory of general oppression, initially proposed by feminists, allows for unjust inequalities of any kind such as race, age, gender and social class to be taken into account rather than assuming,

FIG 1. CLASS BACKGROUND



as Marx did, that all such injustice results from economic inequality created by the accumulation of capital.

Using this "multiple sources of oppression" model to assess nurses' social class as a group requires the examination of a variety of factors. Marxist theory remains valid, but this form of analysis provides just one argument for socioeconomic position.

Liberal statisticians have attempted social classification for many years using a variety of indicators to create hierarchies to assist policymakers and researchers. The current version used by the Office for National Statistics (2008; 2000) is the Standard Occupational Classification 2000, which consists of a nine point scale along which all UK occupation groups are mapped. Each of the nine points is given a title describing the occupations listed within it. The positions are arrived at by empirical observation of the power relationship between occupations and the level of autonomy of occupational groups; within the main nine points are subgroups (ONS, 2008).

This method of classification places nurses in group 3 "associate professional and technical occupations" (ONS, 2000); the subgroup that includes nurses is "health associate professionals". Therefore, within this officially sanctioned hierarchy, registered nurses are classified at the level below medical practitioners and pharmacists. This indicates that, although the socioeconomic status of the profession is above that of carers who do not have the paraphernalia of registration and a professional body, nurses have not obtained the social position whereby they are recognised as a fully professional group.

This clearly indicates that nurses are in the semi professional class (Stronach et al, 2002). This is a group of professions identified by their majority female membership and lower social position (Etzioni, 1969). In the current climate of the rise of managerialism, it can be argued that the main area of conflict and oppression for associate professionals is with their employers.

AN OPPRESSED PROFESSION?

If the nursing profession was in the kind of position of power that law and medicine occupy, then nurses would be able to protect their privileges. On the other hand, the fact that nurses are considered professional at all indicates that the processes of proletarianisation and deprofessionalisation – which Stronach et al (2002) argued are a deliberate attempt to reduce the status of professions such as teaching and nursing – are not yet complete.

In many ways, the interests of the profession and employers do converge: both wish to provide excellent services for clients and an environment where patients feel safe and valued. Of course, in some ways, the aims of management and professionals will be different – for example, NHS trusts are forced to meet year on year cost improvement programmes (Stronach et al, 2002). Consequently, it is hardly surprising that professionals end up in conflict with management. When these disputes arise there is a straightforward industrial confrontation of the type involving any group of organised workers and management. This state of potential and actual confrontation dates back to the early industrial period and, arguably, to the beginnings of civilisation (Webb and Webb, 1920). A manifestation of this conflict is the long history of nurse trade unionism.

The position of nursing within the socioeconomic framework is one of a relatively oppressed group – not as low in the social scale as some, but certainly not in the upper professional tier. Considered in line with Marxist theory, feminist theory, liberal empirical sociological practice or the position of professions within the social milieu, it can be concluded that nursing is unjustly positioned below and oppressed by a number of occupational class groups, such as medicine, pharmacy and professional management.

All this means that the multidisciplinary team caring for patients is not socially equal and, consequently, is unjustly oppressive. Nurses are part of an oppressed class and, as semi professionals, are a subordinate profession. As a result of this, the official line that nurses and nurse educators have been taking for decades

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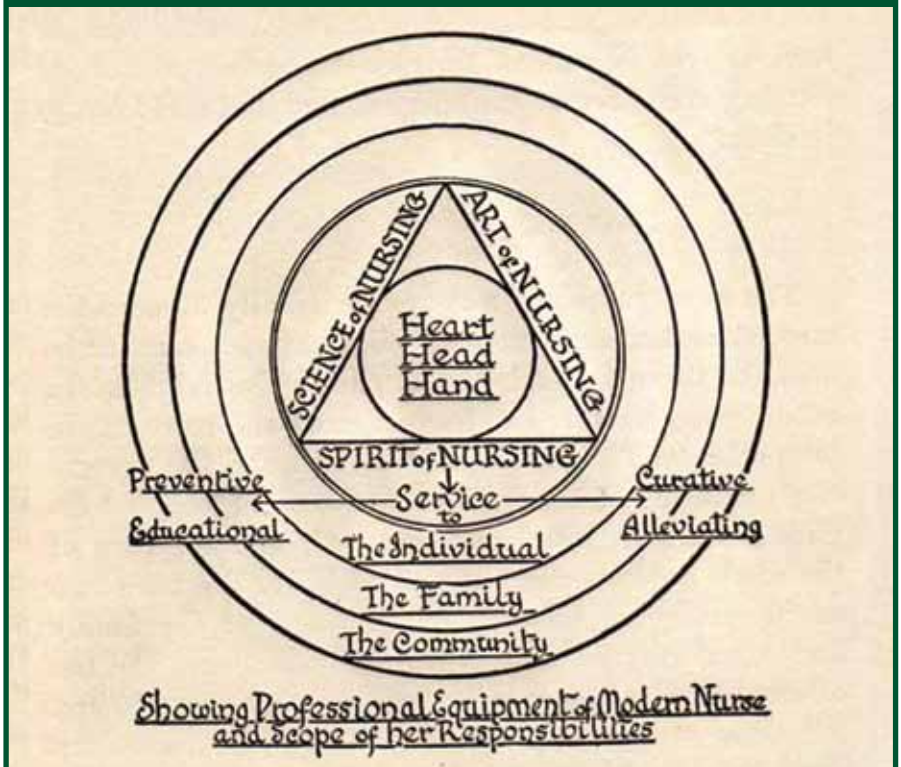
FIG 2. PROFESSIONAL EQUIPMENT OF A MODERN NURSE AND SCOPE OF HER RESPONSIBILITIES



"All vocations, even in their early stages, show three main phases of development. These three phases are represented in the diagram as the art, science and the spirit of nursing.

"It was Florence Nightingale who first insisted that nursing was an art, 'the finest of the fine arts'. Up till her day it had been looked upon generally as a form of manual labor, regardless of how low or lofty the motive might be that promoted the service. Many people still think of nursing as a handicraft rather than an art, and probably this is a correct term for much that goes by the name nursing even today" (Dock and Stewart, 1938).

"The general opinion of those who have studied the question [is nursing a profession?] seems to be that nursing belongs in the group of professional occupations but that it is not yet as well developed, especially on the educational side, as some of the older professions… Because of its educational lag it has been called an 'emerging' profession rather than one that has actually 'arrived'. A better educational foundation for those who enter nursing schools, and better standards of preparation in the rank and file of these schools would help greatly in giving nursing the full standing that is implied by the term 'nursing profession'" (Dock and Stewart, 1938).

– that the nurse is an equal partner in the multidisciplinary team (Corrigan, 2002) – can be shown to be a fiction.

HISTORY, PROFESSIONALISM AND CLINICAL SKILLS

From a historical perspective, the twin oppressions of sex and class potentially place nurses into Rowbotham's (1977) "hidden from history" category. She argued that the history of women, and particularly working class women, has been deliberately repressed by patriarchal society. As such the profession has little sense of historical identity except as one of service to the medical profession. However, this is not a completely accurate historical picture.

One of the crucial dialectics in historic and contemporary nursing is between the desire of this "emerging" or "semi" profession (Etzioni, 1969) to gain raised status through cognitive educational "awards" and maintaining clinical effectiveness while retaining the confidence of the public through "fitness for practice and purpose" (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2001). Much of the literature describes the link between theory and practice as essential, and this is indisputable. However, this is not a new desire, as Fig 2 shows (Dock and Stewart, 1938).

The debate over the status of nursing as a profession and the link to the status of physical work and education has a long history. This is important as it affects the economic, academic and social status of those involved in carrying out direct patient care. This is especially true in nursing specialties known for their high levels of physical care, such medical and elderly care.

Nursing education

In educational institutions, the status of those involved in teaching skills has a lower status than those involved in more academic subjects (Martin, 1989). This can be seen in the emergence in the 1950s of a specific clinical teacher (CT) role. CTs were paid on a lower grade than other nurse tutors and were required to do a six month teaching course rather than the full tutor 12 month programme. This led participants of a survey by the Royal College of Nursing in the 1970s to describe colleagues perceiving their role as one of "failed tutors" (Hinchliff, 1986).

This debate about the status of clinical practice led to the removal of the specific CT role during the changes in nurse professional registration and education in the late 1980s. This remodelling followed the Briggs report on nursing (Department of Health and Social Security, 1972) and subsequently the Nurses, Midwives and Health Visitors Act 1979. This took place at a similar time as the removal of the enrolled nurse (EN) role and the switch from apprenticeship to higher education.

The idea of making a single status for nurses and nurse educators was designed in part to improve the low status given to those nurses and educators involved in the giving or teaching of direct care. However, the consequence of that was a perception – widely held by the general public and healthcare professionals, including many nurses – that RNs and nurse educators withdrew from direct patient care such as washing, feeding and toileting (Department of Health, 1997). This became an issue to the extent that questions were raised in the House of Lords.

The profession and the DH announced measures to raise the amount of clinical skills taught to students in preregistration education (UKCC, 2001; DH, 1999) and to reintroduce a specific practice teacher qualification to the register (NMC, 2006). In

recent times, the NMC has taken the decision to insist on both a list of essential skills to be taught by universities and on placement before nurses can be registered. In addition to this official policy, it is well documented that education on clinical placements often amounts to student nurses being used as an unpaid workforce rather than as valued future coregistrants (Allan and Smith, 2009). Is this the behaviour of a first level profession? It would appear more like that of a craft based occupation returning to its origins.

If the theory is accepted that nurses are an oppressed group, then the action to reintroduce clinical skills as a central theme is simply another act of repression by the powerful political and managerial policy makers. As Tschudin (1999) said: "Nurses have, for very long, suffered from the fact that policies and rules were made for us rather than by us; made by men for women; by politicians for nurses."

Along with other semi professions at the beginning of the 21st century, nursing has been increasingly regulated. For the first time in England, school teachers have to belong to a professional body. Similarly, nursing and other "associate health professions" such as occupational therapy had their professional regulatory bodies reconfigured during the last decade (Health Professions Council, 2008). For nurses, this entailed the introduction of a replacement professional body, the NMC. This was not a simple name change – the UKCC had the majority of its members democratically elected and separated its educational function into four separate national boards, while the NMC finally lost all democratic trappings to become an entirely appointed committee in 2008 (DH, 2007).

There can be no doubt that the nursing profession as a whole is following the agenda of the more powerful members of society in pursuing a more skills oriented approach. However, this cannot be simply looked at as the result of an oppressed group being forced back into a lower social position. Most nurses would agree that clinical skills are highly important and there can be no doubt that the majority of rank and file nurses support the move towards a skills oriented education. This flows from the profession being rightly focused on the outcome of patient care. Nevertheless, this outcome applies to all healthcare professionals – our constant references to fundamental caring skills as being all that should matter to nurses is an indication of our ongoing self identification as a subordinate profession.

CONCLUSION

The nursing profession is oppressed on two social fronts. Nurses are mainly women and as such – in line with feminist theory – the entire profession (including those men within it) is subjugated in the same unjust way that women are within society.

The majority of nurses identify themselves as being working class and the ONS categorises them below doctors and pharmacists in its social stratification. This position in the social hierarchy leads to unfair discrimination and the injustice of oppression by the more powerful groups. Consequently, nurses are oppressed in the same way as other working class professions as part of the economic and social structure of society. It is this oppressed position that leads them to be constantly pilloried for achieving more advanced academic qualifications. The idea that academic achievement is equivalent to loss of clinical skill or makes nurses uncaring cannot stand up to serious examination.

Graduate status does provide nurses with social professional equivalence to others within the supposedly meritocratic social stratification of our culture. Once the profession becomes degree entry only, its oppressed position will be shown up for what it is: thinly disguised class and gender prejudice. ❙

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