TOWARDS
A
SOCIOLOGY
OF NURSING
AN ETHNOGRAPHY IN CHILE

Dissertation submitted in partial fulfilment of the requirements for the degree of Doctor (Ph.D.) in Sociology.
Ghent University, Belgium.
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AN ETHNOGRAPHY IN CHILE

Dissertation submitted in partial fulfilment of the requirements for the degree of Doctor (Ph.D.) in Sociology. Ghent University, Belgium.

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For Bernardo, doctor-maker.
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SUMMARY

Introduction

Based on extensive primary resources, this ethnography constructs the nursing profession in Chile as a sociological object of study and elucidates the underlying structures, ideologies and devices used in the making of contemporary nursing. Nursing as a profession has long been researched from the standpoint of nurses, and yet social matters relevant to its construction, its implications and repercussions are a rather emerging interest. In fact, the prime mover of this research is the critique to the professions introduced in the 1980s sociological literature, as professions relate to one another in a systemic or ecological relation, competing for territory (jurisdiction), clientele, status and rewards. The way the professions are interrelated highlights that profession building is as much technical a process as it is social, and thus through its evolving nature it benefits some occupational groups while depriving others.

This perspective enabled an exploration of the nursing profession in interaction with environing occupations, drawing attention to the dynamics of class relations, gender stratification and self-ascribed ethnic identities, permeating on one hand the structuring of the healthcare system, and on the other hand the internal functioning of nursing. Studying nursing as an ecological entity also seemed useful to overcome structural approaches, not only for gaining an understanding of how interrelatedness occurs, but also for comprehending adaptations to and exchanges with the organisational ‘landscape’ in which nursing tasks and roles take place.

The research has a theoretical affinity with a framework conceiving society as an arena of inequality that generates conflict and change:
Whereas dominant categories of occupational groups strive to protect their privileges, disadvantaged groups attempt to gain more egalitarian benefits. This view was brought into the analysis of the professions, informed largely – though not exclusively – by the social closure theory of Larson, the systemic theories of Abbott, and the notion of ownership of knowledge developed by both Larson and Collins. In this way thus, beneath this ethnography lies a purpose that is ultimately political.

**Methodology**

*Approach:* The main concern of this research was actual professional work in nursing, rather than the rhetoric the professions build and project into their audiences; in other words, how profession making is embedded in day-to-day practices. Crucial to this approach was the involvement of the researcher in the setting as a participant observer. This pursued the construction of first-hand experience resources of unspoken principles and logics behind social action, considering that the research would explore aspects people do not normally think of and uncover conceptual interrelations people may not have words for. Ethnographic observations were indeed used for intensive cross comparison between data constructed discursively with data embedded in the social action, especially through the relationships among nurses themselves and with other professionals.

*Setting:* The setting of the study was a 500-bed Chilean hospital, chosen not only for convenience concerning access to the site, but also for representing theoretical interest for the research question. Given its reputation for providing high-quality service and using modern care equipment, it was anticipated would enhance chances for analysing advanced cross-disciplinary interactions and how they are shaped and reshaped socially, rather than describing traditional linear organisational hierarchies. Prior to accessing the setting, a relevant Ethics Committee granted approval for the research project, and both the Hospital Director and the Head Nurse conceded access agreement.

*Theoretical sampling and data gathering process:* This research was concerned with the construction of relations and concepts. Accordingly, it seemed appropriate to design a semi-structured sample (of sub-settings and of informants) that enabled covering a range of theoretically meaningful professional roles and tasks performed in different sub-settings, but that at
the same time were flexible enough as to develop and refine the emerging categories by adjusting the sample. This adjustment was not meant to increase the sample indefinitely, rather to refine ideas and relations between them as they surfaced during the constant comparison of data involved in the Grounded Theory approach.

The sample was initially aimed at balancing opposing conceptions of professionalism in nursing (for example caring-oriented nursing and technically expert nursing) and different degrees of seniority at work, and exploring the dynamics between them in the assumption that professional groups are heterogeneous entities. The construction of data involved extensive in-site observations, informal talks, semi-structured interviews and hangouts with nurses. As field research progressed, it seemed necessary to involve other actors that were important for an understanding of the systemic relations with neighbouring professions, such as academics, medical doctors and midwives, and extend the observations into other sub-settings.

During the filed work I also sampled and compiled a significant amount of institutional documents and archives connected to the topic of concern, which would provide fresh insights into conflicting interprofessional contact. Documents and archives helped further interrogate observational data and the contents of the interviews in substantive areas, and suggested to go back to particular respondents. Throughout this process, the sampling method was compatible with the Grounded Theory approach, as the sample structure evolved from certain openness to a rather selective choice of participants.

Data analysis: The Grounded Theory – as developed by Corbin and Strauss, and Charmaz – approach allowed the emergence of explanatory concepts across layers of data – be they notes from observations, corpus of interviews, and documents and archives – as the functioning of the concepts being explored evolved and the level of abstraction increased. The analysis moved from an open coding leading to provisional categories of data, to a selective coding, with the categories gaining more stability as the analysis progressed. The categories were then further problematised through an axial coding, evaluating whether the provisional answers were meaningful to the research questions and connecting the categories with the main sociological concepts framing the research.
Important for integrating these documents into the data and contextualise them in the period and context in which they were produced was the adoption of a social-history approach. This approach enabled an interpretation of professional relations as part of key socio-historical processes. The categories arising from these data were then contrasted to and connected with the observational data and the contents of the interviews.

**Findings**

Theoretically, the frame developed from the literature review shows a number of landmarks defining the jurisdictions of the professions, which leads to a continuous transformation of the nature of a given occupation. Change, it is argued, is the driving force of an occupational system. In this light, the main findings point to a sense of status elevation surrounding the construction of a graduate healthcare occupation; university-trained nurses have monopolised the title ‘nurse’ and the practice of ‘nursing,’ excluding in the process other nursing occupational categories. This is not solely important from a structural point of view highlighting an internal hierarchy in nursing; it also suggests that earlier historical inequalities in nursing are being reproduced through the academic training, a social-class consciousness, and a socially constructed otherness embedded in discourses of a so-called ‘eliteness’ of professional groups (as opposed to vocations and crafts).

Similarly, conflicting interactions with other technically similar groups seem to develop from middle-class behaviour, a process intertwined with the increasing technologisation of healthcare and a progressive managerialism, where nurses come to compete with other professionals.

The ineffectiveness of nursing university education in preventing class inequalities echoes its ineffectiveness in preventing gender inequalities. While gender inequalities among nurses have been extensively documented elsewhere, discourses arising from an alleged aptitude of male students for high-technology specialities and high-stress areas seem to naturalise unequal patterns of career choice from a very early stage of nursing training. More intriguingly, this pattern does not seem to arise exclusively from the cultural context of the study – with pervasive inequalities permeating social relations – but it is also actively promoted, as noted, through academic dis-
courses used as the basis of an argument for an empowered, masculinised image of nursing.

While these findings stress the behavioural dynamics of the construction of a professional rhetoric, an increased market of academic credentials and the symbolic value of the credentials in nursing are used as a platform for wielding power and questioning misbalanced patterns of power in organisations, facilitating the transformation of hierarchies and relational patterns among occupations. These latter findings add to an argument of an ideological device being carefully constructed by nurses. This position becomes clearer when analysing the exchanges of the nursing profession with its landscape – and how that landscape has been purposively manipulated – during the implementation of a major reform, in which nurses would create alliances with key actors offering the deployment of advanced managerial skills and receiving legitimation and rights in return.

**Conclusion and discussion**

Building on the main findings, this research elaborated on the internal and the external boundaries of nursing, the strategies it develops with regards to the interaction with environing groups – namely the auxiliary nurse, the medical doctor and the midwife – as well as the areas in which political action takes place, and the devices, strategies and alliances utilised as a means of strengthening the profession. As illustrated in this study, the nursing profession is shaped socially to a very large extent by the ever-changing setting and by the professions ‘out there,’ though it also implements its own strategies to manipulate its environment, both technically and rhetorically, with a view to defend its particular interests from outsiders. By bringing this systemic interrelatedness to the fore – highlighting landscape transformations, internal logics and interprofessional contact – it becomes evident that nurses’ behaviour is heavily regulated in nuce by unwritten rules and that those rules become crystallised in ‘a code’ as nurses are socialised into their professional culture. Of utmost relevance, this nursing code becomes the core element of the profession’s social-closure project, one that enables monopolisation of opportunities and resources as well as exclusionary mechanisms to control its power base. Nurses’ profession building seems in fact to be equated with a socially constructed apparatus which would ensure increasing symbolic rewards.
It is possible to conclude that the system in which nursing is placed challenges the profession to display sophisticated strategies to both adapt to the system and remain within the evolutionary loop of healthcare. The internal functioning of nursing as an evolving species has successfully functioned as an adaptive whole with regards to landscape transformations through a social closure project. Whereas nursing has progressively been concerned with its name and reputation, it has also pursued a monopolising contest for highly valued symbolic attributes, obstructing in the process what may threaten its prestige. This success is explained by types of interactions with other constituent parts of the system, such as mutualism and predation, among others.

Additionally, the ability to adapt to landscape transformations is complemented by an ability to manipulate the landscape. These abilities seem grounded on a larger mechanism of professional functioning, best understood as an ideological device.

By bringing together the overlap of parallel pathways of evolution and the various types of interaction professions develop, interprofessional relations become much more complex than previously thought.

Abbott’s work seamed best fitting for the setting of my research. A process of cultural assimilation between Chile and the historical context he researched has installed the professions at the heart of social dominance, and with them an obsessive race for attaining university status and advanced degrees. Academisation has, as illustrated extensively, reinforced constructs of an undesirable social standing around other trades and crafts, and, importantly, the allocation of wages and symbolic rewards accordingly.

Without aiming to achieve topic representativeness, this work might be criticised for its limitations, either because of the methodological frame through which data are constructed or because of the positionality of the researcher in the filed. This work, however, was meant to increase awareness about the question of concern rather than to give a positivistic account of how professions are built.

Finally, this research finds some resonance elsewhere, pointedly in some sociological work undertaken in the United Kingdom showing the ever-changing nature of the nursing profession, migrating from a politically deprived caring profession to a management-oriented one, but above all
how the internal hierarchies of nursing are being reshaped as to constitute a larger narrative of professionalism.
SAMENVATTING

Inleiding

Dit etnografisch werk is gebaseerd op uitgebreid primair dataonderzoek. Het zet de Chileense verpleegkunde neer als een sociologisch studieonderwerp en heldert de onderliggende structuren, ideologieën en middelen op die een rol spelen in de hedendaagse verpleegkunde.

Verpleegkunde als een beroep is lange tijd onderzocht vanuit het oogpunt van verpleegkundigen zelf, maar desondanks zijn de sociale vraagstukken die relevant zijn voor de constructie, implicaties en gevolgen hiervan een relatief recent fenomeen. De drijvende kracht achter dit onderzoek is inderdaad de kritiek op de beroepen die in de sociologische literatuur van de jaren '80 boven kwam drijven. Deze kritiek kwam naar voren omdat beroepen aan elkaar relateren in een systematische of ecologische relatie, in de tussentijd concurrerend voor de afbakening, clientèle, status en beloningen.

De manier waarop de beroepen aan elkaar gekoppeld zijn laat zien dat het vormgeven van beroepen zowel een technisch als sociaal proces is. Door deze veranderende aard bevoordeelt dit sommige beroepsgroepen, ten nadele van andere groepen.

Dit perspectief faciliteert de verdere studie van de verpleegkunde in interactie met andere (gerelateerde) beroepen en vestigt de aandacht op de dynamieken van klasserelaties, de gelaagdheid van geslachten en zelf tegeschreven ethnische identiteiten. Dit betreft aan de ene kant de structurering van de gezondheidszorg en aan de andere kant de interne werking van de verpleegkunde.
De studie van verpleegkunde als een ecologische entiteit bleek ook nuttig om structurele benaderingen het hoofd te bieden, niet enkel voor het beter begrijpen van de verwevenheid, maar ook om aanpassingen aan en uitwisselingen met het organisatorische ‘landschap’ te begrijpen waarin de taken en rollen in verpleegkunde plaatsvinden.

Het onderzoek heeft een theoretische affiniteit binnen een raamwerk waarin de samenleving opgevat wordt als een arena van ongelijkheid die conflict en verandering voortbrengt: waar dominante categorieën van beroepsgroepen ervoor strijden hun privileges te behouden en achtergestelde groepen proberen om meer egalitaire voordelen te verkrijgen. Dit inzicht kwam in de analyse van beroepen terecht, voornamelijk geïnformeerd (nochtans niet uitsluitend) door de sociale uitsluitingstheorie van Larson, de systeemtheorieën (systemic theory) van Abbott en het begrip van kennis eigendom ontwikkeld door zowel Larson en Collins. Onder deze etnografie ligt hierin dus voornamelijk een politiek doel.

**Onderzoeksopzet**

*Opzet:* Het belangrijkste onderdeel van dit onderzoek was het beroepswerk in de verpleegkunde en niet zozeer de retoriek die deze beroepen hanteren en op hun doelgroepen projecteren. In andere woorden gaat het erom hoe het construeren van beroepen verankerd ligt in de dagelijkse praktijk. Cruciaal voor deze aanpak was het betrekken van de onderzoeker in deze setting door middel van participerende observatie. Dit leidde tot het construeren van eerstehands ervaringen van onuitgesproken principes en logica achter sociale actie. Het onderzoek heeft aspecten die normaliter niet in ogenschouw genomen worden en heeft zodoende conceptuele verwevenheid blootgelegd waar mensen in deze beroepsgroep wellicht zelf niet de woorden voor vinden.

Etnografische observaties zijn inderdaad gebruikt voor intensieve vergelijkingen tussen gegevens die beredenerend geconstrueerd zijn met gegevens ingebed in de sociale actie. Hierbij lag de nadruk vooral op de relaties tussen verpleegkundigen onderling en die met andere professionals.

*Setting:* De setting van de studie was een Chileens ziekenhuis ter grootte van 500 patiënten, gekozen niet enkel voor het toegangsgemak, maar ook vanwege het theoretische belang voor de onderzoeks vraag. Het ziekenhuis heeft een reputatie van het bieden van zorg van hoge kwaliteit en het
gebruik van moderne uitrusting. De verwachting was dat dit de mogelijkheden zou vergroten voor het analyseren van interdisciplinaire interacties en hoe hun vorming en sociale aanpassing. Het gaat hierbij minder om het beschrijven van traditioneel lineaire, organisatorische hiërarchieën. Alvorens deze setting te betreden werd voor het onderzoeksproject toestemming verleend door de relevante Ethische Commissie. De ziekenhuisdirecteur en hoofdverpleegkundige gingen eveneens akkoord.

Theoretische steekproef en gegevensverzameling: Dit onderzoek had betrekking op de constructie van relaties en begrippen. Het werd derhalve toepasselijk geacht een semi-gestructureerde steekproef te ontwerpen (van sub-settings en informanten) die het mogelijk maakte een groot scala aan theoretisch nuttige professionele rollen en taken uit te voeren in verschillende sub-settings. Deze waren tegelijkertijd flexibel genoeg voor het ontwikkelen en verfijnen van de verschillende categorieën. Op deze basis werd ook de steekproef tijdens het proces aangepast. Deze aanpassing had niet tot doel om de steekproef simpelweg groter te maken, maar was meer gericht op het verfijnen van de ideeën en de relaties hiertussen, vooral op het moment dat deze naar voren kwamen tijdens de constante vergelijking van gegevens in de Grounded Theory benadering.

De steekproef was oorspronkelijk gericht op het in balans brengen van tegengestelde begrippen van professionalisme in de verpleegkunde (zoals bijvoorbeeld zorggeoriënteerde verpleegkunde en verpleegkunde vanuit de hoek van technische kennis) en verschillende niveaus van senioriteit op het werk. Bovendien had het tot doel de dynamiek tussen deze begrippen weer te geven, onder de veronderstelling dat beroepsgroepen heterogene entiteiten zijn.

De constructie van gegevens leidde tot uitgebreide observaties in het ziekenhuis, informele praatjes, semigestructureerde interviews en gesprekken met verpleegkundigen. Naarmate het veldonderzoek vorderde, bleek het noodzakelijk om andere actoren bij het proces te betrekken. Deze actoren werden belangrijk geacht voor het begrijpen van de relaties met andere beroepsgroepen (zoals academici, dokters en verloskundigen) om zodoende de observaties uit te breiden naar andere sub-settings.

Tijdens het veldonderzoek nam ik ook een steekproef van een groot aantal institutionele documenten en archieven die betrekking hadden op
het onderwerp en die nieuwe inzichten zouden geven in tegenstrijdig interprofessioneel contact. Documenten en archieven hebben geholpen bij het verder ontdeden van de gegevens als observant en de interviews en leidde tot vervolgonderzoek bij verschillende respondenten. Tijdens dit proces bleek dat de steekproefmethode verenigbaar was met de Grounded Theory benadering, terwijl de structuur van de steekproef veranderde van een zekere openheid richting een meer selectieve keuze van deelnemers.

Data analysis: De Grounded Theory benadering – zoals ontwikkeld door Corbin en Strauss, en Charmaz – geeft de mogelijkheid voor het ontstaan van beschrijvende begrippen temidden van een grote hoeveelheid gegevens (zijnde notities van de observaties, interviews, en documenten en archieven) terwijl dewerking van de verkende begrippen werden ontwikkeld en het abstractieniveau toename. De analyse veranderde van een open codering naar een voorlopige categorisering van gegevens en leidde naarmate het onderzoek vorderde tot een selectieve codering waarbij de categorieën geleidelijk aan robuuster werden. De categorieën werden vervolgens verder aangepast via axiale codering, waarbij geëvalueerd werd in hoeverre de voorlopige antwoorden nuttig waren voor de onderzoeksvragen en het aansluiten van de categorieën op de belangrijkste sociologische begrippen die ten grondslag liggen aan het onderzoek.

Belangrijk voor het integreren van deze documenten in de gegevensanalyse en het plaatsen hiervan in de juiste periode en context waarin ze geproduceerd werden was het gebruik van de benadering van de sociale geschiedenis. Deze benadering laat een interpretatie toe van beroepsrelaties als onderdeel van belangrijke sociaal-historische processen. De categorieën die uit de gegevens naar voren kwamen werden vervolgens gecontrasteerd met de gegevens van de observaties en de inhoud van de interviews.

Onderzoeksbevindingen

Theoretisch gezien toont het raamwerk ontwikkeld uit het literatuuronderzoek een aantal herkenningspunten die de vrije beroepen definiëren, wat leidt tot een voortdurende omgevingstransformatie van de aard van deze beroepen. Verandering, zo wordt gezegd, is de motor achter de systematiek van beroepen. In dit licht wijzen de belangrijkste bevindingen op een zekere statusverhoging rond de constructie van de beroepen in de gezondheidszorg; verpleegkundigen getraind aan de universiteit hebben de beroepstitel
van ‘verpleegkundige’ gemonopoliseerd, evenals de praktijk van ‘verpleegkunde’, zodoende andere beroepsgroepen in de verpleegkunde uitsluitend. Dit is niet enkel belangrijk vanuit structureel oogpunt in het laten zien van een interne hiërarchie in de verpleegkunde; het suggereert ook dat eerdere historische ongelijkheden in de verpleegkunde versterkt worden door wetenschappelijke vorming, een klassenbewustzijn en een sociaal geconstrueerd anderszijn (‘otherness’) verankerd in beredeneringen van elitisme (zogeheten ‘eliteness’) van beroepsgroepen (als zijnde in tegenstelling tot vakgebieden en ambachten).

Op een gelijksoortige manier kan gezegd worden dat tegenstrijdige interacties met andere technisch soortgelijke groepen lijken te ontstaan uit een zeker ‘middenklassegedrag’. Dit proces is nauw verweven met groeiende technologisering van de gezondheidszorg en een toenemende managementcultuur waar verpleegkundigen concurreren met andere professionals in de zorg.

De ineffectiviteit van verpleegkundig wetenschappelijk onderwijs in het voorkomen van klasseongelijkheid weerspiegelt deze ineffectiviteit in het voorkomen van genderongelijkheid. Terwijl genderongelijkheid tussen verpleegkundigen uitgebreid beschreven is in de literatuur, lijkt het discours dat voortvloeit uit een vermeende geschiktheid van mannelijke studenten voor hightech specialiteiten en hoge stress de ongelijke patronen van beroepskeuzes in een zeer vroeg stadium van de opleiding tot verpleegkundige te normaliseren. Interessanter nog, deze ontwikkeling lijkt niet enkel te ontstaan uit de culturele context van de studie – met sterk verankerde ongelijkheden die sociale relaties kenmerken – maar wordt ook actief gepromoot, zoals eerder gezegd, door middel van een wetenschappelijk discours dat de basis vormt voor het versterken van het beeld van de verpleegkunde als een mannenwereld.

Deze bevindingen benadrukken de gedragsdynamiek van de constructie van beroepsretoriek en zorgen voor een grotere markt van academische referenties en de symbolische waarde van de referenties in de verpleegkunde. Dit wordt gebruikt als een platform voor het uitoefenen van macht en het stellen van vraagtekens bij uit balans geraakte machts patronen binnen organisaties. Hiermee faciliteert het de omgevingstransformatie van hiërarchieën en relationele patronen tussen beroepen.
Deze bevindingen versterken het argument van een zekere ideologische inrichting van de verpleegkunde dat door verpleegkundigen is geconstrueerd. Deze positie wordt duidelijker bij de analyse van de diverse uitwisselingen met andere groepen binnen de verpleegkunde. Dit laat zien hoe dit beeld doelbewust is gemanipuleerd tijdens de implementatie van belangrijke hervormingen waarin verpleegkundigen allianties met belangrijke actoren zouden creëren met als inzet gevorderde leidinggevende vaardigheden in ruil voor erkenning en rechten.

**Discussie en conclusie**

Voortbouwend op deze belangrijkste onderzoeksresultaten heeft dit onderzoek de interne en de externe grenzen van de verpleegkunde verder uitgewerkt, evenals de ontwikkelde strategieën over de interactie tussen beroepsgroepen (namelijk de verpleegkundige, arts en verloskundige) en het domein waarin politieke actie plaatsvindt, inclusief de middelen, strategieën en allianties die gebruikt worden als middel ter versterking van het beroep.

Zoals geïllustreerd in deze studie, is de verpleegkunde in grote mate sociaal geconstrueerd door de almaar veranderende setting maar ook door andere beroepsgroepen. Tegelijkertijd implementeert de verpleegkunde haar eigen strategieën voor het manipuleren van haar omgeving, zowel technisch als retorisch, om zodoende haar specifieke belangen tegen buitenstaanders te beschermen. Door deze verwevenheid naar voren te brengen – het laten zien van de omgevingstransformaties van dit beeld, interne logica en contact tussen beroepsgroepen – wordt duidelijk dat het gedrag van verpleegkundigen simpel gezegd sterk gereguleerd is door ongeschreven regels, die werken als een ‘code’ op het moment van het socialiseren van verpleegkundigen binnen hun beroepscultuur.

Deze code verwordt zodoende tot het kernelement van de sociale uitsluiting van andere beroepsgroepen via het monopoliseren van kansen en middelen en door middel van uitsluitingsmechanismen voor het controleren van de machtsbasis van verpleegkundigen. Het sociaal construeren van het beroep ‘verpleegkunde’ door verpleegkundigen lijkt in feite te worden gelijkgesteld met een sociaal geconstrueerd mechanisme dat zou zorgen voor het verhogen van symbolische beloningen.

Het systeem waarin de verpleegkunde zich bevindt daagt de beroepsgroep uit om geraffineerde strategieën te laten zien om zich zo aan te passen
aan het systeem en met deze veranderingen binnen de veranderende gezondheidszorg te blijven. De interne werking van de verpleegkunde als een evoluerende ‘soort’ heeft met succes gefunctioneerd als een aanpasbaar geheel met betrekking tot de omgevingstransformaties door middel van de sociaal uitsluiting.

Waar de verpleegkunde in toenemende mate begaan is met haar naam en reputatie, heeft het ook een monopolisering nagestreefd van sterk gewaardeerde symbolische aspecten. Hiermee houdt het tegelijkertijd al datgene tegen dat haar prestige kan bedreigen. Dit succes kan uitgelegd worden door middel van interacties met andere onderdelen van dit systeem, voornamelijk mutualisme en absorptie (concurrentie met andere groepen die zorgt voor de opslorping van beroepsgroepen door de dominante beroepsgroep).

Daarnaast wordt het vermogen tot aanpassing aan de omgevingstransformaties aangevuld met het vermogen tot manipulatie. Deze bekwaamheden lijken gegrond op een grotere mechanisme van professioneel functioneren, best begrepen als een ideologische apparaat. Door het samenbrengen van parallele trajecten van evolutie en de verschillende soorten interacties die beroepen ontwikkelen worden relaties tussen beroepen complexer dan eerder gedacht.

Het werk van Abbott lijkt het best overeen te komen met de setting van dit onderzoek. Een proces van culturele assimilatie tussen Chili en de door hem onderzochte historische context heeft de beroepen in het hart van sociale dominantie geplaatst. Hierdoor ontstaat een obsessieve race voor het bereiken van wetenschappelijke status en hogere diploma’s. Dit proces van ‘verwetenschappelijking’ (academisering) heeft, zoals uitgebreid geïllustreerd, geleid tot versterkte constructies van een onwenselijke sociale status rond andere beroepen en ambachten en invloed gehad op de loonverdeling en symbolische beloningen.

Zonder te claimen dat de studie representatief is voor dit onderwerp, kan dit werk wellicht bekritiseerd worden voor haar beperkingen, enerzijds vanwege het methodologisch raamwerk waarbinnen de gegevens opgesteld zijn en anderzijds vanwege de positionering van de onderzoeker. Dit werk had echter tot doel om de bewustwording te verhogen omtrent de onderzoeksv-
raag en was minder gericht op een positivistische lezing van de (sociale) constructie van beroepen.

Ten slotte is er voor dit onderzoek enige weerslag elders, vooral in socio-logisch onderzoek uitgevoerd in het Verenigd Koninkrijk. Dat onderzoek markeert vooral de steeds veranderende aard van de verpleegkunde waarbij het evolueert van een apolitiek zorgberoep richting een meer management-georiënteerd vak. Het legt echter vooral bloot hoe de interne hiërarchieën van verpleegkunde opnieuw gevormd worden teneinde een breder verhaal van professionaliteit te construeren.
INTRODUCTION, ETC.

There was once a time when we dreamed about nurses as angelical, vulnerable and graceful figures, kneeled, cape fluttering, beside wounded men on the battlefield, pictured gesturing silence for a hospital poster, or dressed in a brilliant white dress surrendered in the arms of some kissing sailor. That was a time when nurses seemed to unite some of the best blessings of human existence.

In a world crafted by mankind, rather than humankind, there may indeed be place for romanticism and heroism of the aesthetic representation of what it is to be a nurse. For much as we enjoy the idyllic idea as we close our eyes and recall and re-contemplate that prolific imagery, that is not what this research is about. And although many outside the nursing world might think otherwise, nursing is hardly a romantic matter. It is, at its heart, a sociological puzzle.

A journey to a hospital can pose one intrigue after another in every physical corner, from the surrounding roads, where one can overhear ambulance sirens and wonder what misfortune may have visited someone’s life, to the very bedside where nurses fill patients’ records. Of course, one only fleetingly thinks anything of the kind – unless one happens to be a hospital ethnographer. Who are those working in the hospital? What do they do? What brought them there? What is hospital life like? What do they talk about? Do they laugh like the rest of us? Or, in academic parlance, how is the hospital a socially organised setting and what roles do nurses play in there?

Studying society enables tracing the architecture of relations: each piece of the assemblage contains clues to past and present realities, for the pieces
reflect conventions and practices of those who enact social roles. Work is an important part of society’s functioning and of social life, and in this respect my research was very much concerned with nurses’ work, more purposely focusing on its self-styled profession. This lead me to the basic question, ‘is nursing a profession?’, which for those who have read quite some decades of nursing scholarship would evoke a longstanding debate surrounding the professional nature of this occupation. Coming from a country where only a few occupations are endorsed with such an investiture, my question pointed to the basics of social stratification at work, but became confusing during sociological debates in European circles, and much less so in the U.K. and the U.S. This difference brought me to examine further cross-national scholarships, which differed greatly based on worldviews and the role of the state and its participation in defining professional groups and allocating status and privileges. Whereas in the English-speaking world, with societies oriented to open-economy dynamics, the notion of ‘profession’ is contested among high-status occupations, in Europe this discussion seems out of place, where the term, rather than an honorific investiture, is applicable to any specialised area of work, therefore my question – ‘is nursing a profession?’ seemed meaningless, ludicrous even. In this second theory body the professions (les métiers) are subdivided into categories socio-professionelles, whereas the first would primarily dichotomise into professions and crafts, and ranks somewhere in between, which some would call ‘semi-professions.’ Led by two separate traditions, this divide was most surely crucial to approaching (and explaining) my research question.

Looking at the problem through the latter tradition, the answer would have been all too easy. The former, however, aside from being a better fit for the socio-political configuration of the setting of my field research, offered a more comprehensive frame for a nuanced interpretation of the construction of the professions and the attainment of professional status, which has been a constant theme in the claims of Chilean nurses as well as in the international debate. This altered my question, becoming: To what extent is the construction of nursing as a profession shaped by the transformations witnessed by a society? Such change brought aspects of sociological – and historical – relevance to the centre of both my field inquiry and my personal awareness.
The 1920s is one of the very few dates marked in my work, and in spite of its somewhat historical scent, this is not an historical study (with the excused exception of one of its constituent chapters). As a compilation of narratives, this dissertation tells a story, one possibly known by many but told differently. There are unpretentious reasons why I deliberately developed narratives, rather than simply conforming to the plain, formulaic writing of the academy, creating my own way of scientific expression. One aspect is that important perspectives of knowledge come to us in the form of narratives – as we approach other people’s lives through their experiences, their stories bring fresh insights. A second reason is that, while I could not really bring the reader to the actual research field, improving the description of the setting and reconstructing personal stories constituted the most realistic resource to express what I perceived, saw, heard and sensed throughout my field research, otherwise virtually impossible to share in written form. I could also add that narratives modify the mood of the writer (and that of the reader), in ways that facilitate a more intimate connection with the audience, more imagined than visible. Another reason is that, far from being ‘epistemologically opaque,’ narratives are intimately connected with inductive ways of knowing, making the researcher’s implicit subjectivity in the construction of data explicit, and in the process enhancing the possibilities of an enriched sociological imagination. This is why narrative matters and became central to my writing. With that in mind, I composed my articles as if they were parts of a conversation with my unseen readers. Unable to refuse these pluses, and aware of the dearth of literary merits in them, I collected the stories fragment by fragment, one fraction of the whole at the time, as I realised that, unlike fictional prose, real settings and real stories are exactly that, real. Their lure lies in their realness.

Needless to say, as one goes from chapter to chapter, nothing might seem radically new – it is the same voice after all – but I hope one will effortlessly see the intertwinement among the chapters and, above all, consistency and insights. These narratives are concerned with social relations; inequalities begin in social relations.
This work stands both as an account of a large ethnographic study exploring social matters relevant to nursing and as a fresh attempt for the construction of a sociology of nursing.

We have not really had a substantial explanation to the nursing-as-a-profession problem, and most studies addressing the topic are accounts of nurses talking about themselves. That is a major criticism to nursing research – it concentrates more on what nurses think than it does on how they do things.

My methodology aimed precisely to bridge this gap. It consisted of an extensive hands-on ethnographic exploration of the nursing world, combining what I observed with in-depth interviews, hang outs with key participants, and analyses of a vast amount of documents I compiled throughout my field research, contrasting the contents obtained from different sources as to reconstruct a meaningful account of the social construction of the nursing profession as a systemic unit. This perspective enabled an exploration of its interaction with environing occupations, its exchanges with the landscape, its ideologies, its institutions and its internal stratification. Whereas this exploration drew attention to the functioning of the indisputable success of Chilean nursing, it in turn uncovered other problems of sociological interest, such as the detrimental consequences of its social closure project – a social pattern that benefits one group while depriving others.

After a brief opening reporting on the inception of this study, Chapter 1 traces the rise of the professions in medieval societies and contrasts a range of sociological approaches to professional work; the chapter discusses the treatment given to the concept of profession within mainstream nursing literature and expands the discussion by presenting the systemic approach to the profession as to suggest a framework for systematic analyses.

Chapter 2 looks critically at the academisation of nursing education as a mechanism participating in the reproduction of social differences on the grounds of the eliteness of graduate professions; ethnographic narratives are provided for a novel argument illustrating a ‘social distinction’ sense of status elevation through which university-trained nurses have monopolised the title ‘nurse’ and the practice of ‘nursing.’
Chapter 3 adds to the discussion on gender and gender relations at work. While there is considerable scholarship addressing internal boundaries between nurses and male nurses, little is known about the construction of those boundaries in early stages of socialisation into the nursing culture. Not only does this chapter highlight the impairments in life opportunities as gender identity is balanced with nursing identity among male students; it also provides the bases for an argument about the underlying political ideology aimed at portraying an empowered image of nurses.

Chapter 4 profiles a longstanding conflict between two competing occupations, the nurse and the midwife, tracing back the origins of the conflict to the technologisation and managerialism of healthcare. While this chapter brings insights relevant to the appeasement of the conflict, it also points to contextual transformations, external to the professions, as a source or abrasive interaction between remodelling professional jurisdictions.

Chapter 5 sets forth the intricacies of a health reform and the participation of professionals in it. As nurses gain new credentials and the credentials themselves gain more symbolic value, the reform process has opened up spaces for wielding power and questioning misbalanced patterns of power. This argument stresses the increasing system of credentials in nursing and, more broadly, illustrates the transformation of hierarchies and relational patterns among occupations.

Chapter 6 takes a look back to the organisational setting of the reform process previously discussed, in the anticipation that bringing the setting to the fore would favour further insights into exchanges between the professions and their ecology, and how the former does not solely adapt to the latter but also manipulates it.

This work’s commitment to understanding the social dynamics of the nursing profession in Chile carries with it the interest of contributing to the resurgent body of literature in the sociology of the professions. Nurses should realise that the aim of critically analysing their profession is, above all, edifying. This work may indeed stimulate thought and debate among nurses. The same holds for sociologists.
AUTHOR’S PREFACE: THE INCEPTION OF THE STUDY:  
SITU AS A CATEGORY

This section has been submitted in the form of a discussion article to “Ciencia y Enfermería.” And although there is no further use of its contents in the rest of the thesis, it seemed useful to include it here as to understand how this work developed.

Begun in the mid-2000s, my personal inquiry about whether nursing is a profession used as a starting point the concept of “Occupational Situs” (Benoit-Smullyan, 1944). Aiming at proposing a framework for the systematic study of social stratification, the author of that model claimed that the occupations can be grouped into functional, pyramidal units, defining a professional hierarchy and, at the same time, the relative position of each occupation within that hierarchy. This structure highlights the social affiliation of a person to a group and the social function of the group, by using the latin terms status, situs and locus. While the notion of status refers to the ordering of individuals within an inferiority-superiority scale on a basis of socially desirable attributes, be it an economical hierarchy, a political hierarchy or a prestige hierarchy, the notion of situs represents the social affiliation of those sharing a non-hierarchical social trait, be it cultural (language, religion, etc.), biological (ethnicity, age, etc.) or geographic (neighbourhood, region, etc.); the nature of the common trait is, in principle, egalitarian, as it reports affiliation (situs), not a hierarchical rank of desirability (status).

Based on this premise, one can infer that the professions are, social desirability aside, equal – each of them makes a particular contribution to the functioning of society: managing administratively a region, embellishing the city, allowing an artistic experience, taking care of the sick.

It might seem difficult to separate the analysis between status and situs in capitalist societies, as each social group (situs) is strongly associated with certain symbolic or economic desirability (status), generating on one hand mechanisms to turn affiliations into symbols of social rank and mechanisms of exclusivity and exclusion, on the other. Ranks can indeed be easily identified by analysing the constructs surrounding the sexes, the social differences
between intellectual occupations and applied occupations, the preferences for certain types of sports or the apparent lack of appeal of low-qualified works. Changes in *situs* even lead to infer changes in *status*, e.g. moving into another neighbourhood, changing patterns of consumption, turning into another profession. For analytical purposes, however, *situs* and *status* constitute two different categories.

The third type of social position proposed by Benoit-Smullyan, *locus*, points to the function with which each individual contributes to an organised group, e.g.: head of household. The term *locus* (as in *loco parentis*) is considered here as more specific than the term ‘role,’ which is also used in social theory in the analysis of unorganised groups (as in ‘upper-class role’).

*Status, situs* and *locus* thus refer to three different types of social position. Whereas *status* represents higher or lower ranks, *locus* corresponds to the function within a group and *situs* to the nature of that group. Although the three of them often operate simultaneously, it is not necessarily so, as they are different social phenomena. Different statuses even do not correlate with one another; economical or political statuses, for example, do not coexist with admiration or deference, though do coexist with covert or overt forms of imitation, in other words, aspiration.

While these concepts are important to this standpoint, what are their relevance to the sociology of work? This shall be elaborated in the next section.

**Occupational situs**

As explained, the notion of *status* indicates relations of ordination among individuals, based upon socially desirable attributes. This is to say, *status* represents a vertical dimension of the social order. This verticality is evident among occupational groups, which can be ordered in a scale of social desirability. The notion of *situs*, however, introduces a horizontal differentiation among occupations. There are good reasons to sustain that a unidimensional stratification may not be an optimal model to comprehend the functioning of occupations in a given society, as it offers an oversimplified view and therefore a rough, unrealistic representation (Morris & Murphy, 1953), such as those categories used in census tabulations.

Morris & Murphy (1953; 1959) employed Benoit-Smullyan’s coined term *situs* to create a model representing the occupations as “categories of
work” somehow differentiated. The sales occupation and manufacturing, to use their same example, may be placed within the same situs, even if their category may have little to do with the status, possibly similar, they may enjoy. By combining the two categories, status and situs, the model becomes a series of superior-inferior ranks (status) crossing groups of occupations organised by affinity (situs) horizontally. The resulting representation is a bidimensional model.

Arising from an era of great optimism – science and production scenarios rise in post-war sociology with a subsequent debate about what a profession is and what it is not – it is no surprise that this discussion in the United Stated coincides with an increasing interest in nursing academic circles about whether nursing ranks as a profession (Bixler & Bixler, 1945; 1959). Such discussion brings to the fore a political agenda to reach higher status for nurses, making up one of the most enduring struggles for prestige in the whole body of literature on the topic.

In reconstructing the Western world, there are attempts to validate a certain conception of society, devoted to in the vast sociology of Parsons. Here, functionalist models arise – those explaining how functional to a stabilising society social groups are – with which to evaluate the functionality of occupations in covering society’s needs, and the extent that a single occupation or a group of occupations can cover those needs. In this light, the ‘healthcare situs’ becomes a group of interdependent occupations contributing to society’s other spheres, typically the work sphere. Summarising, an occupational situs is a functional category, each situs contains occupations (functional to the situs) and those occupations may enjoy different degrees of status (within their situs and across situses).

**Limitations of the Occupational Situs Model**

While the situs approach solved some problems concerning the analysis of the professions, it raised others. In one influential work (Goode, 1969), the horizontal and vertical dimensions (situs and status, respectively) are combined in a pyramidal representation. The apex is assigned to what they call the ‘true profession,’ the one that owns par excellence the necessary knowledge to make the whole occupational situs work. The remaining occupations are placed in lower strata and are named ‘pseudo-professions,’
‘para-professions’ or ‘semi-professions,’ for they do not own the true profession’s knowledge (Goode, 1969; Etzioni, 1969), and still at the base of the structure are the non-professional occupations. What this model clarifies is that, despite its apparent descriptive potential concerning the rise of new occupations at the time and the coexistence of interconnected occupational groups, its empirical applicability is limited by the fact that a whole situs may certainly enjoy a higher status than that of others. In this way, the horizontality and parallelism among situses tend to disappear and, with them, the bidimensionality of the model (Gerstl & Cohen, 1964).

On the other hand, the practical usefulness of the situs approach is also limited by the behavioural aspects of the professions. Despite putting the functioning of occupational groups into perspective in the process of social differentiation (Morris & Murphy, 1959; Hatt, 1950; Foote & Hatt, 1953), it failed to acknowledge the influence exerted by the members of a given profession on the profession. Even considering the functional relation between the individual and the profession, the personal aspects of the professional performance shape intellectual and instrumental skills as well as the orientation adopted by the profession in the long run, modelling as a result its political potential. Such potential may then vary within the same situs and operate in some social contexts but possibly not in others (Hall & Schwirian, 1968). Additionally, non-professional or ‘proletarian’ groups, often exert strategies based on mass mobilisation, which tend generally to trigger more political repercussions (practical or symbolic) than those resorted to by highly trained occupations, in ways that influence their political status.

One can possibly infer that the situs approach, beyond its empirical limitations, would be eventually rooted out from the sociological discussion insofar as newer paradigms began to take the place of functionalism, society and work develop increasingly complex, and the post-war social model became the object of criticism on different fronts. If the usefulness of the situs approach was that of predicting attitudes, behaviours and life styles – consequently, the formation of sub-cultures (Morris & Murphy, 1953; Morris & Murphy, 1959; Morris & Murphy, 1961) – based on occupational categories, its application would later be substituted by the study of class identity.
Although the concept of occupational *situs* continued to appear sparsely until the 1970s’ literature (Pavalko, 1971; Dunkerley, 1973), it would seem reasonable to discard its use today in the analysis of the professions. The question of whether nursing is a profession thus remains, at this point of the analysis, unanswered. I shall then provide a more extensive review about the main sociological frames for understanding the professions and address the question of concern.
The professions: conceptual scaffolding used in this research

This chapter has been published as two separate journal articles intended to reach a nursing audience – in both English and Spanish – as a means to update the social theory of the professions as applied to nursing. While the first one focuses on the origins of the professions and its repercussions on the nursing-as-a-profession rhetoric, the second presents an overview on the main sociological frameworks to analyse the professions, with emphasis on its application to nursing. Most of the content whose primary interest was not pertinent to a sociological discussion has been dropped from this chapter.


The professional status of nursing – the starting point of this research – has been a passionately debated issue among nursing scholars and much of the debate rests upon the question, does nursing rank as a profession? The
concept of a profession, however, is vague and confusing since it can be used in different, even contradictory ways. This cannot only be a technical label, an attribute or a social symbol but also an honorific status. Nonetheless all of them seem to be a desirable state of an occupational activity. The discussion within nursing has explored several approaches to reach a conclusion on the topic, and this debate is today largely considered passé among nursing scholars, placing nursing in the realm of the “emerging professions” or “semi-professions” (Porter, 1992; Reed, 1993; Hiscott, 1998; Hood & Leddy, 2006; Cutcliffe & Wieck, 2008).

In this chapter, I present an overview of the origins of the professions and the main frameworks through which the sociology of the professions has addressed the subject. I begin by recalling the prominence of the theological notion of social order and the longstanding influence of this notion in shaping state-labour relations, including the definition of professional bodies. I then pose a discussion about sociological traditions as applied to the analysis of professional work and expertise in contemporary societies. Afterwards, I move on to what becomes the main focus of my research in the subsequent chapters: the systemic relations that connect the nursing occupation with other system components and the consequences of this interaction in the making of modern nursing.

**Origins: Theological Notion of the Professions**

In this section I offer a brief overview of the theological conception of social order and how it has had an influence in the notion of professional work. This conception, although relevant mostly for historical purposes, provides an understanding of the social differentiation that characterises the professions in comparison to other forms of work.

It seems indisputable today that medicine and law have been the icons of professionalism. These are indeed ancient occupations, rooted in the mediæval theological model of work and state (Bouckaert, 2007; Bourdin, 2004), which means a complex structure of the Western way of thinking the society until well into the twentieth century. This approach, also known as the traits approach or the structural approach, is grounded on a dogmatic view that elevated the state into the category of exclusive universal law guar-
antor, in ways that defined the political philosophy and the state corporative system. The corporatism was thus transposed from the Catholicism to the state structure, and extended to an entire conception of politics.

Crafts and professions were at the core of community development in the Middle Ages (Dubar & Tripier, 1998). Workers themselves were grouped by trade in neighbourhoods, struggling to define and delimit the expertise and territory they intended to keep under control. The status of the professionals meant both erudition and social standing, becoming a juridically legitimate entity by means of a qualification. One can still find degrees reflecting this principle, such as in Professeur d’État (State Teacher) and Diplôme d’État de Docteur en Médecine (State Medical Doctor), among others. A professional body – that is, a corporative form – echoes such theological notion of social order and public administration (Bouckaert, 2007), recalling the idea of body of Christ (corpus = body), where the different members make up a unified whole symbolically. Similarly, a profession, as in professio, implied that one must “profess” an ideology and engage in it as a life choice, under oath and by means of ordination, becoming an expert in certain matters and allowed to profess a ministerium. In this picture, medicine and law were the first non-theological disciplines created at the core of the medieval universities (Carr-Saunders and Wilson, 1933) with which they would begin an endurance tradition. Work, in turn, would become an issue of increasing importance in civic life as well as in spiritual life.

Following the Catholic doctrine, thus, a person who does not work does not have any dignity to live by, which would be eventually reinforced through the Church-State integration in terms of the corporate symbolic order and social hierarchy. This structuring, encompassed by the notion of dignity conferred by the professional status, would separate the sphere of work in “liberal arts” – thus, professions – and “mechanical arts” – without that status. The liberal arts were intellectual, sacred, theoretical and abstract, whereas the mechanical arts were empirical, practical, and popular. This stratification reflects the hierarchical, masculine Roman religious view not only of labour, but also of life and society, whose influence would be widespread all over the Christian world.
Despite the rise of an Anglo-Saxon alternative model of professions – as a result of the Reformation in Germany and the detachment of England from the Roman Catholic Church – the same structuring elements were used, though in a different light. For instance, the vocation, the sine qua non condition to aspire to a higher, professional dignity, can spring as a personal calling with no intermediaries, and the labour activity supported and regulated by a community of equals, a fraternity. These elements are at the core of the Germanic dogma, a *völkisch*, worldly order, that contrasts to the hierarchical Roman, sacred order (Hahn, 1995; Thornhill, 2007).

The religious origin of the professions has had a great impact, as they create a dichotomy between professionals and non-professionals, between sacred and secular matters; in other words, between the educated and the uneducated, between order and disorder. In this light, a professional was meant to professes what was only knowable by faith, the conversion into an ideology, and a personal calling, the vocation. Aspiring learners thus were not allowed to prepare only by themselves but by following a master who assisted in accepting the calling and developing abilities, values and beliefs. This would give legitimacy to knowledge and practices, but would also provide disciples a uniqueness and exclusivity which, in the long run, would create lineage. In this way, a profession would become a community and a social symbol, underlined by means of a rite of transition, the oath, bringing together two components that are important for this perspective: the admission into the lineage and the adoption of a set of values, to become consecrated into the profession.

While this analysis is relevant as far as it goes in the theological-political arena historically, it brings to the fore old-fashioned ideas framing the professions, which have had a privileged position in nurses’ self-interpretation, undermining greater legitimacy and empowerment, as they have long been socialised into the idea of vocation and abnegation, and in the process creating a culture of selflessness. This perspective was important to approach my research problem and formulate further questions.
Conceptual turns in the sociology of the professions

Sociology has largely been concerned with the construction of professions (i.e. Parsons, 1939; Hughes, 1958; Freidson, 1970; Friedman, 1973; Abbott, 1988; Dubar & Tripier, 1998; Sciulli, 2005; Vanderstraeten, 2007; Dingwall, 2008). The analysis has pointed to divergent directions, ranging from the social symbol embedded in the concept to its technical application. In earlier stages, sociological thinking strived to find a proper definition, identifying the professions with the privileges of male-dominated social elites. Most contemporary theorists, however, would regard a profession as “the knowledge-based category of service occupations which usually follow a period of tertiary education and vocational training and experience” which help deal with “the uncertainties of modern lives in risk societies” (Evetts, 2013: 781).

In reviewing the literature, four conceptual turns may also be identified that have driven the study of professional groups, namely a historical perspective, a structural perspective, a functionalist perspective, and more recently, a systemic perspective. In the following I will summarize some main features of the three best-known perspectives as well as the main limitations provoking conceptual turns. I then present the systemic approach and a framework for the analysis of nursing arising from this approach. This systemic approach became the main perspective of my research.

1. The historical approach

The historical approach deals with the development of occupations and how they “evolve” into full professional status through a common pattern, a professionalisation process. While the established professions – the medical profession, the legal profession and the priesthood – were raised to a central sociopolitical position in medieval societies (Dubar & Tripier, 1998; Bourdin, 2004; Bouckaert, 2007), they also became a social symbol, and therefore denoted a desirable status. The defining values of the medieval professions and their common patterns, however, do not define a “natural” process for all the occupations (Brante, 1988). Additionally, theologically oriented qualities such as vocation, selflessness, and corporatism presume similarities between the medieval civilization and contemporary societies, thus considering a single and absolute underlying professional ideology. Consequently, the relevance of this approach is rather limited. This is not to
say that one should not be writing histories of the professions, but rather that extrapolating supposedly common patterns of development to all the professions becomes misleading.

2. The structural perspective

The structural approach stands as probably the most recurrent perspective, emerging from the rise of industrialism. Flexner (1915), the first author voicing views on professional work, inspired a number of authors transposing his claims into other disciplines. Drawing upon his observations on professional behaviour, he proposed what came to be the professional cornerstone, proclaiming a constellation of traits as the “ideal” prototype of a profession. These traits are too well known to merit much attention here, though they may be summarized as: intellectual expertise seeking to understand and master complex problems of human existence, a set of learnt practical skills, vocational orientation to social ends, self-organization, and selective and specialized training and licensing. They are repeatedly thought of as the organizing principle and the standard “requirements,” with occupations in a race for seeking fulfilment and prestige.

Even though nursing authors (Bixler & Bixler, 1959; Gomm, 1996; Jones & Stewart, 1998) also assimilated this perspective motivating the forge of a structural foundation, there is major problem at the heart of its conception, which has implications for nursing – namely the assumption that erecting a given profession depends on internal forces only, the capacity to build an institutional form that fits those criteria. This is not to say that structural concerns are not important, nor is it to say that structure does not provide usable resources for improving nursing.

Nonetheless, our analysis suggests the following three insights supporting the claim that the “nursing-as-a-profession problem” is a subject that needs further consideration: (i) most likely to reinforce the status quo, structural concerns depict semi-professions as caught in a static sociopolitical limbo between nonprofessional and professional categories, without the possibility to move into the “protected areas” of the established professions; (ii) given that most occupations have today embarked on a similar institutionalization trajectory, it seems limiting to see structural achievements as
strong support for a professional project in the long run – if this be a process
of “professional status for everyone,” then the notion of “profession” would
no longer be a distinctive category, becoming thus a superfluous word; (iii)
analysing occupations in a vacuum, detached from the system, ignores
mutual modifications that the system components exert on one another
through their interaction, focusing the argument on internal forces only and
preventing nursing from controlling its environment.

However well constructed nursing may be, it becomes evident that the
structural approach does not raise challenging questions to any further
extent so as to support analyses of nursing development. The reality that
professional groups in fact face is much more complex than achieving a set
of traits and therefore what they need are frameworks that encourage new
trajectories for change in their disciplines’ course.

3. The functional perspective
The rise of modernity came to be a turning point, for sociology itself and for
the analysis of work as supporting the functioning of industrial societies. Of
especial relevance became the inerwar and post-war period, pioneered by
Carr-Saunders & Wilson (1933) and Parsons (1939), who emphasized the
“function” of professionals.

Carr-Saunders and Wilson discussed the usage of the term “profession”
and observed the traits that would symbolise a professional group, such as
prestige, social manners, and lifestyle. Their work, however, was impaired
by their own convictions of a “self-evident” profession, and the lack of meth-
odological rigor (Prest, 1987; Abbott, 1988).

To Parsons, on the other hand, the complexity of modern society – by
which is meant capitalist economies – evolves and makes labour more speci-
alized, rational, and specific. The specificity of function, in turn, refers to the
rationality (as opposed to traditionalism) of a profession (Parsons, 1939).
While professional specificity on critical problems of human life is used in a
tactily “functional” exchange to receive in return large freedom and privi-
lege, rationality operates as a means of building authority, insofar as knowl-
edge prevents doing the work just in the way the predecessors have done it.

Whereas functionalism might bring some insights to nursing, stressing
the necessity of rationalizing the work and specifying nurses’ functions, an
analysis in this light would lead to paradoxically misleading deductions, as it suggests a certain degree of “functional” stability in the structuring of health systems, legitimising in the process asymmetrical relationships and inequalities.

4. The systemic approach

Contemporary sociology has a more prolific perspective to offer, especially on how occupational categories relate to one another socially within a labour system (Abbott, 1988, 2002, 2010). This standpoint is concerned with what occupations do rather than how they are structured to do what they do. Indeed, such a perspective has become enormously influential, and raised provocative questions as it conceives occupational settings in an active perspective, one that reflects the multidimensionality of ecological interactions, and how the system as a whole strives continuously to reach a balancing point.

Whereas previous standpoints focused on the internal structuring of a given profession in isolation of that of others, the systemic approach implies that the external forces have relevance in shaping the professions, the system components being reciprocally affected in the process of actual professional work, making up an interacting system; in other words, an ecology. Abbott, an influential theorist on this topic, holds: “Prominent in this interaction is competition […] Knowledge experts compete with one another through redefinition of each other’s work” (Abbott, 2001: 137). Further, “there is no list of structural qualities or given functions that defines a profession. Rather, a profession is any occupation that competes for a work […]” (Abbott, 2010: 175).

With this background in mind, the following three insights are central to approaching nursing in this light. First, while change is the fundamental force in an interacting system, such change is not unidirectional. Thus, the current state of a profession cannot be regarded as a definitive reality; practitioners may gain status but equally lose it, therefore established professions may fail in protecting their privileged positions, giving up place for emergent occupations, especially those becoming more recognized as ethical and trustworthy. Second, the development of a given profession depends on that of others. Much of the understanding about the professions
would take the topic no further forward insofar as the case-by-case logic keeps acting as blinkers; alterations in the zones of interaction is what moves the professional status into upward or downward directions. Third, structural claims and prerogatives of vindication are not as powerful a factor as the actual occupational activity professionals perform. Recognition is often claimed by the deployment of rhetorical resources, although how roles and functions are performed in the field is what defines professionalism and acknowledgment. Attaining control over an area of work is the key element of a profession, and therefore induces in its audience a sense of loyalty and exclusivity towards the profession – a monopoly – that ultimately engenders legitimation among its clientele and establishes conscious awareness of its powers in the society at large.

All in all, the active attention to the sociocultural milieu of professions that this perspective advocates for seems to have a meaningful resonance with the transformation of a society. As societies become more complex, work tends to increase in sophistication, specialization, and diversification, alongside an increasing number of professionals in an increasing number of professions. In this light, it seems reasonable to discard strictly structural standpoints, reduced to accounts of a profession’s efforts and achievements. With the dimension of systemic complexities providing a more comprehensive focus, it was anticipated would provide the most appropriate means to explore the functioning of the nursing profession, becoming apparent, too, that the ethnographic approach would be meaningful for an understanding of actual professional work. This perspective in fact structured the fieldwork research through the framework I elaborate on in the following section.

**The ecology of Nursing**

Building on Abbott’s (1988, 2001, 2010) notion, the focus on exogenous forces that shape nursing from the evolving system must entertain the interplay with other occupational categories, which may constrain or enhance the profession’s boundaries. In ecological systems, species evolve, diversify, migrate and settle in distant habitats, adapt themselves to landscape transformation, compete for sustenance, grow defensive structures, may become territorial and dominative, and some develop symbiotic dyads. Other species even run a constant risk of predation and extinction.
One might object to the fact that this perspective regards healthcare systems’ comportment in the same manner as that of biological systems. This is an important concern, and human ecologies are certainly much more complex than that; one cannot fully address this approach without considering nursing’s built environments and their sociocultural constructs. Again, the dynamism of this approach represents a promising step to study more adequately the evolving functioning of nursing work in its social context.

As shown in Figure 1, the ecology of nursing involves the mechanisms of control that define its practice, which are symbolised as “milestones” on its boundaries (Nancarrow & Borthwick, 2005), enhancing or constricting its area of work, its jurisdiction (Abbott, 2001, 2010). The modes in which healthcare organisations are socially organized (Handel, 2003; Godwyn & Gittell, 2011) configure the ecology, embedding institutional values, assumptions and beliefs. This range of representations is transformed into and indeed is legitimised by means of rules, mechanisms, and procedures informing relationships as professional behavioural outcomes. The system is permanently recreated insofar as the balancing point is as fragile as it is difficult to reach, given the always-changing environment. Understandably, these interactions and mechanisms, which I will elaborate presently, may be unnoticed by analyses oriented by earlier approaches.
a) State control: One of the obvious forces in the labor landscape is the control exerted by the nature of the state across societies, and despite its obviousness it is often overlooked. The dominant literature in nursing, although its pioneering spirit and leadership, develops in a particular cultural context – the Anglo-American world – where the market-oriented professional functioning is more prominent than the functional contiguity between state, universities, and professions in other cultures (Evetts, 2002). Countries such as France and Germany, by contrast, embed the essence of the Continental model of state, centralised and controlling, and as such, influences public universities, defining the actual professions and favouring and establishing in the process a strong minority of “free” professions (Neal & Morgan, 2000; Evetts, 2002). Similarly, it has also been reported that supra-national entities, such as the European Union institutions, have favoured this regulatory approach to the professions, and in the process have diminished the power of national professional bodies (Neal & Morgan, 2000). Both the state and supra-state control are challenging for nursing, as those occupations with less privilege tend to become “proletarised.”

In light of this picture, it is understandable why nurses in less state-controlled and more free-market-oriented settings, such as Chile (Jara et al.,
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2009) – often regarded as the leading example of Latin-American nursing – enjoy a rather respectable reputation, and why it is less so in most African countries, which have a strong dependence on funding from states (Obong Oula, 2004; Mpevo Mpolo, 2012). Similarly, countries in South East Asia, such as Thailand (Jetin, 2010) and Vietnam (Anh & Winter, 2010), have witnessed an increasing proliferation of universities hosting nursing schools, partly explained by demands on universities for survival strategies. From this growth it is expected that such strategies will open up access to scientific degrees in nursing.

This “landscape” transformation in emerging economies may be used as a niche of opportunity for nursing – beyond that of some European nations _ becoming as powerful a factor as social recognition in promoting the status of nursing in those countries.

b) Bureaucratic structure: A second crucial component of nursing’s environment is the structuring of hospitals, where nurses most often perform their core occupational activities. Two major moves have happened in the healthcare sector since the post-war period – one is the evolution of the hospital into an organisational entity, a “professional bureaucracy,” and the other is its internal planning as a “divisional structure” (Gourdin & Schepers, 2009).

The influence of bureaucratic structures on the autonomy of the major health professions is a topic of increasing interest (Traynor, 1999; Traynor et al., 2010). Professionals who work as employees in organisations experience a great hierarchical control conveyed in guidelines relating to knowledge application, preventing professionals from enjoying full autonomy, leading to degrees of discretionary decision-making rather than actual autonomy (Evetts, 2002). This antagonism between professional knowledge and administrative purposes, however, is not necessarily an unmoving barrier. For example, Johnson et al. (2009) and Levay and Waks (2009) claim a tendency towards new practices of delegated power and mechanisms to improve professional freedom, in ways that question traditional modes of managerial authority, resulting in cultures that combine auditing ideas with professional criteria.

In this regard, the force of unionisation may act as a barrier counterbalancing the bureaucratic influence over employees’ discretion – the more
power workers develop, the less the bureaucracy has an impact on professional decisions. There is a sense in which this tension may become a source of conflict, however, it has been established that a degree of social conflict is necessary to create change and development (Collins, 1994; Dahrendorf, 1996; Dahrendorf, 2011). This may give professional groups more self-determination so as to define their scope and judgement, with negotiation abilities playing an important role in holding professional interests.

Bureaucratic structures, as part of the built environment of nursing, can be thus reconsidered and relativised with regards to specific organisational patterns. Bureaucracies, too, tend to vary and evolve (Clegg et al., 2011), and that implies the chance to incorporate the nursing political agenda into boards of management and organisational definitions.

c) Gender-bound asymmetries: There is extensive literature on gender and how it informs nurses’ relationships in both obvious and subtle ways (Davies, 1995, 2004). It seems necessary, however, to highlight general agreement of interest to nursing. First, women who work outside the home are disproportionally grouped in the services sector, which comprises several nonfully established forms, namely self-employment, part-time, temporary, and sporadic jobs (Adkins, 1995; Acker, 2011). It can also be said that nurses deal with and perform a considerable amount of unpaid work within their salaried jobs, even non-nursing work, arguing that it is required for their task organisation and their patients’ good (Allan, 2000; Allen, 2007), which in the end represents an invisible, cumulative burden.

The second is that labor relationships are essentially founded on family roles (Adkins, 1995; Grunig et al., 2008), which adopt several patterns of domestic interaction. What is underlined here is that, even though the domestic centrality of women in workplaces may put the nurse in an advantageous position, working conditions of women and the meaning of sexuality are shaped as forms of control and exploitation over women as subjects of work.

While gender inequalities in nursing have long been discussed, these inequalities deserve special treatment, as gender, ethnicity, and social class are ties that in nursing tend to operate simultaneously (Weston, 2011), and are among the main concepts underpinning the social transformation of the professions. Even in the social sciences, gender, class, and ethnicity have
been treated in separate traditions and theory bodies (Andersen & Collins, 1995; Acker, 2011), though how inequalities operate requires a conjoint, thorough analysis, as they are intertwined and embedded in organisational regimes. This perspective has also become important in Asia, developing specific frameworks regarding gender inequalities (Ueno, 1996), including those concerning nursing (Ushiro & Nakayama, 2010), under the influence of Western theory.

d) Social mobility: Today’s hospital organisation combines caste logics and meritocracy mechanisms, producing a highly stratified reward system. Regulations are often categorised by medical and non-medical professions, a divide that explicitly includes different salaries, conditions – or even limits – for promotion, fields of practice, privileges, and social constructs such as status, freedom, and authority. This somehow illustrates status consistency for “categories” of professions, reducing social mobility to the limits imposed on those categories. This part of the social landscape refers to a dimension of inequality, as the distribution of resources is fundamentally structured on a basis of academic titles rather than personal talent, clinical performance or commitment towards the organisation – a committed, experienced, and talented nurse may certainly receive wages lower than, or at best equal to, those assigned to newly graduated members of dominant, established professions.

Nurses risk accidentally assuming such structuring as fair, allowing it to operate across the health system as a whole, in which case they would remain unrecognised and underpaid, despite performing exceptionally well or taking on extraordinary burdens in the name of their patients’ good. It is thus important to evaluate the extent to which the prospect of high employability for those embracing a career in nursing may result in willingness to work under such a hierarchical structure and therefore maintain the status quo. Again, in the best interest of nursing it is important to develop a political consciousness, consolidating in the process the nursing agenda in the organisational cultures.

e) Institutional order of hospitals: In a sense, hospitals have been expropriated to nurses; what was once a place to care is today a place to cure. The biomedically oriented institutional order is perhaps the greatest constraint...
for nursing to develop its mission. This constraint comprises three problems for nursing:

i) The seniority of the medical profession represents a self-evident tradition that brings nurses and the other health occupations into a disadvantageous position, with their scope of practice being permanently negotiated with doctors, in asymmetrical, imbalanced conditions.

ii) Even when the ethos of nursing has been agreed as the human care (Watson, 1999), modern hospitals are places conceived to cure, which subsequently informs nurses’ roles as well as expectations from other members of the system. As a consequence, the actual work required from nurses (Allen, 2007) poses a menace to the independent professional ethos, triggering internal ideological contradictions.

iii) With the biomedical paradigm of health and illness as such a determinant in nurses’ performance, it seems reasonable to anticipate that if the system as a whole does not evolve into a new paradigm, it becomes difficult for nursing alone to prompt a significant paradigmatic change, in which case that order will continue to define a “traditional nurse,” a notion which seems less compatible with autonomy (Group & Roberts, 2001) than with functionality to the biomedical paradigm. Influencing the system at large would thus seem more meaningful, so that detecting and forming coalitions with relevant political counterparts becomes vital in this systemic transformation.

f) Parallel occupations: Medical practice has historically offered niches for nursing practice enhancement. Nurses have developed technical as well as personal abilities to cover what physicians have disregarded (Fealy, 2006; Greiner et al., 2008; Shi & Singh, 2009; Dreher & Glasgow, 2011). This same enhancement mechanism has been utilised by midwives and physiotherapists, among others, making up a process of constant redistribution of tasks and responsibilities.

With the aforesaid landscape conditions, the interplay with coexisting professions, both vertically and horizontally, is what ultimately defines the area of work, the jurisdiction – the construction of a profession is, in other words, the identification of problems, the conceptualisation of those problems, the development of problem-solving strategies, and eventually the appropriation of the area of work, building and establishing in the process a
settlement in that area (Abbott, 2010). Similarly, defending its domain from potential competitors and invaders, and adjusting its jurisdictional scope to environmental changes is how a profession becomes established. Although a relatively young profession, nursing has not only defined its settlement, but also continually adapted to landscape transformations. Without adaptation effectiveness, nursing would have fallen out of the evolutionary loop of the healthcare ecology, opening up room for other occupational categories to take on nurses’ roles.

Any analysis of nursing development may thus begin with a close inspection of these areas of contact with other occupations to explore how their systemic interaction defines and redefines one profession’s success, and to what extent that is affected by the success of that of others.

g) Intraoccupation tensions: Finally, in doing systemic analyses, one needs to bear in mind that the forces within nursing may not be equally strong – practitioners, scholars, union leaders, they all look at the profession from a different angle. Nursing scholars consider nursing practice critically and thus lean towards the improvement of a scientific reasoning in the practice of nursing and the adoption of nursing terminologies. Conversely, practical nurses may tend to consider that nursing theory is somehow unrealistic, and therefore scholarship may be relatively neutralised by practical knowledge.

Additionally, several views and trends may be found within the nursing discipline, which represent interacting components not necessarily equally emphasised – human care, healthcare management, delegated medical roles, among others, each of them stressed as differing versions of professionalism, becoming competing interpretations. On a nationwide scale, nursing associations represent another intranursing force, as they advocate for legislative and regulatory initiatives to negotiate with the states politically and to protect nurses’ interests. Worldwide, nursing organisms forge the projection of a global perspective on health issues and policies (D. Benton, pers. comm., October 19, 2011,) which brings nursing into a more visible and influential position (Cody & Kenney, 2006).

Bringing it all together, these dissimilar versions of what nursing is and what its vector of growth should be requires an exhaustive examination of the nuances and interpretations of the intraprofession system as well as an authentic discussion on the future of nursing as a profession.
Conclusions
In this theoretical analysis I have discussed the construction of nursing as a profession, based on the major theoretical frameworks in the sociology of the professions. Whereas analyses inspired by historical, structural, and functional approaches may threaten to confine nursing through static definitions, the systemic–ecological approach may more fruitfully raise helpful questions concerning status construction.

By analysing nursing in a systemic perspective, it becomes evident that social ecology informs the areas of contact between nursing and those coexisting professions, resulting in reciprocal implications. Similarly, environmental conditions, such as landscape transformations, require changing and rearranging the constituent elements of nursing as a subsystem in order to adapt to those external transformations. As explained, the ecological logic of the professions is characterised by the instability of the system, and therefore establishing a profession cannot be regarded as a definitive, invariable reality. Rather, change is the fundamental force of occupational systems. Although there are a number of social milestones defining nursing performance, the relative success of nursing lies heavily on its ability to adapt to that continuous transformation as well as to protect its jurisdiction from competitors; this behaviour is in fact more compatible with that of fully established professions. Having change as a constant, the current status of established professions cannot be regarded as a definitive reality either and this is anticipated as a vector of evolution for a wide range of emergent occupations.

The present analysis also sets the bases for comparative nursing studies, proposing a framework for empirical applications of the systemic–ecological theory, with a view towards the consolidation of a “sociology of nursing.” Analysing the nursing occupation in any given country might begin by examining the milestones that define occupational boundaries, either the environmental forces or the interacting comportments. Additionally, this sociological prism may broaden descriptions of the nursing profession into more articulate definitions, considering the particularities of cross-
national differences, their social realities, and their evolving nature, uncovering in the process problems of a social nature informing nurses’ work, such as class, social mobility, ethnicity, and inequality.

In using the ecological approach, this discussion invites readers to reconsider an old debate about professional building in nursing and to expand formulations of professionalism, which accounts on structural achievements cannot move further forward.
Eliteness, aspirationism and nursinghood: social-class identity

Building on ethnographic data, this chapter brings fresh insights into the academisation process of nursing education, which highlights social transformations as a more comprehensive focus for examining the development of nursing. The results point to class-consciousness patterns in nursing academisation that participate in reproduction of social inequalities, and importantly, shows that class identity formation is as powerful a factor as gender identity in the development of modern nursing.


Nearly all the literature that deals with the development of the nursing occupation has examined the phenomenon through two major concepts: gender and academisation. On the one hand, there is a rather extensive literature on gender and the ways in which it has an effect on nurses’ relationships, particularly shaped as forms of control and exploitation of women as subjects of work (Adkins, 1995; Acker, 2006). On the other hand, further
schooling is considered as a crucial factor in the evolution of simple trades into occupations with full professional status, materialised in theorisation, empirical research, postgraduate studies, but more than anything social mobility.

Analysing the results of the academisation of nursing, however, one can no longer disregard its relations with social reproduction, i.e. the replication of institutions and structures that perpetuate social inequalities (Bourdieu and Passeron, 1970). Hospitals are the places where nurses most often perform their core occupational activities. Here nurses are connected with other occupations within a socially organised setting and, as such, the hospital represents a field of large cross-class interaction that provides valuable information concerning social reproduction and social mobility.

Noticeably, most of the discussion on nursing development focuses on structural achievements, disregarding the ways in which nurses are socialised within an occupational system (Abbott, 2002). As such, a system relates occupations to one another, which means they have mutual implications. As Abbott (1988, p. 33) states: “the professions make up an interacting system, an ecology. Professions compete within this system, and a profession’s success reflects as much the situation of its competitors and the system structure as it does the profession’s own efforts”.

This chapter thus intends to bridge a very significant gap, as the impact of academisation on social mobility has been taken for granted, or at best this association has been a concern of very little discussion. The key question in this discussion is: To what extent is nursing social mobility shaped by social transformations and by nurses’ interactions? I examined this problem by focusing on two concepts of critical importance in social reproduction theory: social stratification and social mobility. These concepts are addressed through four major sections: (a) the academisation of the nursing occupation; (b) social aspects of Chilean nursing; (c) socially based tensions among nurses; and (d) socially based conflicts of a fractured occupation.

The chapter concludes by posing a discussion on the particularities of the academisation and social mobility of Chilean nurses, that in the case of eventual changes would lead to policy implications for nurses individually and for nursing as a whole in that country.
Academisation of the nursing occupation

During the last twenty years there has been a concerted attempt in nursing to gain full professional status. Following the structural approach of professional work (Flexner, 1915), nursing has focused on the traits that were thought of as the bastion of autonomy and status. Accordingly, much attention has been paid to intellectualise the practical activity they perform, to improve self-regulation of practice, and to gain entry into the academy.

Whereas until the mid-twentieth century nurse training was based on an apprenticeship model, the second half of the century witnessed a shift towards an academic curriculum, hence a growing access to scientific degrees in nursing. However, the link between organisational patterns and the academic training seemed to remain quite unchangeable. Nursing schools moved from hospitals into universities. Yet, what is performed in hospitals is taught in university rooms, and mirrored back in hospitals by a new generation. Whereas teachers bring experience, students reproduce it in a practical exercise. This is a circular idea that may be conceptualised through the social reproduction theory; Bourdieu and Passeron (1970) argued that the educational system is an instrument of social reproduction, not of mobility but of replication of a social space of quite stable patterns of domination and inequalities.

Although it is difficult to obtain precise measures of the social class background, nursing is considered as a helping female vocation and a middle-class occupation (Callinicos, 1983, Erikson and Goldthorpe, 1992 and Weston, 2011). The notion of class refers to the distribution of capital, or “the set of actually usable resources and powers” (Bourdieu, 1984, p. 114). In a productive setting then, class interaction is crucial for a critical appraisal of the distribution and actual use of powers among occupations. Such setting is a system (Abbott, 1988), by which is meant a complex set of mechanisms that outline expectations, control and competition, as nurses coexist with other occupational categories. The distribution of resources and powers thus depends largely on the reciprocal relationships with the system components.

Building on Wright’s (2005) statements on class analysis, nurses’ performance in the practice arena can give first-hand evidence to provide
insights of nursing dynamics. As a consequence of class interaction, Wright (2005, p. 22) argues that “what you have determines what you have to do to get what you get”. This is a topic of great importance to nurses, since such capital may open access to life opportunities for them and offer them the chance to voice their own views on health policy, as well as define the ways to shape the role they perform.

While the link between healthcare organisations and nurse training is important from a structural viewpoint, what are the repercussions of nurses’ academisation in preventing social reproduction? In other words, is academisation a turning point in redistributing resources and powers to nurses?

In the following, I shall provide relevant background information on how nursing is shaped within the Chilean context. I then present the methods and findings of the ethnographic study and discuss nursing tensions that consistently surfaced during the ethnography.

**Social aspects of Chilean nursing**

In the twentieth century, philanthropy had a significant role in the charitable sphere of education and social welfare in Latin America. Before central governments took part in this, it was religious institutions and religiously inspired people from the bourgeoisie who managed the provision of basic services (Guarda, 1978 and Sanborn, 2006).

In healthcare, the rise of charity associations among the ‘female’ elite class generated the appearance of a proto-nurse. Organisations such as the Drop of Milk Society and the Chilean Red Cross (formerly Chilean Red Cross of Ladies) organised services to meet the poorer population’s needs concerning health and nutrition (Alvarado et al., 1973, Illanes, 2006 and Subercaseaux, 2007).

There is a sense, however, in which this activity brought women into “circulation through the extra-domestic space” (Ossandón and Santa Cruz, 2005, p. 98) and eventually into contact with other classes. Such contact was in fact a pivotal factor in women’s integration into the public sphere. Well-educated ladies thus migrated from volunteering into the employment market, with teaching and nursing among the most eligible occupations. The status of nursing was thereby one of the upper class so that nursing
became an element of class distinction (Bourdieu, 1984), especially among those sitting on hospital boards of management.

On the other hand, a medical assistant known as practicante arose from both the hospital as an ally of the physician and the army’s organisation. The practicante was similar in scope to the nurse, but more focused on surgical matters. The nurse was quite subordinated to the doctors’ will and had more responsibility for taking care of the sick. Whereas the practicantes had a rather practical knowledge, nurses earned university training by the second decade of the twentieth century (Muñoz and Alarcón, 1999), by which time dispersed institutions providing nurse training had merged into a single university.

Nurses’ entry into the academy brought two results that are important to the present analysis. Firstly, nursing was raised to the status of a graduate healthcare occupation. The practicantes, in turn, tended to disappear gradually from the sanitary scene as a newer occupational figure emerged in the form of the auxiliary nurse. Secondly, accessing university education was intended to overcome highly selective entry requirements – at that time difficult to achieve – without further recruitment from outside the educated elite. That was a progressive process of exclusion and segregation.

Later on, however, educated ladies were attracted by occupations that offered better conditions and salaries, such as law and medicine. This fact opened up nursing for an emergent middle class.

With the foregoing historical backdrop, this analysis now examines the place of nursing in the social structure of the early twenty-first century, including the way it shapes the relationships to other occupational groups and defines its function within the system.

**Ethnographying a unique nursing ground: setting and methods**

The inception of this study is in part due to earlier explorations of nursing identity formation in Latin America. This work suggested the need for a more thematic focus on the social construction of nursing, resulting in a further exploration of what nurses do, rather than how nursing is structured. To that end, the ethnographic approach was chosen as the most appropriate way to examine the topic of concern. This involved reflective engagement with forty nurses, spending time with them in their day-to-day
activities, taking notes, sharing some practices, interviewing, having casual
encounters, and returning from the field to our offices and back again, in a
circular process of analysis and questioning. This data gathering process
spanned the period 2010–2011.

Specific attention to the study setting was necessary for a number of rea-
sons. Firstly, Chilean nurses are considered to be highly trained healthcare
providers; in order to become a nurse one must undertake five years of uni-
versity education on a full-time programme. Roughly sixty percent of the
whole is devoted to theory; students begin their practicum in the hospital
from the 3rd semester onwards under a lecturer’s supervision first and then
moving gradually onto clinical nurses’ mentorship.

The setting of the study, a 500-bed university hospital, was selected on
the basis that it has a reputation for being a high quality institution among
the Chilean hospitals. It is recognised that high quality care is related,
among other reasons, to nurses’ performance (Kutney-Lee et al., 2009,
Aiken et al., 2012 and Lake et al., 2012). As this was a teaching hospital, it
offered a significant chance to study knowledge exchange and socialisation
practices. In combining these threads of interest, such a setting seemed to
have a meaningful resonance to explore the nursing occupation in the Latin-
American context.

Access to the study participants was agreed with both the Head Nurse
and the Hospital Director after obtaining the approval of the relevant Ethics
Committee. To meet the ethical requirement that consent should be
informed, each interviewee was given a description of the study and then
asked to discuss his/her experiences within a nursing context.

The hospital employs 1800 people, across a wide range of staff groups.
Nurses are grouped within the nursing department, which is made up of
about six hundred nurses, including qualified nurses and certified auxiliary
nurses, often referred to as ‘paramedics’. Our observation of nurses’ activi-
ties covered a purposive sample of seven different wards, on the basis of
degrees of ‘closeness’ to patients. With this I aimed to balance two theoreti-
cally opposing conceptions of ‘good nursing’, namely technically expert
nursing, such as that provided in the emergency room and the intensive care
unit, and caring-oriented nursing, such as that provided within the general
hospital ward and the chemotherapy unit.
Alongside the observation process and casual conversations, I interviewed a wide variety of informants individually, ranging from nursing students to experienced nursing managers, including clinical nurses and academics, together with those who had indirectly participated, as they took part in the situations being observed. Based on a semi-structured guide of open-ended questions, the interviews explored several topics planned while reviewing the literature on professional development. Interviews lasted ninety minutes in average and were tape-recorded.

Participants’ willingness to speak to me was an early indicator of the fact that this study was a channel to communicate a piece of information they found critical for the future of the nursing discipline. This assumption was crucial for my way of approaching the fieldwork and the data analysis.

In order to overcome the risk that I might overlook obvious everyday practices while recording field notes, I engaged a second observer, who was an anthropologist, unfamiliar with hospital work. This enhanced the reliability of the data gathering process, as we compared data and discussed while the patterns surfaced.

Since my interest was to study the construction of class behaviour in nursing and its implications in building professional status, it was important to consider the development of concepts and processes. As for discovering this dimension, the Grounded Theory approach (Corbin and Strauss, 2008; Charmaz, 2006) provided the most appropriate means for conceptual integration. This facilitated the emergence of conceptual inter-relations from theoretical statements embedded in the technical procedures of coding. These relationships were rethought, adjusted, and refined until pieces of data cohered together in a meaningful way to answer the question of interest.

The study findings are presented through a narrative ethnography approach (Gubrium and Holstein, 2008) as a means of highlighting my participation in the data construction, the interplay between my subjectivity and the subjectivities of those whose perspectives are in view, thereby giving a more vivid picture of the social setting. These are the dynamics of the movement named ‘the new ethnography’ (Goodall, 2000), which is best communicated through personal stories and enriched description of the settings.
Empathising with nurses: first impressions

By taking a reflexive view of the nursing setting, I reconstructed this setting by aggregating pieces of observational data, from which I recreated what came to be my naturalistic setting of inquiry.

A typical ward environment is made up of a nursing station, shared-patient rooms for up to six people, examination rooms, medicine storages, built-in wardrobes, lavatories, a hallway that frequently works like a waiting room, staff rooms, a clerical office, and often a few forgotten rooms that have been closed down. Most of nurses’ activity takes place between the nursing station and the patient rooms. Most of auxiliary nurses’ activity takes place between patient rooms and their staff room.

This setting is an important part of the everyday lives of the nurses I observed. The hospital becomes a place to work, eat, and sleep for the nurses. In some respects, due to their year-round presence on a twenty-four hour basis, nurses, like their patients, are ‘hospitalised’.

Fluorescent lighting, rotating shifts, unusual eating times and unexpected situations are all regular parts of their day. In addition, people often enter hospital on the worst day of their lives. In the examination rooms, the hallway and in the waiting room, one comes into contact with the many faces of grief, pain and vulnerability. My impressions as field researcher led me to the view that thousands of patients come and go, but the nurses have a constant presence, managing emotional stress and physical tiredness.

The air smells of human bodies and medicines. In the hallways, stretchers are pushed here and there, carrying patients, crashing into and going through restricted-access doors. In a patient room, spotless-looking nursing students help an elderly gentleman to sit up in bed and change his linens while auxiliary nurses take patients’ temperatures, heart monitors beep, and a constant blowing sound is heard from oxygen masks. In the centre of the main corridor, a middle-aged man wearing a white smock is holding an X-ray film in front of his eyes, surrounded by a small army of youngsters dressed likewise.

A nurse and an assistant are doing a regular bedside-ward round, checking patients’ records. At the nursing station another nurse is seated, writing pages of records and filling out forms while she answers the phone.
Voices, rings and beeps mingle into a constant background noise. There are several notices of all types fixed on the walls; these include phone number lists, conversion tables, treatment algorithms, fast-food-delivery flyers, wash-your-hands reminders, visiting hours, and the portrait of a nurse gesturing silence.

Dictionaries define a hospital as a place where people stay when they are ill or injured and require care. From our observations, it is evident that a hospital is much more than this. The structural details I observed suggest that multiple realities coexist for multiple individuals interacting in a complex social setting.

**Nurses after nursing**

This study was concerned not only with the structural details of hospitals, but also with their narratives. Nurses’ stories bring fresh insights into nursing work and nursing occupational identity and status.

In this reconstruction, I isolated and used nurses’ stories as the master cases to illustrate the emerging categories. Five individual nurses’ stories constituted the narratives with which to construct a more nuanced picture of what nurses do.

i) Millaray is a recent graduate nurse. She has a short-term contract in the internal medicine ward. Millaray originates from a family of peasants in the Andean foothills, with which she keeps up a relationship via her widowed mother. Millaray’s personal motivation is to increase her salary to be able to help her mother financially.

ii) Like many others, Roberto is a fireman who decided to become a nurse. A father of two, he works at the emergency department and in his time off he takes extra shifts as an ambulance nurse and, occasionally, gives some lectures on resuscitation techniques. He is known for his charismatic personality and his efforts in getting close with the assistant personnel.

iii) Pia has been working shifts in the intensive care unit for five years. Recently married, she is seeking a job with normal office hours. Thanks to her vision and personality, her colleagues regard her as a good candidate for the chief nurse position.
iv) Diana works in palliative care and wants to further develop her career by doing a master’s degree in administration. She graduated a few years ago and appears to be in her early thirties.

v) Marta is both the chief nurse of the surgery ward and an exceptional person. She grew up as a nurse as the hospital grew. She became an assistant in the late 1980s and became a nurse in the 1990s, thanks to a good deal of family sacrifice, a bank loan, and what she said was “God’s help”.

There are some similarities in the professional paths that these nurses have taken and in their personal lives. Certain personality types and people with specific personal preferences gravitate towards certain occupations (Huntington, 1974 and Chusmir, 1990). However, many of today’s nurses are people from low or average income families, with very few or no professional referents, resulting from the rise of the middle class in the late 1970s and 1980s in Chile. This trend is particularly clear in healthcare, as sanitary reforms and the expansion of public health measures in the 1960s (Szot, 2003) meant that many people looking for a better life turned to healthcare for employment opportunities.

Indeed, recent evidence has shown that only 7 percent of nursing students and about 1 percent of nursing auxiliaries come from private-paid schools (Ministry of Education of Chile, 2012), which serve the elite (Gauri, 1999 and Arum and Velez, 2012). In contrast, over half of medical students were educated in such schools.

There is a notion that nurses are driven by an overwhelming desire to help people. Yet in the Chilean society of the early twenty-first century, this thinking is more clearly related to how working-class people help each other by sharing basic subsistence goods and performing selfless acts. Rather than the symbol of distinction that it used to be (Alvarado et al., 1973, Illanes, 2006 and Subercaseaux, 2007), helping seems to reflect a mutual system of support on which the social relations of low-income families is based (Happe and Sperberg, 2003).

I identified Pia’s social background as a ‘negative case’ because it stood in contrast to the general pattern. An evident manifestation of such contrast was her recurrent talks of leisure and cultural activities as a subject of interest, with apparently no counterpart to share this interest satisfactorily,
together with an accent uncommonly heard among nurses that makes the others refer to her as ‘the posh one’.

Being at the hospital collecting these stories, observing interactional dynamics, and patterns of taste and language, it becomes evident that nurses appear to share a middle-class consciousness. This becomes clearer when compared to the culture of ‘ordinary people’ in the street who understate manners and protocols but embrace effort and honesty. Hence a sense of class integration – the assimilation of values, beliefs and behaviours considered appropriate within a community – develops in their interaction and may be extensively reinforced throughout academic training, as the majority of nursing instruction is provided by other nurses, who agree on approval requirements and safeguard community values. Nurses’ individual origins and the notion of social class, then become central in nursing identity.

**Caught in a dead end**

Nurses’ values and attitudes may shape relationships with other nurses professionally and socially. This was a key focus of my analysis.

Nurses are responsible for taking care of people, and this seems to be at the core of their sense of duty. It has also been argued that such orientation permeates their personal life and the construction of nursing’s professional ethos (Watson, 1999).

When entering into the nursing world, therefore, what one could expect is to find oneself in a place of tranquillity and understanding, surrounded by a caring community. The fieldwork data, however, suggest that nursing relationships in workplace groups can be dramatically different. Hospitals tend to be high-stress work environments (McMurray and Clendon, 2010), but for reasons that I will elaborate presently, nursing is, socially speaking, an arena of severe competition.

Aware of the necessity to develop her career and reflecting on her experience in doing administrative arrangements, Diana stated:

> When someone [nurse] wants to make progress, there appear obstacles, obstacles and more obstacles. It’s like, when I said I wanted to study a master’s and I got enrolled, none of my colleagues were willing to cover my shifts.
This reiterates a tension that, as the fieldwork progressed, became clearer:

*We, nurses, should be closer and more united to each other.* (Marta)

*Some colleagues here give themselves airs, you know, like a centrepiece. They consider they should become chiefs, and that’s why they want to study further. They say they want to learn more and change things. I also wanted to study last year but they said it was not my turn, that there was someone else before me, but eventually nobody studied. On my second attempt, nobody ‘could’ change my shifts.* (Roberto)

The object of this tension is based on the fact that the individual progress of nurses is not well looked upon, as it does not seem to be congruent with their socially ascribed identity of selflessness. Additionally, nurses are competing for a scarce resource: social mobility. Becoming a qualified nurse represents a kind of upward intergenerational mobility, through which a low or middle-income person may substantially increase his/her employability and earnings, but individual social mobility remains limited. Lacking the power to change the way hospitals are organised socially, the tendency is to inhibit channels for individual progress. Although it is rare, there are exceptions in personal social mobility:

*Pia married a doctor. I believe it was a disaster for her career: the other colleagues are unfriendly with her, and it’s because she’s changed … she dresses differently now, she’s changed the way she speaks and has other friends … Have you noticed that nurses who are doctors’ wives only join with other doctors’ wives?* (Diana)

*I guess that’s not for what I am, but rather what my husband, an important doctor of this hospital, symbolises to the rest of my colleagues… that’s why they take distance. Also because I don’t actually need as much money as they do… jealousy you know. I don’t find them bad persons but the relationships between they and I were somehow broken off.* (Pia)
Rather than a professional competition, it seems to be a purely class-based struggle, a clash of aspirations to reach the top. This quest for social mobility involves inter-professional relationships too:

The thing is, thirty years back we’re trained to get the attention from junior doctors. Today that doesn’t happen anymore but there is an implicit competition between nurses and doctresses. (Marta)

The social transformation of nursing as an occupation and the subsequent competition for status and mobility generate tensions that can result in hostilities, difficult validation experiences and contradictions that need to be relieved:

If one of us [nurses] gets into trouble no one will help her or protect her, except a friend... but no colleagues. We aren’t close to each other, not really. Doctors and auxiliary nurses do protect themselves... but we don’t. (Millaray)

This is not politically correct, but I always tell my students, ‘to a nurse, there isn’t any worse hazard than another nurse’. (Marta)

Such hostility may be analysed with reference to Marx’s (1976) concept of superstructure – a class is the base on which the social consciousness, the superstructure, is built. What is necessary is to rethink the academisation of nursing, not just as an abstract concept but as one with practical implications for nurses as individuals. Moreover, organisational parameters for social mobility can influence the impact that nurses can make as a collective group. These parameters include conditions for promotion, collective privileges and development policies, disregarded since nursing attained and consolidated academic training.

Next to each other but not together

Although in most countries qualified caregivers are referred to as nurses, Chilean nurses were categorised as being either nursing auxiliaries or university nurses, with the latter category gaining more prominence and putative privilege due to its higher social class origins, with which it was anticipated would garner a more professional status for the nurse.
For over half a century nursing auxiliaries have been under nurses’ training, meaning under nurses’ rule; nurses determined, to a large extent, which duties should or should not be delegated to auxiliaries and what to teach them. This was ratified in the mid-nineties, when the Paramedics and Nursing Auxiliaries Association accepted that, in a clinical setting, nurses’ instructions are a part of their routines (Ministry of Education of Chile, 1995).

A concern of auxiliary nurses has been the title ‘nursing auxiliary’, since in practice they are not permitted to use the title ‘nurse’. From the outset, they were grouped under the collective title of ‘Nursing Auxiliaries’ rather than ‘Auxiliary Nurses’. However, there was an attempt to remove any trace of a relationship of dependence which the former title suggested by changing their collective title to ‘Paramedics’; with this it was clearer that their orientation was related to healthcare systems rather than to nurses. Nevertheless, their ‘nursinghood’ remained quite unalterable.

At the turn of the twenty-first century there occurred another important change for this group; the Paramedics and Nursing Auxiliaries Association succeeded in attaining an enhancement of their training when courses were extended for up to two and a half years. Nursing auxiliaries could now pursue the degree of Higher Education in Nursing Technician, also known as TENS (Técnico en Enfermería de Nivel Superior). This was a crucial move, since it was intended to ease access to university education as well as convince a group of nurses to provide this training.

As TENS training is practically similar to what nurses’ training used to be, the gap between nurses and TENS-trained auxiliaries has become narrower, both in terms of their practical knowledge and how they are perceived in society. Additionally, there is a relation of contiguity between the two groups, since they coexist together in a special symbiotic dyad, because of the strong similarities in their social origins, and the intimacy developed during their ‘seclusion’ in the wards. This may explain why both groups attempt to show how they differ from one another. With this background in mind, it is easier to understand nurses’ concerns when an auxiliary is called ‘a nurse’ by the public, as the following extracts from our data illustrate:

She is not a nurse – Millaray said while looking over her glasses inquiringly – she is an auxiliary nurse. The clarification sounded absolutely precise. The
patient did not respond. Maria, the auxiliary, serpentined through a crowd in the hallway and vanished. (Field notes)

When I was a newly graduated nurse my mentor taught me: ‘Auxiliary nurses are the maids of hospitals. You see? You order, they obey’. Only recently did it occur to me that it may be worth considering the extent to which this is true. (Diana)

We watched in disbelief. The word maid returned hundreds of references and flashbacks of tense situations we had witnessed between nurses and assistant nurses. (Field notes)

When I started dating with an auxiliary, it was terribly criticised, you know. They said that I’m a professional and she’s an auxiliary... this is not well looked upon. I knew it, but we insisted. Later on our chief nurse realised... the meetings were the only moment she was not looking only at me. (Roberto)

This concern among nurses to hold themselves and nursing auxiliaries as two distinct groups has origins in the 1940s. Through women’s magazines, nurses tried to educate the public to the fact that they must not be confused with auxiliaries, as the following extract from Revista Eva illustrates:

There exists only one type of nurse: the professional nurse, the one who holds her title and diploma after pursuing a 3-year training in a nursing school. She is recognised for her uniform and her work, which is to watch always the patient [... and] to control her subordinates’ work. [...] Girls of hospital rooms: these are not nurses and will never be, unless they undertake training in any of the schools. (Revista Eva, 1948, p. 37)

Nursing auxiliaries’ identity has been built on the idea of a labouring class, contrasting with the ‘professional class’ claim of university nurses. Referring to this, Maria’s colleague explained:

We are called by our first names. Nurses, instead, must be referred to as ‘Miss’, for real! They are women who keep their distance. There’ve been very few cases in which a nurse and an auxiliary have become friends, but this is censored by both nurses and auxiliaries, so in public they have to pretend they aren’t friends. (Maria’s colleague)
Yet this detachment seems to be at a more discursive level than the cultural practices domain:

*I've noticed nurses share social behaviours with auxiliary nurses, rather than with doctors. The sense of humour they enjoy, the vocabulary they use, the kind of music they listen to, they are all connected by these things.* (Field note)

 Barely possible to be ignored and above all the background noise, we could hear lively music and shrieks of laughter coming from a staff room. The nurse who was writing at the nursing station lifted up her head and looked at me saying with a tone of embarrassment, ‘Do you see what we have turned into? Professional form-fillers!’ Music went on. (Field notes)

 If this antagonist stratification of health care grades means unequal privileges and rewards, how can this construction be best understood? In my fieldwork I uncovered a general agreement among nurses, which holds that a nurse is the only irreplaceable team member; this excludes auxiliaries. Such an idea is predicated on the assumption that nursing is more important than auxiliary nursing, since it is a ‘connecting’ piece without which no hospital could operate effectively. It is difficult to determine how dispensable or indispensable a given occupation really is, since such a notion is linked to the benefits that power holders want to preserve for themselves, as well as the potential of social disruption they might cause by withdrawal of labour (Parkin, 1979).

 Moreover, auxiliary nurses not only have been systematically excluded from any analysis of Chilean nursing, and the very few references to them either seek to explain that nurses are not auxiliaries, or to state that auxiliaries’ training was handed over to nurses (Chilean Nurses Association, 2012 and Chilean Society for Nursing Education, 2012). They have also encountered difficulties when trying to set up programs in higher education institutions (Mönckeberg, 2007).

 The analysis suggests the following three insights concerning the relationship of nurses and auxiliary nurses. Firstly, the title ‘nurse’ and the practice of ‘nursing’ have been monopolised by university-trained nurses, although it is evident that auxiliaries as well as other healthcare providers
perform certain nursing roles and functions. Secondly, auxiliary nurses have been excluded from analyses of the nursing occupation in Chile, resulting in an incomplete picture of the history or development of Chilean ‘nursing’. Thirdly, nurses and auxiliary nurses operate in a relationship of power, wherein the former is dominant and the latter is subservient. This relationship closely mirrors and is likely a reproduction of the historical doctor–nurse asymmetry, which has resulted in a lack of political power for nursing as a whole.

Nevertheless, despite their subordinate position in the nurse-auxiliary dyad, it seems clear that the development of auxiliary nurses will continue to grow. Whether this growth ultimately leads to the merging of the two groups is unclear, but nursing could be significantly strengthened with such a merger.

Social reproduction of a middle-class occupation

Having reviewed the creation of boundaries between nurses and auxiliary nurses, it is necessary to revisit the internal boundaries of university-trained nurses. Confronting these boundaries it is possible to see a duality between an old-fashioned idea of elite ladies who became nurses and middle-class people who ‘should’ adopt a professional-class identity despite their cultural closeness to auxiliary personnel.

Conversely, these values are in fact internalised across the organisational grounds; outside the hospital organisation auxiliary nurses and university nurses appear to experience greater degrees of freedom, with both adopting exchangeable nursing practices and building closer relationships. The most valued rule of nurses’ identity, ‘do not allow them to call you by your first name,’ is easily broken.

Has the social identity of nurses become stronger than a professional-class identity? It would appear so. According to Larraín (2001), contemporary Chilean identity has been strongly influenced by both social class and occupation. Thus, as society’s middle class grows it seems reasonable to discard the old-fashioned ideas of ‘eliteness’ of professional groups. This has import for the construction of the professional discourse, so linked to exclusiveness and distinction, and in the case of nursing, a mystification of ‘ladi-
ness’ in the social imaginary as well as in the academic discourse, as our data illustrates:

- Senior lecturer: Nurses don’t have to just call themselves professionals, you know, they also must behave accordingly.
- Interviewer: I’m not sure I understand...
- Senior lecturer: I mean, nurses must not look like their own maids.

This discourse reinforces the status quo of the social order of hospitals, which remain very hierarchical and stratified on the basis of social class origins. In time, this discursive production leads to the reproduction of inequalities:

Nurses rarely, if ever, marry auxiliaries. That’s uncommon, even weird. They rather marry doctors ... or male nurses but this is also uncommon, not that weird but still uncommon. I see it’s more common that an auxiliary nurse dates with a male nurse, but not in the other way around. Same for doctresses, they never date with male-nurses. (Diana)

Bourdieu’s notion of social reproduction offers a framework for understanding these practices and behaviours among nurses and their co-workers. The academic training that the nurse acquires not only reproduces a body of technical knowledge but it is ultimately political for society at large, as it reproduces social institutions and structures:

What attracts our attention when leaving the field and comparing our notes?

Millaray continues to work extra time on weekends, typically 12-hour shifts, not for time off but for extra bonuses. Roberto, the fireman, broke up his hidden relationship after six months of being pressured to do so. Thanks to her husband’s influence, Pia eventually got out the night-shift system and has a normal life. Diana remained within what has always frustrated her, the difficulties to find support to go back to college. On the third floor, Marta is striving to find the right words for a presentation before the Ministry of Health.

Ironically, as we stepped out of the hospital, the air smelt pure and sterile. (Field notes)

Discussion and conclusions

I have made a case for and analysed the nursing occupation in Chile, based on two major components that emerged in the analysis, namely the
social transformation of nursing which shapes nurses’ relationships and the singular academisation process and its ineffectiveness in preventing the reproduction of social inequalities. Although this case study is limited to a single institution, as a field of large cross-class interaction, a hospital reflects many of the features of the broader society.

In using academisation as a key factor in professional development, authors usually refer to the access to full professional status. However, class-consciousness and social behaviour may more usefully provide a focus for examining the development of nursing in a given country, as professions are connected to the social transformation of society. Any analysis of a country’s nursing system might begin with the following question: How has the nursing occupation been shaped by social transformations? This does not imply that structural concerns are not important, and it is recognised that it is not possible to write histories of single occupations in isolation of histories of other occupations. Accordingly, I have analysed two parallel occupations, the nurse and the auxiliary nurse, socially similar, but different through detachment, resulting from a socially constructed ‘otherness’.

As explained, the process of class identity formation is as powerful a factor as gender identity and gender relations in the development of modern nursing.

The social identity of nurses, qua university-educated professionals, constitutes their cultural capital and their power. If the academic credentials that nurses gained have eased access to employment markets, these same credentials may be used as a means of critical analysis of social stratification in nursing, namely the asymmetries and inequalities that are reproduced through nurses’ socialisation into organisational cultures that are supported actively by nurses as social actors in these same cultures.

The setting of a Chilean hospital provided a case study of the social impact on nursing that has resulted from the academisation of nursing, resulting in the reproduction of earlier historical class differences that have existed in nursing. These class differences are manifest in the socially constructed distinction between the nurse and the auxiliary nurse, resulting in a schism within the nursing family in Chile. The analysis illustrates how university-educated nurses have appropriated the notion of nursing, and in the
process have excluded non-university auxiliary nurses despite their own academisation. A critical part of this analysis will be how the political power of nursing as a whole would be increasingly improved.
In previous chapters I have discussed the evolution of nursing education into an academic curriculum. Along with that process, the growing interest of men in nursing has often been considered a significant landmark in the development of a ‘female’ occupation. Contrasting with that idea, in this chapter I present paradoxical results of nursing education in what concerns to its development, namely its ineffectiveness in preventing gender-based inequalities, as the interest in empowering nursing politically may lead to favour an increasing number of men entering nursing in ways that facilitate male students’ progress.


As a ‘female’ occupation, gender consciousness has been a powerful factor in nursing identity, so are gender relations in the development of modern nursing. The academisation of nursing education may thus serve as a means for increasing awareness and raise important issues concerning the reproduction of gender inequalities.
While there is evidence concerning inequalities at workplace, little is known about how this can possibly originate earlier through nursing training practices. This chapter was a contribution aiming at bridging an important gap in the current literature on nursing education, as the impact of academisation on gender inequalities has been taken for granted, in the conventional assumption that the access of women to scientific degrees reflects the development of a given society. The key question in this discussion is: to what extent are nursing gender relations shaped by the socialisation process within the academy?

I examined this problem by drawing upon a corpus of interviews, focusing on two concepts of relevance to this analysis: masculine identity and gender relations. The chapter concludes by inviting a discussion on the particularities of nursing education and its linkage with social equality, which might have a strong resonance elsewhere.

**Gender-based Social Inequalities in Chile**

Major political reforms have undergone in Chile over the past five decades. Despite the manifest development of the Chilean economy and its integration into the global market, social inequalities still persist. Substantial income differences (Morley, 2001; Castillo, 2011), as well as geographical (Bicudo, 2011), health (Ewig & Palmucci, 2004; Fuentes et al., 2013) and educational inequalities (Levin, 2011; Mizala & Torche, 2012) have framed the making of the early twenty-first century’s Chile.

Intriguingly, the concentration of income in the wealthiest segment of the population seems to be intertwined with an ‘existential argument’ that justifies and legitimates social inequalities in that country (Castillo, 2011), suggesting that the legitimacy of social differences is ultimately embedded in cultural self-interpretations of social groups.

Gendered underpinnings, in turn, inform social differences insofar as women are largely grouped in the service sector, typically in teaching, social work and nursing. This is partly because of a gradual move of women from domestic work to the employment market, therefore taking on ‘helping’ vocations (Nagl-Docekal, 2004), and also partly because of conventionalisms that tend to favour men for authority representations (Ridgeway,
2011) and how they are perceived as fitting chief posts, structuring in the process rather rigid patterns of career choice.

Recent evidence has shown that women’s labour supply in Chile has grown steadily since 1990 against relative stability for men, although it remains fairly low in international comparisons, standing at 37 per cent, even significantly lower than in other countries in Latin America (Contreras et al., 2011). Additionally, earlier studies (Contreras & Plaza, 2010; Contreras & Plaza, 2006) suggested that conservative attitudes in the country influence female labour force participation.

While this backdrop is relevant as far as it goes in the socio-economical arena, what are the implications for the nursing occupation? In the following, I will provide relevant background information on the participation of men in the nursing employment market. I then present the methods and main findings of a qualitative study, and discuss patterns that consistently surfaced during the production and analysis of data.

**Men in Nursing: Masculinity at Workplace**

Men in conventionally female occupations have not only been a concern of little attention (Pullen & Simpson, 2009) but also an often neglected phenomenon in the study of social inequalities.

Nursing in Chile is also a predominantly female occupation. By using the Chilean Nurses Association’s (2013) records and the public statistics on education and employment (Ministry of Education of Chile, 2013b), it is estimated that between 6 and 10 per cent of Chilean nurses are men. Once perceived as a type of ‘intrusion’ into a domain forged by women, male nurses are today an integral part of the nursing family.

There is a common belief that male nurses have shown positive results in their careers. This may be understood through what some authors describe as a ‘monopoly’ of attractive positions (Williams, 1993; Budig, 2002) resulting in higher rewards than those of women, in both wage and image. Male nurses seem to benefit from the assumption that, as men, they should increase their leadership, and therefore adopt a more competitive attitude towards their work (Floge & Merrill, 1986; Heikes, 1991), reaching strategic positions in hospital boards (McMurry, 2011) or grouping together in high-technology specialties (Williams, 1995; Evans, 1997; Simpson, 2004;
Connell, 2012). Undoubtedly, this echoes the widespread idea that women are emotional and fragile, while men are strong, rational and able to control their emotions (Evers, 2010). Similarly, authors such as Brown (2009) claim that male nurses find themselves in a dilemma between their masculine identity and the nursing role, which seems connected to a pattern of professional specialisation. The public image of the nurse is in fact associated with womanhood and womanly qualities (Heldens & Schilling, 2012; Kelly et al., 2012), portrayed by the prolific imagery in the media market (Almodóvar, 2002; Brixius et al., 2009; Harding, 2007).

Despite that these claims have shed light on gender inequalities in nursing at workplace, there is little evidence in relation to nursing students and how nursing education might engender this phenomenon in an early stage of the socialisation process. Integrating this perspective in a closer analysis may bring important insights to this discussion.

**Study Design**

The study involved individual (22) as well as group (6) interviews with beginner and advanced nursing students (separately) from a Chilean university. By this I aimed to balance two contrasting points of the students’ socialisation process, namely the ‘ideal nursing’ communicated to beginners, and the ‘real world’ nursing experimented by advanced students. The students were chosen purposively as informants in an earlier stage of a larger study exploring nursing identity construction; the average age was 19 years and 23 years, respectively. As key informants (Denzin & Lincoln, 2000), they expressed an interest in the core theme of the project, seemed to be knowledgeable about it and were willing to communicate a piece of information they found critical for the future of the nursing discipline.

Based on a semi-structured guide that reflected the literature on gender and professional identity, the interviews ranged between 60 and 120 minutes, were tape-recorded, and included males and females separately to contrast their views on gender interaction. As for the group interviews, each group was mixed-gender.

Access to the study participants was reached after obtaining the approval of the relevant Ethics Committee. To meet the condition that consent
should be informed, each interviewee was given a description of the study and then asked to discuss his/her experiences within a nursing context.

In the study of gender interactions, it was important to consider the development of processes, concepts, and patterns, therefore the Grounded Theory approach (Corbin & Strauss, 2008; Charmaz, 2006) provided the most appropriate means for conceptual integration. The codification process was rethought, readjusted and refined until reaching a meaningful answer to the research question.

**Findings**

A stereotyped image of male nurses in society surfaced at different stages of the discourse, producing a high degree of reiteration. While there is a nearly automatic comparison with the physician’s role as a referent for nursing identity, the public image of the nurse seems to cause family pressures to discard the idea of nursing as a fitting career for men.

“In the media, the male nurse scarcely stands out, because it’s still not a job for men. It’s sometimes difficult to find male nurses, and when patients are seeing by one they call him «doctor», he is the doctor to them, it is hard to call him «nurse».” (Pedro, 5th year)

“If you are a male nurse, you are automatically labeled as gay-ish, something like that. In short, really that’s the image projected by a male nurse”. (Anita, 5th year)

“I have classmates who studied in men schools and they later have alumni gatherings. Then, they are asked: «so, what are you studying?», «Nursing» and they say like: «no! What the hell! What happened to you?»” (Pamela, 1st year)

“When I told my father I was going to study nursing, he was like ‘Pedro, I raised male kids: sons, not daughters’. And therefore I entered the school having my doubts… when mum and dad said to me that I’m studying a career that is for ladies, I felt disappointed. Ok, let’s be objective; it’s true, there are only ladies here. (Mario, 1st year)
While this information may seem of little relevance, as stereotypes about nursing have been extensively documented, the perceived image of the male nurse brings important inputs for the question of concern and is central to our underpinning thesis. As illustrated in Fig. 2, male students are socialised within a female environment, having very few or none masculine referents, important for professional identity formation. Besides, students attempt to take no notice of the feminised academic discourse in nursing, one that makes reference to ‘her’, the female nurse, having as reinforcement the biased translations of textbooks into the Spanish language. As a result, men and the male gender become virtually invisible.

Figure 2. Social environment informs self-interpretations of masculinity, which is in conflict with the selfless, feminised identity of nursing. Nursing training, in turn, participates in the socialisation of nursing students; lacking male referents along

With this background in mind, it is easier to understand how a discourse of self-compassion – ‘poor me’ – develops among male students. Further, another discourse of compassion develops among female classmates – ‘poor them’ – who adopt a supportive attitude towards males, arguing that it is
difficult to a man to be sensitive to emotional needs of patients or to do tasks such as those relating to the caring dimension of nursing practice.

“One is very protective towards the guys, even selfless sometimes. We give them advice, lend them our notes and photocopies, and in the end they get higher grades than us!” (Veronica 5th year student).

- María: nursing teachers are mainly women, and at the clinical campus nurses are usually female, too. The role they play is very maternal. Their favourite one in a group of students will always be him, the guy. And it tends to happen to us too; if we’re a group of 5 women and 1 man rotating in clinics, we girls will want to help him.

- Antonia: Yes! Definitely! ….he is like our number one.

- María: As if we weren’t aware of this issue, of the maternal role we take, we’re always helping him.

- Antonia: It’s because we know they’ve more difficulties in handling things.

- María: yes.

- Antonia: we want to protect the guys, ‘cause they are clumsier at the compassionate part…. 

Group interview. 5th year students.

“We try to look after them, because we know they’re not used to these things.” (Magdalena 5th year student).

“It’s annoying that the lecturers always speak in gendered terms: ‘she, the nurse’ but never of ‘he, the nurse’. And when we study nursing theories, we realize that there’re no male authors!” (Francisco, 1st year student)

“Girls worry about us. And we just let them love us.” (Pedro, 1st year student).

As illustrated in Fig. 2, these two discourses of compassion engender a special symbiotic dyad between male and female students. This dyad may be analysed in reference to a pattern of gender relations built upon roles of a ‘mothering woman’ and a ‘needy man’. The main point here, however, is not that male students become somehow dependent on female fellows, but that they are also perceived as ‘needy’ by lecturers and supervisors, reaf-
firming role construction. Throughout the fieldwork I uncovered a general agreement among teaching nurses, which holds that the entry of men into nursing was beneficial for the future of nursing, as it is perceived as supporting the status of the profession. Such an idea is predicated on the assumption that the masculine presence could counterbalance an alleged lack of political power.

On the basis of the participants’ discourses, it would seem that lecturers tend to show a more welcoming attitude and a rather preferential treatment towards male students. This might be a reflection of an unconscious but active effort to masculinise nursing, or at least to increase male to female ratios. While I had no access to academic records to analyse comparatively, the discourses suggest that male students may experience greater degrees of liberty to take initiatives in clinical settings, a feeling of confidence that might reflect nurses’ preference for male students, disregarding their lack of interest in ‘female’ tasks (i.e. making beds, washing patients) or being more considered when they do not feel productive.

- Student: just to give an example, instructors make us, girls, suffer very much, it’s really stressing! However, they allow men to pass with no difficulties; they let them be who they are.

- Student: Maybe, it’s because it’s more personalized, he is «him», and to him everything is given differently. We, girls, are «students», but a male student has a «name».

(Group interview, 5th year students)

“*The problem is, among so many women we cannot be distinguished. We are so many. But the man will always be the man, he’ll never be overlooked.* (Anita, 5th year)

- Student: nursing teachers are mostly women, and in the practicum nurses are normally women, too. So nurses adopt a very maternal role with students, therefore the favourite student in a group will always be the man. (Group interview, 5th year students)

“*There’s even a competition among female students, but not against men. Actually, we couldn’t see them as an opponent. In clinical practicums men defi-
nately have better results than ours, although sometimes we see their marks aren’t necessarily correlated with their efforts, nor with their skills.” (María, 5th year).

“Men have a privileged relationship with instructors. They feel closer, more confident and more relaxed than us.” (Nadia, 5th year)

- María: We aren’t questioning men’s knowledge, it’s their attitude. They’re more… they’re lazy. It’s like, if they get one thing done in the whole morning, that’s it. Then they go away, snooping around in the emergency room in case there’s a heart stroke, things like that.
- Nadia: Yes. And after that they’ll have a coffee break. We, instead, are working all the time. Men constantly come out with pretexts, they always have good pretexts.[laughter]

    (Group interview, 5th year students)

Here, once again, the stereotyped idea of nursing as a ‘female’ work surfaces through male’s interest in high-technology units, exploring roles they may consider more attractive, likely a way to withdraw from a caring role as their main duty. Similarly, male graduate nurses tend to concentrate in such units as well as in administrative posts. With this idea in mind, it may seem reasonable to infer that nursing teachers may facilitate male students’ orientation towards a more ‘masculine’ practice, adapting approval requirements to their interests. It becomes apparent that male nurses’ expectations for a masculine performance echo early exposure to ‘hero-like’ roles that are perceived as complex, hazardous, and challenging. The posts choice thus becomes more suitable to traditional sexual roles, relegating the care to the perpetual notion of femininity, largely rooted in the country that served as a setting.

**Discussion**

In this analysis I made a case for and analysed gender-based inequalities in Chile as constructed through nursing education, drawing on two major concepts that emerged in the analysis, namely gender relations and masculine identity. Although this case study is limited to a single institution, I did not aim to achieve topic representativeness in answering the question of
concern. Rather, to raise awareness on the linkage between the nursing education machinery and the reproduction of historical gender-based inequalities which have undermined the nursing profession. In analysing these inequalities I used a systemic approach arising from the sociology of the professions, and in so doing I have focused the analysis on the internal stratification of nursing (Abbot, 1988; Abbott, 2002; Abbott, 2010).

The phenomenon analysed is twofold. On the one hand, men who enter nursing are generally perceived as declining in status (DeCorse et al., 1997), and accordingly male students seem to look for a mechanism to counterbalance that perception. In addition to that, the educational experience stresses their male identity as they are expected to assume a nursing role, a result aligned with Brown’s (2009) claims describing this as the male-nurse’s dilemma. Whereas this dilemma has reportedly hindered retention of male students elsewhere (McLaughlin et al., 2010; Jeffreys, 2012), in this study I uncovered a mechanism aiming to overcome that dilemma – a pattern of differentiation in the educational system.

On the other hand, there is a perceived need for strengthening the image of nursing, with an increasing masculinisation as an apparent benchmark, and a channel of vindication for nursing as a profession in a setting of severe income and educational inequalities (Morley, 2001; Castillo, 2011; Levin, 2011; Mizala & Torche, 2012).

Discourses of compassion emerging from the invisibility of men in nursing development (Roth & Coleman, 2008) may threaten academic integrity, and in the process reproduce (Bourdieu & Passeron, 1970) those same inequalities in question, both in the educational practice and at nursing workplace. The growing interest of men in the nursing profession must not only have political consequences for nursing as a whole but also tangible consequences for nurses as individuals, such as mutual recognition of talents and more egalitarian gender relations.

Conclusion

Male students face a dilemma when confronted to the caring role of nursing, questioning whether their masculine identity would match such a role. Previous research has dealt with identity issues among male nurses,
though this study brings new insights on gender identity construction in nursing students.

In the setting of my research, a culturally feminine profession tends to be considered as a rather supporting activity. Male students, accordingly, learn how to pursue socially respected nursing roles as a channel to conciliate both personal identity and professional identity. As this analysis illustrates, such a process may be facilitated by a differentiation pattern embedded in educational practices, leading to a form of gender stratification within nursing from a very early stage.

While the increasing number of men embracing a career in nursing may have a meaningful resonance with the transformation of contemporary societies, opening up nursing to men, if not handled judiciously, may lead to the reproduction of earlier historical inequalities. There is a genuine reason for nursing itself and the whole healthcare community to celebrate the benefits of the academisation of nursing. Though this same academic rank may be used as a means for critical appraisals of how nursing education meets key challenges, such as the forging of a fairer society in Chile and elsewhere.
4

OF RED AND BLUE:
CONSTRUCTION OF FIELDS AND JURISDICTIONAL PROBLEMS

This chapter draws on historical data, despite the fact that it arose from observations through which I problematised visible features differentiating nurses and midwives. This led me to explore historical disputes between them. And although this conflict may not be at the heart of my inquiry, it was important to gaining an understanding of the construction of professional fields, of the mechanisms for the definition of jurisdictions and of the disputes for knowledge ownership, and how these three components are meaningfully connected.

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Despite their similarities, nursing and midwifery have embarked on significantly separate trajectories in Chile and have become rather different occupations – they are trained in schools detached from each other and even develop strongly opposing identities. Their interaction in fact becomes an arena of competition which discloses conflicts periodically. For instance,
issues of ownership of the care of new-borns, overlapping roles in healthcare management, projects aimed at relieving nurse shortages by enhancing midwives’ nursing skills, and attempts of state entities to homogenise nurses’ and midwives’ competences.

I build on historical and contemporary literature and present a rationale concerning nursing/midwifery jurisdictional conflicts as constructed in their interaction. This chapter thus bridges a very significant gap in the literature on nursing/midwifery development, as the systemic interaction has been a subject of very little analysis. The key question in this discussion is: How have socio-historical processes shaped the identities of nurses and midwives in Chile?

Constructing core themes is important to disaggregate generic problems into dimensions and to guide future analyses. I examine the problem comparatively by drawing upon pre-existing documents, grouping the data into five core themes of importance for further discussion. The chapter concludes by presenting a discussion on the particularities of these two occupations in Chile, that in the case of eventual changes would lead to policy implications for more coherent and integrated care.

**Background**

Over the course of the last four decades there has been a concerted discussion among healthcare professions in Chile concerning the definition of fields of practice. Most of the discussion is aimed at reaching greater autonomy and legitimacy, and at shaping their scope of practice legally. As I have discussed in the precedent chapters, writing histories of a single occupation in isolation of histories of other occupations, however, assumes the existence of a common pattern of professionalisation and that development depends on internal forces only; in other words, that one profession’s development is independent of another’s. That perspective neglects mutual implications that cognate professions may have. In the setting of my field research, those implications may be understood with reference to the concept of “social closure” (Evetts, 2013; Larson, 1977; Reeves, McMillan, & van Soeren, 2010) – professions develop market-oriented schemes, exclusionary mechanisms to gain monopoly control of an area of work, assuring
self-interests in terms of power, salary and status, so as to thwart the interests of competing occupations.

In reviewing the growth of nursing and midwifery in Chile, their conflicting interaction showcases an arena of competition between the two fields: for instance, about overlapping areas related to the care of the newborn, on which both nursing and midwifery claim a jurisdiction. Also overlapping are roles in healthcare management that nurses and midwives share, in part due to midwives’ education which in some measure is rooted in a nursing background, and also in part due to their common sphere of practice, more organisationally oriented rather than interventionally oriented. Whereas the domain of medicine is interventionist – doctors intervene inside the body by prescribing medicines, removing organs, and so forth – nurses and midwives are generally placed on an interpretive, mediating domain, outside the body – they run the wards, coordinate workflows, and look after the patients (Glouberman & Mintzberg, 2001). This standpoint is crucial as to question how boundaries are defined in such a shared domain.

Furthermore, nurses maintain that there have recently been attempts driven by state bodies in order to relieve nurse shortages (Chilean Nurses Association, 2012) and a so-called midwife surplus by enhancing midwives’ nursing skills, continuing in this manner to homogenise nurses’ and midwives’ competences.

It is important to acknowledge, at this point, that these tensions do not develop by their own dynamics, but in interaction with the socio-historical context. In the following sections I will show how, despite the similarities between these two professions, midwifery and nursing have embarked on significantly separate trajectories in Chile. I draw our core themes on socio-historical circumstances relevant to professional development and the actual role of nurses and midwives in healthcare systems.
Methods

Given that my interest was to compile and analyse thematically major concepts in the literature with relevance to a long-standing interprofessional conflict, I addressed my research question comparatively through a social history approach (Burke, 2005). This approach focuses on the lives and struggles of people excluded from official histories; in this case, the history of medicine and healthcare in Chile. There is a reason why I used historical documents, rather than ethnographic data; and the reason is that there is no actual interaction between the two professions. Nonetheless, some visible futures of nurses and midwives (Fig. 3, Fig. 4) were at the origin of these ideas.

Figure 3. Chilean Midwives (University of Chile)
Search processes: In addressing my question, I did not define strict search terms to be used on specific databases, but rather kept an open-end attitude towards conceptual recurrences in the twentieth-century and early twenty-first-century literature; this process included gathering disparate sources – books, journal articles, theses, conference proceedings, technical reports, legal documents, newspapers and institutional websites – tracking their annotated bibliography, classifying the content, creating thematic families, and organising and reorganising the findings until pieces of data cohered together in a meaningful way to answer the question of interest.

Among the main sites used for searching historical documents were: the Library of Congress of Chile, the digitised archives collection of the Chilean National Library, the San Francisco-based Internet Archive, the Latin-American newspapers section of the Centre for Research Libraries, the Medical Heritage Library, digital newspaper collections, Chilean universities’ libraries, and relevant professional association’s websites, which comprised documents written in Spanish, English, Portuguese and French.
Background literature was retrieved from searches on the Web of Science and the Latin America-based Scientific Electronic Library Online (Scielo), and from tracking reference lists. Additionally, in order to overcome the risk that I might overlook important sources, we consulted senior researchers in both healthcare and history.

The search yielded a compilation of 6 historical books, 17 contemporary books, 3 dissertations, 23 research articles, 121 newspaper articles, 87 archives (magazines, letters, minutes, study programmes and reports), some of which were discarded after judging conceptual and methodological relevance and validity, or not cited here due to either content repetition or space limitations.

**Analysis:** In analysing professional interaction and cooperation, it was important to focus purposefully on the emergence of historical processes and patterns that consistently surfaced throughout the exploration of the phenomenon, so as to reconstruct and develop a historical-narrative account (Roberts, 2001; Waldman, 1980) of the conceptual themes arising from the included sources. The analysis focused on the period and context in which the data sources were produced, as well as the reasons they were produced for, in order to scrutinise their validity and enhance the reliability of the analysis.

The resulting categorization was organised in a number of themes and contents that were reduced, refined, rethought and adjusted as new information surfaced, using the cross-disciplinary standpoints of the article authors (sociologists and midwife/nursing researchers) to compare and discuss the data. Arising from this process, we agreed upon themes that comprised key socio-historical processes illuminating a discussion on jurisdictional conflicts, such as those highlighting the early origins of the caring professions as a source of diverging identities, the progression of two seemingly distinct disciplinary traditions and academic-training paths, struggles concerning the division of labour and mechanisms of boundary expansion, and the increasing utilisation of law in defining demarcations between professional fields. Taking into account recent developments in nursing identity in Chile, it also seemed meaningful to enhance the analysis by including a last theme on social-class consciousness and social mobility.
Findings and discussion

Early origins of nursing and midwifery in Chile

Nursing in Chile originates in philanthropy and its role in the charitable domain of education and social welfare. Before becoming a State service, it was religious organisations and religiously inspired groups from the elite class that managed the provision of basic services (Guarda, 1978; Ponce de León, 2011; Sanborn, 2006). The Sisters of Charity – who were known to be skilled nurses and teachers – were among the first to work in post-independence Chile, early in the nineteenth century, taking responsibility in hospital administration and care. These nuns brought their savoir-faire into the hospitals and legitimised and dignified an activity that would become increasingly secularised (González & González, 2008; Yeager, 2007).

The rise of charity associations among elite ladies generated the appearance of basic nursing services to meet the poorer population’s needs concerning public health and social security (Alvarado, Sheetham, & Rojas, 1973; Illanes, 2006; Subercaseaux, 2007), evolving gradually from volunteering into the employment market. This turning point was crucial for the emergence of the social worker, from which a newer occupational figure emerged in the form of the visiting sanitary nurse (Illanes, 2006; Mooney, 2009). The status of nursing was associated with the educated elite (Ayala, Fealy, Vanderstraeten, & Bracke, 2014) and the nursing profession became an element of class distinction, reinforced by the centralisation of training in a university by the second decade of the twentieth century (Muñoz & Alarcón, 1999).

The history of midwifery contrasts to that of nursing. Although traditional birth attendants (parteras) had long existed in Chile prior to independence, their work became thoroughly discredited, judged, intervened, and regulated by the royal authorities during the colonisation of the country (Zárate, 2007). Besides the influence of religious views at the time regarding the notions of body and healing, the extensive control exerted over the parteras was facilitated by a number of characteristics surrounding their figure, namely illiteracy, poverty, ethnicity, gender, and a supposed connection with the supernatural.
Soon after Chile won independence, one of the main concerns of the nascent state was public health. What was a long story of political constriction over the *parteras* came then to be one of medical domination, for that increasing development of science and the interest of medicine in pregnancy and child delivery (Zárate, 2007). Although episodic, formal training as midwives (*matronas*) began by the 1830s and the teaching was undertaken largely by obstetricians. Newly built maternity homes, which also served as residential midwifery schools, were not only important facilities for maternal care but also a foundational landmark of women’s professionalisation, as it gave more prominence to the effectiveness of the care that midwives provided (Zárate, 2007). Midwives acted as nurses but also served as a means to vulgarise scientific knowledge on childcare into a popular language (Illanes, 2006), structuring in that way an incipient discipline of infanticulture.

The organisation of maternal wards within hospitals, which had become medical institutions (Zárate, 2007), brought midwives into contact with the nursing personnel under the nuns’ administration, usually unskilled workers who functioned as hospital helpers. One can possibly infer that the relation of contiguity between midwives, medical students and nurses developed during their ‘seclusion’ in the hospitals meant a means of knowledge exchange, which would eventually arrive at the formalisation of nursing training in 1902.

Yet, that move cannot be completely understood in isolation of the national context at the time. The bitter massacre of the War of the Pacific (1879–1884) fought between Chile and the allied nations of Peru and Bolivia seems to have been a turning point. Whereas the nuns dealt with the poor, there was not any organised nursing service to assist the war wounded, other than the willingness of the civilian population (Sater, 2007); as Sater & Herwig (1999: p120) stated, “the paucity of medical personnel included an absence of professionally trained nurses and field medics.” Being the causalities of great significance, along with a civil war occurred in 1891, the need for an organised service became apparent, resulting in a number of medical doctors educated in Europe (Cruz-Coke, 1995) advocating for a nursing reform. By that time the sanitary principles attained by the British during the conflict of 1854–56 were becoming
increasingly popular, in ways that gradually influenced nursing training in South America (Bullough & Bullough, 1979; Sánchez, 2002).

This historical backdrop brings three results that are important to the present analysis. Firstly, the humble social origins of midwives were certainly challenging and perceived by the science as a threat (Zárate, 2007). Conversely, nurses grew organically as hospitals grew, under the influence of Roman Catholic sisters and actively supported by scientific medicine, so that nursing became an occupation of interest for well-educated women. Secondly, whereas midwifery was essentially meant to assist a natural process, namely pregnancy and delivery, nursing emerged to face an unnatural one – taking care of the poorer population’s needs, and assisting those who experienced the horrors of the war. This is a turning point for development but also for disaggregation, where the two professions would seem to be more different than alike. Thirdly, there is a sense in which midwifery work involves elements of nursing. Despite not being thought of as taking care of the sick or the wounded, midwives have unquestionably provided care to women and new-borns, and it is recognised that today’s midwifery has expanded its scope of care to women across the lifespan, becoming clearer that their ethos is thereby one of a caring profession.

It may appear acceptable to argue that the two groups drew upon two different points in history divergently, and therefore they cannot merge into a single occupation. However, the notion that ideas and institutions do originate and evolve at several points simultaneously, may have a meaningful resonance for the caring professions. Nonetheless, the connection of this historical backdrop – largely unknown – with the identity construction today is rather blurred, given a major historical gap. Further evidence is needed to understand how their origins might contribute to exploring the processes of differentiation more closely.

The academic training of nurses and midwives

Although formal midwifery education in Chile began in the 1830s, nursing schools emerged about a hundred years later as a separate entity, involving both the sisters who had ran the hospitals and provided care since the 1850s, and helpers who worked in the hospitals (González & González, 2008; Zárate, 2007). As midwifery and nursing education increased in
length and sophistication, and earned university training, they remained distinct from one another and developed rhetorically antithetical identities; such a detachment has been a constant feature of their parallel evolution. Even though we encountered a major historical gap in this concern, there are some crucial writings about an integrated project proposed by some universities in the twentieth century. A merger of nursing and midwifery into a single occupation – namely the Nurse-Midwife – started in the late 1960s (University of Valparaiso School of Nursing, 2013; Florenzano et al., 1991), and rose mainly by epidemiological circumstances that Chile faced at the time – child malnutrition and mortality. That training, offered only by a few universities, was expanded to five years and aimed at strengthening the workforce for child and maternal care (Murray & Veraguas, 1996). To some extent, such a merger could have led to a sense of mutual identification of midwives and nurses within a wider profession. It has been argued, however, that two main reasons led to a schism in the new nursing-midwifery fraternity: (i) the public health system failed in creating specific positions for the newer occupational figure and therefore most nurses-midwives typically worked as nurses (Murray & Veraguas, 1996; University of Valparaiso School of Midwifery, 2013); (ii) the length of the programme became discouraging to prospective students.

Carrying this view into practice, it seems reasonable to have separated the curriculum again. We may find in this history, though, a covered agenda of a rather actively supported fission. According to Murray & Veraguas (1996), those schools offering a united study programme were fiercely opposed in this by prominent members of the Chilean Midwives Association, who thought there was “a need to protect midwifery as a separate profession” (p.99). The trade agenda to destabilise the nurse-midwife project was reinforced by the figure that the midwives saw in nursing, which prompted antagonism: “As a profession Midwifery is competing with both medicine and nursing for space and status” (Murray & Veraguas, 1996: p. 99). There is also some evidence which suggests that the fruitlessness of such a project was addressed on both fronts: that of midwifery and of nursing (University of Valparaiso School of Midwifery, 2013).

On the other hand, although midwives have claimed to make up a different discipline, midwifery education is at least partly rooted in the nursing
reasoning – students are taught to understand professional problems from a nursing approach, therefore they define problems through nursing taxonomies and vocabulary, and organise their professional activities within the nursing-process frame. Given that terminology reflects as much the background one looks through as it does the role one performs, it is difficult to determine how different the midwifery reasoning and the nursing reasoning really are.

While the back-and-forth of this nursing/midwifery duality is relevant with respect to the technical arena, it becomes problematic to visualise the place and relevance of the subject of care in this discussion. The argument rather points to the disputes for a jurisdictional field with which the discourse of distinctiveness can be justified. If the challenging scenario of child and maternal health was important for the inception of an integrated project, the subsequent debate does not seem to have followed from it. Whereas the earlier historical backdrop seems of little relevance in identity structuring today, the fears of a technical overlap appears to gravitate towards antagonist relations and detachment. The “counterproject” of separate schools has then resulted in very little contact and a lack of opportunities to identify and valorise each other’s knowledge and skills, and therefore the opposing identity would instead rest upon an unawareness and the discourse of differentness, hardly upon a fundamentally different educational ground.

**Division of labour and boundary expansion**

Having reviewed the social history of nursing and midwifery in Chile as well as the construction of an “otherness” through the academic training, it is necessary to focus the analysis on the internal boundaries of healthcare system and how they lead to jurisdictional conflicts. These boundaries can be understood in reference to the concept of “division of labour.” Drawing on an ecological notion, division of labour in its most optimistic sense reflects cooperative interdependence on the basis of systemic dynamics (Hughes, 1993).

Modern hospitals, where nurses and midwives most often perform their core occupational activities, have witnessed two major changes: the hospital evolves into an organisational entity and is characterised as a ‘divisional
structure,’ founded in a process of rationalisation and bureaucratisation (Gourdin & Schepers, 2009). It is this divisional setting which positions nurses and midwives on a common sphere of practice, described by Glouberman & Mintzberg (2001) as “organisationally oriented”. This standpoint is important for understanding the definition of jurisdictional boundaries, as such an organisational/ interpretive domain carries a certain degree of ‘flatness’ for nurses and midwives. Remaining at that level without crossing the edge of the interventionist, medical domain, nursing and midwifery would have no option for vertical expansion, and therefore there is no solution other than horizontal expansion. Nonetheless, the non-medical occupations have also experimented varying degrees of medicalisation as health technology evolves, which responds to mechanisms of Taylorist rationalisation and delegation of work from one profession to subordinated ones (Dingwall, 2008). This is, in other words, a vertical expansion, which again brings professionals into a competing logic.

Expansion is considered to be an important strategy in professional development. Abbott (1986: p195) explains that if a given profession does not expand either quantitatively or qualitatively to handle the demands of its clients, “it faces invasion from outsiders”. Chilean nursing has experienced a bolder medicalisation over the last decades, taking over responsibility in procedures such as echography, extracorporeal circulation, electrocardiography interpretation, preventive screening tests, and even rewriting prescriptions and extirpating certain veins. Although not at a large scale yet, these roles are often seen as an advancement – alternatively said, “expansion” – but more importantly, they have opened up nursing and left bare areas that had traditionally been a part of the nursing practice, such as ambulance nursing, sterilisation divisions and nosocomial infection departments, with some non-nursing professionals occupying now those areas.

Midwives, in turn, have adopted a certain degree of ‘nursification’ as well as taken on sophisticated medical procedures, placing themselves on the rather interventionist side – they ordinarily handle the female organs, implement surgical techniques, diagnose, prescribe medicines, and certify births and deaths (Ministry of Health of Chile, 2010). This has been referred to in the international literature as “an assimilation phenomenon,” both to nursing and medicine, to survive the earlier vilification from the
medical profession and prevent falling out of the evolutionary technologisation of healthcare (De Vries, 1996; De Vries & Barroso, 1997).

Moreover, midwives frequently work either in the hospital or in private surgeries for independent practice. As a result, the perceived image of midwives in society seems closer to an ideal prototype of profession. This has been earlier reported by Murray and Veraguas (1996, p:99), stating that Chilean midwives have historically been associated with a “parallel relationship to medicine.”

With this in mind, horizontal and vertical expansion becomes as powerful a factor as the divisional nature of hospitals in the analysis of conflict sources. This mechanism is in essence a competition to preserve or enhance a jurisdiction, and as such its repercussions on collaborative relationships among workplace groups need to be appraised thoroughly. Both boundary expansion mechanisms and mutual unawareness may threaten a genuine search for integrated care.

**Jurisdictional conflicts and the struggle for legal demarcations**

Concerning legal delimitation of jurisdictions, nursing’s strategy in Chile has been to monopolise the notion of “care management” (gestión del cuidado), although it is evident that midwives and other professionals perform certain nursing roles and functions. Aside from a historical vindication, it has been argued that the legislation related to this – coming into force in 1997 – is a reflection of society’s acknowledgment of nurses’ mandate and that the aspects in dispute become acts that are “exclusive” of nurses (Milos, Larraín & Simonetti, 2009; Milos, Bórquez & Larraín, 2010). That assumption, however, is ideologically aligned with the nursing stance; it is recognised that the role of nurses remains fairly unknown among the general population in Latin America (Gomes & Oliveira, 2005; Holmqvist, 2009; Samaniego et al., 2011; Zapata & Alcaraz, 2008) and then the self-interpretation of nurses may differ from the constructs associated with them in the social imaginary.

The legal support to nursing may, rather, be a result of the nursing representatives’ ability to negotiate politically, given the nurses’ crucial function in the healthcare reform. Those claims may thus be regarded as a discourse of a persuasive type. Since Chilean nurses have traditionally had a predomi-
nantely biomedical role (Poblete & Valenzuela, 2007), the notion of care management can create a channel for detachment from the medical practice and also for gaining access to hierarchical posts, excluding in the process other disciplines under the umbrella term of “caring sciences.” Inadequately, the laws have been largely utilised to form delimitations between professional fields, rather than uphold areas of conjoint action.

The fact that several occupations provide care and that their responsibility also involves management tasks embeds the inconsistency of those claims on the gravitation of the concepts “care” and “care management” into a single profession. Such inconsistency has indeed been the object of allegations before the Chilean National Audit Office (Contraloría General de la República), a State authority allowed to discern and apply a common interpretation of administrative laws. This organism has ruled that the concepts of “care” and “care management” are wide in nature and therefore apply to several health professions (Contraloría General de la República, 2008). From a legislative perspective, nurses cannot thus abrogate ownership on them.

To illustrate this conflict further, the enforcement of a common examination allegedly aimed at regulating entry into midwifery and nursing practice, by initiative of State entities, can serve as an example. This event caused ardent activism among nurses, reaching media coverage and boycotting the examination, with the argument that the authorities disregarded self-regulation of and disciplinary differences between the two professions. The debate stressed that an examination of this kind strategically targeted the enhancement of midwives’ skills in ways that would reach an equalisation to those of nurses. As a consequence, the Chilean Nursing Association’s campaign underlined that the Chilean Society for Nursing Education had been working in a nursing-discipline-oriented certification, defended as the only valid examination for practical nurses (Castellano et al., 2011).

In the light of the jurisdiction theory (Abbott, 1986), we can interpret from this situation that, insofar as a common examination fed fears of invasion, revoking such enforcement obstructed any possible evidence of midwives’ nursing skills. Our position becomes clearer when contrasted to those stances claimed by the two professional organisations, arguing on one hand an aspiration for illegal incursion of midwives in the field of nursing.
(Chilean Nurses Association, 2012), and the non-existence of an “exclusive” disciplinary training for nurses, on the other (Chilean Midwives Association, 2012). Likewise, a two-year training proposed to midwives to become nurses was firmly opposed by nurses and eventually withdrawn.

Without attempting to prophesy a never-ending dispute, it seems more fruitful to discuss further the nuances of such a conflict, in ways that promote theoretical agreement and inspire a cooperative practice. While the advances in legislation on the healthcare professions cannot take for granted a solution for earlier historical differences, the greatest challenge that midwives and nurses will be facing is the indivisibility of the subject of practice, the human being, long disputed by the caring professions rhetorically.

Social-class consciousness and social mobility

In Chile, most nurses and midwives originate from low and average income families as a result of the rise of the middle class in the late 1970s and 1980s. Recent statistics have shown that only 7 per cent of nursing students and about 4 per cent of midwifery students come from private-paid schools (Ministry of Education of Chile, 2012), those serving the elite (Arum & Velez, 2012).

Identifying midwives and nurses as motivated by helping vocations, in the Chilean society of the early twenty-first century represents a way of thinking more noticeably related to a solidarity principle developed on the basis of performing selfless acts and sharing basic subsistence goods. Helping thus seems to imitate a mutual system of support on which the social relations of low-income families is founded, through which they deal with the financial challenges of unemployment (Happe & Sperberg, 2003).

On the basis of previous evidence (Ayala et al., 2014), we can suggest a sense of class integration and therefore a class consciousness, which opposes that of medical doctors. If this be true, then we can anticipate that one group’s progress will not be well looked upon by the other group, as the middle classes are competing for a scarce resource: social mobility. To many, becoming a healthcare provider in Chile is a chance at upward mobility through which a low or middle-income person may considerably increase employability and earnings (Ayala et al., 2014).
With this social background in mind, one may see nurses and midwives in a rather unfavourable position to reach greater legitimacy, not only for being part of ‘genderised’ occupations – typically below a male-dominate profession – but also for the way hospitals are stratified by social class. As shown in the present discussion, nurses and midwives represent middle-class women and this seems to be at the core of their social identity. Larraín (2001) illuminates these matters, stating that contemporary Chilean identity has been strongly influenced by both social class and occupation. In combining these perspectives, we may claim that nurses and midwives have been an object of systematic omission from the official history, and therefore their sudden appearance in the public sphere has flared up a crisis of identity revealed in the form of an urge for uniqueness and social recognition, developing in the process a class-based competition.

**Conclusions**

In this chapter I have made a case for and analysed the socio-historical development of conflicts between midwives and nurses in Chile, based on two major components that emerged from a reconstructed history, namely the social construction of relationships and the historically disconnected identities, whose consequences on the professional projects are likely to have an impact upon how nurses and midwives interact in contemporary care settings in Chile. The analysis illuminates how a leading example of professional development of nursing/midwifery in Latin America implies a struggle historically constructed.

In using historical data to study a given profession in the contemporary ground, authors usually refer to the turning points embedded in a professionalisation process. However, reconstructing the picture of systemic interactions may more usefully provide a focus for examining the development of the caring professions, as occupations are linked to social-historical transformations.

The analysis of a country’s healthcare system might originate in the following question: How have the healthcare professions been shaped by social-historical transformations? This implies that it is not possible to write histories of a single occupation in isolation of histories of other occupations.
Accordingly, I analysed two parallel occupations, the nurse and the midwife, technically similar, but different through a socially constructed otherness.

As I have elaborated through the preceding analysis, there are a number of reasons that endorse strongly opposing identities between the two groups. It is crucial in any identity construct of two parallel entities that one entity has properties that the other has not. The findings of the reconstruction elaborated presently, however, suggest influential similarities that relate the two professions to one another, namely patterns of enhancement through assimilation mechanisms, an organisationally oriented division of labour, a legally shared domain of care and care management, ‘genderised’ relations, and social-class consciousness. These similarities represent a great prospect for potential empowerment. The differences seem borne out of misconception, and they may rather be a topic for theoretical, disciplinary discussion, one that prevents conflicting reactions in the trade arena.

International discussions tend to bring midwives and nurses working together more than ever before, given the challenges of peoples’ needs and professional understaffing, recognising the commonalities and the various paths for nursing/midwifery professional training. It would be meandering to benefit from the social closure project of the professions – that of professional competition for market and status – at the expense of the necessities for care. Whereas the closure project seems to be preponderant in similar nursing/midwifery tensions in other countries of the region, such as Peru (Arenas, 2012), that quality care can best be met by cooperative efforts has been repeatedly reinforced elsewhere in the globe (Ament, 2007; International Council of Nurses, 2007, 2011; Jasper et al., 2013). We have to entertain the possibility of an eventual fusion of the two professions, an evolution witnessed earlier by occupations such as barbers-surgeons who joined the physicians (French & Wear, 1991; Prioreschi, 2003), a wide variety of technical specialists merging together in a large engineering fraternity (United Nations, 2010), and the legal occupations in the field of law (Clark, 2012). An important part of this analysis will be how the political power of the caring professions as a whole would be progressively enhanced, conceivably focusing on global, comparative analyses.
The time has come: thinking of the system of credentials in nursing

This chapter brings together the notions I have addressed in precedent chapters, such as the social structuring of health organisations and the social closure mechanisms implemented in the making of the nursing profession. Certainly, the chapter evolves out of further engagement with sociological literature and reviewers’ comments on my manuscripts, and as such, it was intended for health sociologists. I examined nursing credentials as an institutionalising mechanism interrogating the notion of medical dominance as a relational pattern.


Nursing in Chile has gained a respectable position among healthcare professionals and enjoys a high opinion within the larger Latin-American nursing community. Begun in the early twentieth century, its uninterrupted academisation process has grown in length, sophistication and diversity, developing an ever-increasing and complex system of academic credentials. Such a system, although often brought into discussion for education plan-
ning, has not been the object of analyses with regards to whether it has led to a redistribution of ‘usable resources and powers’ (Bourdieu, 1984) among professions, and whether such credentials have served to interrogate established ideologies and structures that legitimise traditional patterns of power in organisations.

While the central debate about professional development and academi-
sation of nursing is well documented in the literature, research using empir-
ical data to help advance theoretical arguments is scarce and pays only lip
service to the political influence on professional power building. Of studies
that have been published regarding nursing credentials in Chile, the overall
concerns are academic aspects – the rapid proliferation and content of
degree programmes, and the national standards of quality for these pro-
grammes (Behn, Jara & Nájera, 2002; Rivas & Osorio, 2005; Jofré & Par-
avic, 2007; Castellano et al., 2011). Despite three major works (Urra, 2004;
Jara et al., 2009; Núñez, 2012) devoting some attention to the linkage
between the two concepts – academic credentials and power – one cannot
speak of an actual discursive shift in the scholarly debate. Urra (2004), on
one hand, points to the lack of regulation on paths and requirements for
specialised practice after degree studies, while Jara et al. (2009) and Núñez
(2012), on the other hand, discuss the historical lack of recognition of post-
graduate qualifications in the labour market and recall some underlying
ideologies for the continuous transformation of the nursing curriculum.

The latter is a concern that merits especial attention and is central to my
analysis. Not only are academic credentials a rough indicator of a certain
understanding in a given field and a ‘passport’ for the trained workforce to
access the employment market and clients’ respect and trust; in the deepest
sense, credentials are devices for controlling occupations and appropriating
their wages and privileged positions, and therefore are a central element of
modern social stratification (Collins, 1979; Collins, 1990; Rivera, 2011).
Likewise, credentials symbolise cultural capital – status, standing and power –
and therefore credential holders become not only members of a knowl-
edgeable segment of society but also of professional groups driven by partic-
ular ideologies.

Relationships and relational patterns in organisations archetypally
develop from ideologies. In this chapter I look at what ideologies lie
beneath current patterns of power in nursing, what institutions have been used as legitimation devices, and how these ideologies and institutions have shaped ongoing processes in the making of contemporary nursing in Chile. Behind such concerns lies a central question: Do academic credentials make power shifts possible, and what credentials make nursing thrive?

Drawing on ethnographic data, these concepts are addressed through five major sections: (a) the established patterns of power in the Chilean society and in organisations; b) the struggle for nursing validation in a current scenario of reforms; c) the construction of partnership with bodies becoming allies; d) the structuring of credentials in nursing; e) the attitudes arising from context and nurse training. The chapter concludes by inviting readers to pose a debate concerning the use of academic credentials in shaping ideologies and power relations in the making of contemporary nursing in Chile and elsewhere.

Background

*Established patterns of power in organisational settings in Chile.*

In order to frame the common structuring that shapes organisations as a social and cultural space, Ifirst discuss relevant background information concerning the *latifundio* as a dominant model of land administration in Latin America since the colonial period and the impact it had on socio-political relations.

Not only did *latifundio* have a major position in land tenure, but it also resulted in a model of production and work relations. The logic of *latifundio* was rather conservative: for much of the nineteenth century and early twentieth century, families of landowners kept control of the economy, shaping the political relations among classes in the form of oligarchies.

Nowadays, the *latifundio* model is still considered to be an influential pattern in Chilean cultural identity, namely a *criollo* (creole) traditional identity (Herrera-Sobek, 2012). Most of the population lives in central-Chile, the largest agricultural zone, generating work relationships based on ties to the hacienda stratification (Keen & Haynes, 2009) – landowning families on top of the structure, and campesinos (peasants) or *inquilinos*
(tenants) in lower strata. Whereas landowning families originated in the European-descendant aristocracy in Latin America, campesinos derived from local indigenous peoples and their mestizo offspring, with skin colour being an important trait in determining a person’s social rank (Forment, 2013). Structured as a “microsociety with a social life on its own” (Barr-Melej, 2001) and sometimes perceived as a “feudal society” (Austin, 2003), the latifundio is characterised by verticalism and a ‘sacralisation’ of and, consequently, an attachment to this order, to authority, compliance and obedience to the established structure (Hojman, 2006; Bucciferro, 2012), a principle repeatedly reinforced for generations through textbooks used in official public education on the basis of nationalism (Illanes, 1991; Barr-Melej, 2001).

Although the latifundio in Chile was largely confiscated in the 1960s and early 1970s, its labour-repressive functioning remains at the heart of the cultural and political organisation of state administration and public service institutions, rigid and paternalist, influenced by other organisations shaping cultural processes, such as the armed forces and Catholicism. At a cultural identity level, these forces have meant a strong Eurocentric class and ethnic stratification in the contemporary society at large and within organisations.

**Patterns of power in healthcare institutions.**

Healthcare organisations are not solely service institutions. They are also cultural realities configured around a set of organising values; in our case of interest, those enacting the latifundio’s hierarchical system. Gómez & Rodríguez (2006, p.47) illuminate these matters, stating: “Based on the historical perpetuation of this [latifundio] model […] even with the changes and the process of modernisation of the State, which resulted in the opposition to paternalistic authoritarianism, individuals still seek to establish paternalistic relationships in all aspects of their civil lives, with bosses, union leaders or whoever is considered to have/represent power to them.” In this light, it becomes apparent that the established pattern of power in organisational settings is one of linear subordination logics, preconceived upon a tacit understanding of ‘what this is all about’ – who is ‘above’ and who is ‘below,’
regarding family background, social-class consciousness and ethnic self-ascribed identity.

This relational principle of Chilean organisations is equally embedded in hospital cultures, reported earlier, for example, as the great might of the medical profession (Cerededa & Hoffmeister, 2008), the social-class struggle among nurses (Ayala et al., 2014), and the institutional paternalism towards patients (León, 2008; Myser, 2011). This picture ultimately represents hospital functioning as tied to a unidirectional flow of power and authority.

Given this picture, which could be thought of as an unbridgeable chasm in nursing’s quest for recognition, it is no wonder that an increasing proliferation of universities offering advanced degrees in nursing fuelled expectations among nurses, which in turn was perceived as a promising political platform to challenging and remodelling established institutional structures.

In the following, I will present the methods and findings of my ethnographic study and discuss tensions that consistently surfaced during the ethnography and their linkage with the development of a credential system in nursing.

As the methodology I use has been described in detail in precedent chapters (particularly in Chapter 2), there will not be further explanation in this particular chapter.

**Striving to validate a domestic metier**

Healthcare in Chile has undergone a major restructuring as a result of a state reform begun in the 1980s. Contemporary hospitals now face market constraints in response to pressures for survival strategies, being transferred increasing managerial responsibilities and eventually further self-direction. Such change has meant a highly specialised bureaucratic structure, namely a growing number of high-rank posts and coordination bodies, and a number of goal-oriented control mechanisms. Once a medically centred domain, healthcare now witnesses the rise of hospital management; it is in this new scenario that nurses have seen a potential niche to reach detachment from medical dominance. While this project proved to be appealing to the
nursing community, questions arise about how the nature of nursing might differ outside the vertical, medically dominated conception of healthcare, therefore drawing on a notion other than that of a helping occupation. If this might have driven a significant nursing take-off, where is nursing heading into? What are the underpinning ideologies of the nursing project? Could it possibly hinder the healthcare reform process? How would hospital governability be still conceivable without medical dominance?

*Nurses begin to feel uncomfortable with the bystander role.* Nurse representative.

*There is no such a thing as a divide between curing and taking care of the patient, as nurses want to show. The reality is that doctors know best their patients’ situation and lead the team accordingly.* Chilean Medical Association’s (2013) public statement concerning nursing divisions of ‘Management of Care’ in Hospitals, extract.

In charting the profession’s course, nurses have considered a carefully constructed plan basically aimed at validating their centrality as a connecting piece in the organisation and coordination of services (Ayala et al., 2014), in other words, their domestic metier. This domestic centrality thus becomes of political significance, as medical authority has meant not only technical prominence but also male dominance. As a result, bordering and assigning vocabulary to the nursing organising activity in part represented the legitimisation of a ‘female’ particular type of wisdom translated into a particular set of abilities, modifying in the process self-interpretation and aspiration of nurses:

- *Interviewer:* nurses have more ambitions than any of us thought imaginable.

- *Nurse representative:* yes, but the difference is that our struggle flag is the patient’s flag.

Nurses’ move has then meant to challenge the socially constructed barriers, including ethnic background, gender relations and social class – otherwise stated, nurses’ mobility defies a long-standing social stratification tied to the *latifundio* structuring. Aware of this move that was perceived as a
threat, the Chilean Medical Association (2013) would delegitimise the nursing stance as if reaching high-rank posts would violate the social order of the organisations as much as the cultural expectations on what it means to be a nurse. Such reaction would eventually transpire into the public sphere, depicting an image of nurses as a nonconforming group, whose detachment will allegedly have rather damaging repercussions on the provision of care services and on doctors’, taken-for-granted, leadership.

**Allies: call and response**

I have argued that validating its organisational role has been a crucial move of nursing in its attempt to become a freer occupation, owing this achievement to a number of forces and alliances. While the nursing project has been strongly opposed by medical leaders, the reform scenario has opened up organisations for a rare climate regarding the political history of nursing.

With the State as the grand ally in this process, its rather distant relation with nursing has now turned into a tacit pact of cooperation greatly rewarding for the latter: validation leads to legitimacy, legitimacy leads to rights. Of State entities with importance for the nursing’s political endeavour, two have been decisive in the current scenario: the Ministry of Health and the Legislative Body, one wanting administrative expertise and the other granting authority and privileges in return.

We have reached a number of landmarks in such a short time. First, making our management of care official by law and as a responsibility exclusive of nurses. Then an agreement with the government on implementing high posts for nursing offices in every hospital as a requirement for accreditation. And now this new law regulating nurse education. Yes, we have done many important things.

Junior nurse.

In developing this pact, nurses would indisputably consolidate a substantive growth while learning how to bargain, intertwining on one hand the best interests of public health, and on the other hand their own collective interests. In other words, this is a result of nurses’ awareness of their political significance and the use of power accordingly. The medical community has historically endeavoured to acquire public office in the Chilean health bureaucracy (Molina, 2005), though nurses now enjoy a political renais-
sance, to some extent outranking doctors from key positions and beginning to look at themselves more confidently as a political group pursuing a balance of power.

A second nursing’s ally is the National Federation of Public Healthcare Professionals, non-medical university-trained workers joining forces for improved working and living conditions. In general terms, nurses’ achievements are applauded by that association, as what marries such partnership is the shared aspiration of not fully established professions, those outside elite-ascendant groups, striving for social mobility and symbolic rewards:

This Federation rejects the Medical Association’s claim on the new nursing offices of management of care [...] management expertise cannot be ascribed to one single type of title; non-medical professionals have long performed those roles. National Federation of Public Healthcare Professionals’ (2013) public statement concerning the position of the Medical Association on Nursing Management of Care, extract.

I also identified the formation of a third alliance, which with its clientele, nurturing with it a relation that induces a sense of loyalty towards the profession, engenders legitimation among its audience and establishes a conscious awareness of its powers. Discourses of ethical integrity have indeed arisen over the last few years, those highlighting that nursing’s ethics mandate is to defend the best interests of its patients, to advocate for their rights and to act on their behalf. There are genuine reasons to uphold such a mandate, and that has equally served as an outlet for an implicit alliance, intelligently used by nurses in the public sphere under the dictum: ‘I take care of you.’ (Chilean Nurses Association, 2012, p.39. Emphasis in the original).

These three alliances set a new code of symbolic capital, which surfaces in the form of a shift in the use of nurses’ collective powers. Whether this shift results from the acquisition of further credentials in nursing is unclear at this point, though nurses could significantly shape rules of organisational governance as newer disciplinary developments can be used to wield power.
The structuring of the nursing credentials

Nursing credentialing has not only received the influence of the health-care reform but also that of a major educational reform, both constituents of a larger reorganisation of the State embracing open-economy dynamics.

In the 1980s Chilean traditional, public-oriented universities were affected by budgetary restrictions and administrative approaches. Funding devoted to university education dropped from over 4.5 per cent of the total public spending in 1980 to 2.8 per cent towards the 1990s (Lehmann, 1990), process intertwined with the deregulation and increase of higher institution fares for both public and private universities, and a self-funding/credit policy. As occurred likewise in several other countries in the region, higher-education institutions were then converted into ‘university companies’ (Sotelo, 2000; Cancino 2010) and other non-university institutes and centres, best described as ‘factories of educational goods’ (Donoso, 2009). Accordingly, universities aimed at inserting their brands and building mechanisms of publicity to seduce their targets, which resulted in an open race for credentials for those outside the educated elite. And although non-elite study programmes may be worth between U$3’330 and U$7’930 per year (Ministry of Education of Chile, 2013), the vast majority of the subjects studied at university level have positive returns on the investment (Meller, 2010), with nursing ranking among the top five careers (Ministry of Education of Chile, 2013).

The content and nature of the nursing curriculum have also changed, extending the length up to five years; the latest modifications point to a more theoretically-integrated programme, the introduction of a strong managerial approach to healthcare and research methodologies.

We were told that getting the degree of Licenciado by increasing the number of years of training would allow us to pursue other degree programmes if we so wish, but also to acquire new knowledge to get better positions once graduated. Not many study postgraduate degrees but I feel that training was a good thing for our management role, perhaps we do need to learn more, I don’t deny that, but at least it gave us more confidence. Clinical nurse.

Started in 2005, a debate on a law for university-based education as the sole route of entry to the practice of nursing has recently reached its apogee; although detractors of the law project presented more significant and com-
pelling arguments than those advocating in favour of a nursing ‘universitisa-
tion’ (Chamber of Deputies, 2014), the project was passed by the vast
majority of deputies. This result, so ideologically convenient for the nursing
profession, may well reflect greater abilities of nurse representatives
involved in lobby activity effectively, given the awareness of nursing’s cur-
rent position in the market, without which negotiation could not have been
possibly conceivable. In the political arena there must be agreement on the
values to be exchanged between the parties, along with views on a range of
acceptable concessions that equally protect particular interests. More
importantly, it is necessary a consciousness on the various machination
strategies that each side could eventually implement in a given case sce-
nario.

On the other hand, the demand for nurse postgraduate education has
also changed, though at the level of non-degree practical training (diplom-
ados), noticeably those aimed at management skills, highlighting that
nurses’ core occupational activity might still remain a rather applied field.
The evolution of these particular types of credentials are best explained by
thinking the social processes and mechanisms for expansion of professional
jurisdictions (Abbott, 2010), those areas of work under control, in our case
of interest the managerial detachment of nurses from the curative aspects of
the medical practice. Similarly, requirements from the job market change
over time, demanding more complex skills. Such is the case in which
nursing, drawing on the notion of ‘management of care,’ has placed admin-
istration and leadership at the core of the nursing professional project. Such
differentiation, as relevant as it goes in the socio-political grounds, may be
understood with reference to the concept of ‘social closure’ (Larson, 1977;
Abbott, 1988; Reeves, McMillan & van Soeren, 2010; Evetts, 2013) – pro-
fessions develop market-oriented schemes, exclusionary mechanisms to
gain monopoly control of an area of work, assuring self-interests in terms of
power, salary and status, so as to thwart the interests of competing occupa-
tions. In this light, closure, as opposed to openness, draws attention to the
differences between related professions, with the notion of ‘ownership’ of
knowledge and expertise (Larson, 1977; Collins, 1979; Heller and Wilpert,
1981; DiMaggio, 1982) amalgamating the acquisition of legitimisation and
authority.
Postgraduate degree programmes, however, have not necessarily seen the same fate befall (Jofré & Paravic, 2007). An apparent lack of interest may be enlightened by Collins’ (1979, p.192) view on credentialing: “education is part of a system of cultural stratification [...] the reason most students are in school is that they (or their parents on their behalf) want a decent job;” therefore their interests are not necessarily those of nursing academics, who find in the discipline a way to satisfy their own intellectual appetites. The employment market for master and doctorate holders in nursing remains fairly limited, as they do not seem to be regarded by employers as a valuable contribution to nurses’ skills.

The problem of nursing postgrad schools is that they’re disconnected to the practice and that there is a mismatch with organisations’ requirements, as they need a nurse ‘to do’, not to overthink things. Manager nurse.

A nurse is a nurse, with or without postgrad schooling. Hospital Manager.

These degrees are rather used for mentoring new faculty nurses for the limited number of academic positions; additionally, nursing education is job-oriented and therefore nursing scholars often must combine their intellectual interests with technical teaching. Suffice is to say that this combination usually represents hardship and stalemate, especially in proposing and managing large research projects, and acquiring a researcher identity: a research career in nursing might then begin and end with a dissertation:

Lack of time has been for ages the argued reason – “nurses don’t have time to do research.” Equally, here at the university, nursing scholars have long argued the same. It is my personal belief though that even postgraduate nurses lack confidence to do research autonomously, and even to imagine themselves dealing with complex research projects and large budgets. Senior Lecturer.

Whereas the marketable value of postgraduate credentials is quite restricted, there is a sense in which nursing postgraduate schools have triggered a stronger identification of nurses towards the nursing discipline. Until the 1960s most nursing scholars in Chile had no postgraduate credentials; training expanded into specialities that mirrored the medical specialities (Jara et al., 2009) in ways that fragmented the nursing thinking into the practical aspects of the profession and those values embedded in the paradigm of health and illness. It is in the 1980s when some nursing schools
begin to organise master programmes and in the 1990s doctorate programmes, though their repercussion is still to be seen. Nevertheless, it is believed that they may signify an important influence in the rise of a more critical thinking among nurses, counterbalancing old, tired ideas of precedent currents of thought, those relying on values such as selflessness and abnegation as the driving force of the nurse identity.

**Changing attitudes**

Having reviewed the institutions, processes and ideologies that lie beneath the making of nursing credentials, it is necessary to answer the main topic of concern, that of whether this machinery has served as a means of interrogating old-fashioned patterns of power.

With the Medical Association actively upholding a destabilisation, the major nursing political project – which would allow nurses to become hospital directors – had a rather abrupt end in 2004, an annus horribilis for the nursing community, when the few brand-new director nurses who had only recently taken office were obliged to forfeit their posts, furnishing no consideration for their merits. As one of our interviewees stated:

- *It was all over the press. We all perceived that as a hit below the belt; we didn’t really know those colleagues personally, but we felt so much empathy for them, they represented the end of a long, long struggle of nurses to get rid of doctors’ yoke. It somewhat revived the memory of old strains with doctors and there was some tension in the air. For them, it was just distressing that someone with a rather ‘housekeeping role’ could get the highest position in the hierarchy and be at the helm.* Senior Nurse.

This reflects an old pattern of working relations in hospitals, as explained by another nurse:

- *Some doctors behaved like ‘awful landlords’ and were in fact referred to as such, ‘the patrons of the parcel.’ It wasn’t uncommon that some of them would come up the stairs and, as stepping in the ward, they would shout their head off: ‘Where is the nurse?! Nurse!’ almost as if they were calling their personal servants.* Senior Nurse.

- *That’s undeniable. It used to happen. Some colleagues abused their position time and time again, I know. They played the despot over the nurses. The junior*
doctors now learn that professionalism and despotism cannot possibly flourish together; the one has its roots in our best reasoning; the other grows out of our worst moods. Senior Doctor.

Were the perceived failures of the nurses a consequence of attempting to be a leader in a male-dominated domain? It would appear to be partly so. Healthcare has a longstanding convention on male doctors as fitting hospital boards of management, particularly those building upon their political networks; also, hospitals are usually given the names of former director doctors, which as I tracked back became a homage-paying pattern surrounding the medical patriarchy.

There is a sense, however, in which gender differences cannot be the sole explanation for this conflict. In 2011, after an open call for applications, a nurse would win a tough competition and become the director of one of the largest and most symbolic hospitals in Santiago de Chile; then again in 2012, a nurse would gain a post as the director in another metropolitan hospital. This landmark was regarded by most nurses as both the pinnacle of a nurse’s professional career and a fool-proof demonstration of their political latitude. Shall we consider this event as a turning point in the historical power asymmetries in nursing? It would be unjustifiably deterministic to assume that the reach and impact of nursing credentials are the sole force of nursing’s collective ability, ignoring that other type of credentials may equally contribute, and that individual candidacies rely heavily on personal trajectories and interests. For indeed the two director nurses have in common that both obtained further training after graduation, though not postgraduate degrees in nursing, and that both are male-nurses. To whatever extent gender might have been decisive, the figure of a nurse sitting on top of the hospital board could become a sign that belies common assumptions on nurses’ capabilities.

Despite this political transformation, my observations uncovered what may be considered as a subtle incongruity between discourses which nurses have taken on and the actual relations at a non-political level:

- Why don’t we augment the fluid rate for this patient? – as if the doctor wished to disguise his order in the shape of a request. The nurse, at the other end of the desk, wraps up her duty with a tone of agreement. – Yes! Field notes.
This picture echoed earlier signs I had encountered regarding the interaction between nurses and doctors to the extent that it became a predictable type of working relations: reporting for deciding; dictating for implementing. Relational patterns have changed, and yet working logics seem to remain as a counteracting burden for nurses. It can be argued that this logic only affects the clinical dimension of nursing, though this is its core occupational activity which engrosses a considerable part of a nurse’s day.

All things considered, it becomes evident a change in the way nurses experiment and exert authority and approach the political sphere. This change seems to be influenced in a tangential manner by the emergence of nursing postgraduate programmes promoting new ideologies, a result potentiated by the transformation of the curriculum and the acquisition of extra-nursing skills. Rather than a complete failure, their annus horribilis was perhaps beneficial after all and may well have turned into what nurses where prepared for: the time for a more open attitude towards power.

**Conclusions**

Since the early 2000s a number of publications have revived the discussion on nursing education in Chile. Overall, these analyses suggest the potential impact of credentials on nurse positioning, though lacking explanation on how exactly credentials are used to wield power.

In this ethnographically informed chapter I have explored what ideologies, structures and processes have mediated the development of nursing credentialing, and particularly the extent to which credentials may serve as a means of interrogating those established patterns of power which have historically undermined the nursing profession’s course. Regarded as the leading example of nursing development in Latin America, the setting of the study represented a meaningful case for gaining insights into the nursing profession. By considering credentials as means of social stratification in healthcare, I have looked into the transformations that the country has witnessed, with especial attention to an ongoing State reform.

Established with the colonisation, organisational patterns reflect to a large extent repressive means to maintain an authoritarian rule concerning class, gender and ethnic stratification. The State reform has led nurses to
adopt a more open attitude towards power, often described as a group lacking desire to exercise power.

At a political level, with the objective of transforming the future, there are signs that represent an important rupture with the past. Firstly, by focusing on external social dynamics produced by the State reform, it becomes evident how operationally induced political changes have made an implicit pact possible, through which it was foreseen would garner a greater position for the nurse in the doctor-nurse power interplay. Secondly, the transformation of the State has promoted the rise of hospital management and with it a policy of individual candidacies for high-rank posts, disregarding family ties and elite professional titles. Thirdly, the materialist, technical component of the nursing credentials has moved gradually into a more symbolic, cultural component (Wright, 1998) which, alongside a modification of the curriculum, has greatly shaped socio-political processes concerning upward moves and cultural expectations, process facilitated by strategic alliances. Fourthly, a social closure project has successfully precluded the interests of other professions, such as midwives, gaining monopoly, rights and privileges, and eventually a new code of power for nurses.

While these changes signify advances in the political sphere, observations at a non-political level suggest a persistence of asymmetries, though there may exist a discontinuity of old patterns of relations – although there are discourses of autonomy that might fuel a mass mobilisation of nursing labour force, nurses have not been liberated in the clinical domain; yet we could not expect a completely new beginning despite the manifest ongoing process of renewal.

While some authors elsewhere have contended that nurses’ taking of power may result from a process of liberation from oppression and linear hierarchies (Roberts, 2000; Daiski, 2004), it would seem that this also represents a crucial dilemma for fully-established professions, due to processes of democratisation in organisations and society at large. This argument becomes increasingly plausible when contrasted to the transformation of the nurse curriculum which has espoused larger social reforms opening up organisations for wider representativeness.

Finally, that increasing representativeness in Chile bodes well for non-elite professions collectively and will continue to challenge dominant posi-
tions more openly, leading to rotation in power and ultimately forging a significant transition into more commensurate relations. Irrespective of how consolidated the credential system may be, the perspective of credentialing as a social process offers a unique window of opportunity for further scrutiny of historical patterns of power shaping relations in the country.
On institutionalised expertise: organisation, disorganisation, reorganisation

Most of the precedent chapters developed from revisiting field data and reading the findings horizontally. That is, reflecting on the commonalities among them. This particular chapter however, arose from the missing parts of my writings. At some point, I began thinking of the setting of my research more purposively, and looked at the organisational transformations and the intertwined dynamics of profession-making. And that is what it became, an article that helped me tie up the previous ideas more tightly.


This chapter brings the organisational setting of health reform to the foreground. Most of today’s healthcare practitioners perform their activities in organisations, and yet as researchers analysing professional development focus more on professional roles and tasks in isolation of their social envi-
environment – meaning organisational landscape – they neglect the organisational functioning shaping profession building.

Drawing upon ethnographic data and institutional documents, I examined the process of institutional change within the hospital dynamic by looking at what demands and supplies take place in the actor-environment exchange and how coexisting interests shape ongoing processes of modernisation.

While health reform is commonly considered an economic and technical process, I suggest that a parallel social process is evident in the approach of internal organisational dynamics. The chapter ends with a discussion on organisational culture and organisational capital as a focus for further understandings on professional development and the application of expert knowledge.

Most actual professional work in healthcare is nowadays performed in organisations. While healthcare organisations have served as the setting of numerous analyses about professional development, researchers have focused disproportionate attention on professionals’ roles and skills, placing the organisation as the mere ‘background’ where activities occur. Professions and organisations have, in fact, been researched in two separate traditions. Not only do organisations exist on the basis of technical tasks coordinated to obtain expected ends, but also of social relations among the actors intervening in organisational processes. Organisations become interacting environments where varieties of interests coexist and such environments are shaped by social forces with reference to those interests.

By bringing the organisational background from back to front as the main focus of the analysis, that ‘landscape’ (Abbott, 1991) in which social actors have ecological exchanges, among them and with the landscape, I uncovered further nuances of the dynamics of institutional change. This chapter puts in perspective the ethnographic data through my working experience during a reform period, in which I look at: a) what supplies and demands take place in that actor-environment exchange, and b) how coexisting interests shape ongoing processes of modernisation – or, rather, reorganisation – of hospitals. I address these concerns through three major areas entitled organisation, disorganisation and reorganisation. The chapter concludes by posing a discussion on health organisations as embodiment of
social processes and cultures, and how disorganisation-reorganisation developments may contribute to the application of expert knowledge, qua organisational capital, in the continuous transformation of both the professions and the organisational landscape.

**Methodological note**

Again, in order to avoid content repetition, most methodological details will not be provided here. And yet, it is important to add that alongside the observation process, field research involved reflective engagement with workers, ranging from porters and clerks to clinical professionals, sharing some practices in their day-to-day activities, taking notes, interviewing, having casual encounters, and analysing and questioning the data.

At an early stage, my assistant and I had to deal with multiple negotiations to accessing the sites, as the personnel were changing from shift to shift. Also, this setting had not often been an object of ethnographic analysis, so that it appeared difficult for the participants not to regard the observation as a form of supervision or assessment. This idea tended to disappear as the study progressed and more rapport was established. Assuring that the content of both observation and interviews would be confidential contributed to participants’ willingness to participate.

**Organisation: the hospital stays afloat in a social sea.**

A hospital can be understood as organised flows of specialised work: stretchers are pushed here and there, carrying patients, crashing into and going through restricted-access doors, heart monitors beep, blood samples are taken away, papers are printed, signed and archived, telephones ring. Voices, rings and beeps mingle into a constant background noise, the noise of work comprising a large number of complex activities coordinated timely in a year-round occurrence on a twenty-four hour basis (field notes). Their unifying feature is that they are organised. Coordinated action is the principle of how users can have their injections injected, their records written, their wounds dressed and their tumours removed. Any interruption in these flows might threaten the provision of care.

Those activities, however, do not occur by their own technical dynamics. *Hordes of personnel rush into the hospital near 8 o’clock to register arrival on a...*
What may seem bordering on chaos in the hallways in reality is a part of the day-to-day hospital routine – in a matter of moments, they leave the changing rooms wearing uniforms and head out onto the wards to relieve the night staff. The demeanour of some groups contrasts to that of others – the doctor has the walk of a cavalier, stately in the centre of the main corridor, the matron that of a strict housekeeper overseeing activities, and the nurse that of a busy maid. In nursing stations auxiliaries murmur at a supervisor whilst going over union pamphlets. My impressions as field researcher lead me to the view that it is here where most of their social disputes are put up, that the organisation has symbolic relevance for the professionals working here, and that their interacting dynamics are as much technical as they are cultural, with this cultural dimension becoming the driving force of organisational life.

Workers come to the hospital not only to do the work they do. Most also pursue a career, which itself is “a repository of social forces or social choices” (Clegg & Cooper, 2008). Professionals, in particular, perform skilled acts in exchange of recognition, status and wages, creating as a consequence collective connections, affiliations, influences, tensions, competitions and struggles.

On the other hand, as a bureaucratic structure (Gourdin & Schepers, 2009), the hospital assigns each actor an ‘office’ (Weber, 1982) circumscribed by instructions and attributions; in other words, rules. Though, things work in the way they do, not simply by virtue of the existence of rules, but mostly because those who work share a tacit agreement on conforming the rules, creating in the process interdependence, stability and certainty.

Moreover, hospitals are among the largest public institutions in the country. They have often been regarded as slow-responding organisations, the icons of public service’s senile lassitude, best described through the metaphor of ships as a heavy Titanic, difficult to alter direction quickly and stay afloat when challenging obstacles arise, as opposed to nimble and light sailing boats; those sitting on boards of management would inevitably either be desperate for not having actual control over the helm or simply resign themselves to do ‘as much as and when the circumstances allow them to.’ What turns the organisation into a heavyweight ship seems to be
embedded in historical cultural practices: groups’ interests and willingness (or lack thereof) to change, along with a longstanding belief which holds that, once acquired, a job post becomes inexpropiable (Blöndal & Curristine, 2005). As a result, the organisational culture grows rigid, characterised by irresponsiveness to challenges for improvement, heavy reliance on either family ties or affinity between groups for internal functioning (Abbott, 2009), and a restricted interpretation of one’s own scope of practice due to the limiting factor of red-tape on innovation.

This is not to say that a hospital is a monolithic entity, nor is to say that it is an ordered system as such. By unravelling its organisational dynamics, the hospital scene, as constructed culturally, becomes a perpetually changing flux moving along various paths. While technical and social activity may inform one another in ways that define the organisation’s own interior logic, the counterbalancing effects of their forces seem to keep the system stable.

And yet, whether a setting with such characteristics could eventually avoid the ‘Titanic’s fate’ with a ‘reform ahoy’ is at this point in the analysis unclear.

**Disorganisation: reforming winds blow**

The announcement of a major State policy reform in the early 2000s was alarming news – politicians were determined, health workers on guard. This frame aimed to drastically rearrange hospital organisation, which triggered a politically inflamed confrontation, unleashing an apparent disorganisation – otherwise bureaucratic irrationality (Weber, 1947; Hummel, 1994) – of hospitals.

Part of that rearranging sought universalistic health coverage. Universal coverage, however, would interfere with a consolidated private health insurance market, encountering strong resistance among conservative sectors (Lenz, 2007; Pribble, 2013) and certain professional groups. Lenz, as well as Pibble, suggests strong political ties between the medical profession and the Parliament, exerting fierce opposition towards the reforming initiatives along with collective activism and a media campaign aimed at reaching support from the general population. Having said that, it is important to recall a divide between professionally minded and scientifically minded doctors, as their scientific societies had an active role advising the government (Lenz,
Not only did this process create an atmosphere of public distrust, but also one of internal uncertainty and inadequacy in organising care.

Another crucial part of the rearranging was the modernisation of hospital management, historically criticised for its amateurism and ineffectiveness (Lenz, 2007). Aside from the introduction of specific management training, thinking of the future of the hospital strategically meant posing some basic questions across the institution, such as: Who are we? What do we do? What are our fundamental values? Where do we want to head into? These questions, though necessary, uncovered a wide range of interests across organisations, highlighting an ideological fragmentation and representing a significant impediment to embrace the reforming spirit timely.

Medical doctors, on one hand, feared to lose control over a system they consider must lead, and perceived the remodelling of the sector as a threat, given the participation of elite doctors in the private healthcare market and the way the new policy sought to redistribute resources and impose algorithms and deadlines. Hospitals were, in fact, used to continue to perpetuate medical dominance over health problems, advising patients not to support the State’s initiative and adopting an apparently indifferent attitude towards change. Their actual position, however, would be later revealed in mass mobilisation ad persistent industrial action as the reform progressed.

Other health practitioners, on the other hand, would welcome a number of commodities (Abbott, 1991) – in the form of guidelines, protocols and high-tech equipment – which anticipated would enable to apply knowledge and judgment dispensing with close medical control, reviving as a result a persuasive discourse of professional autonomy. This new scenario would also encourage a moral rhetoric holding that, unlike doctors, their mandate was to protect their patients’ interests rather than their own. The organisation, conversely, became a platform for their political action and a channel for voicing historical claims of vindication:

“We are determined to get the recognition gap bridged. We know, and society should know, that our function in hospitals is absolutely indispensable. Recognition and respect for our autonomy is, at least, what we deserve.” Nurse representative.

It is still possible to identify another exchange, that of blue-collar groups, chronically excluded from politics and decision-making processes
(Grossman, 2005; Arthur, 2008), aiming at taking more responsibility in organising care, for technological evolution would inevitably cause an increasing delegation of technical tasks:

- Auxiliary representative: Our struggle ain’t over. Since 2007 we’ve been presentin’ our demands for legitimation of our new roles in the reform to get rewarded accordingly.
- Interviewer: you, guys, have more ambitions than any of us thought imaginable! (laughs).
- Auxiliary representative: We hate to be bystanders. Like I said, mister, our struggle ain’t over.

A third important part of the reform considered the redistribution of authority, by which was meant that newly created national entities would now oversee and inspect health processes and results, while healthcare services should just act as care providers. In a sense, such division also had an effect on the internal hospital logic, as one of the organising principles, as well as a representation of symbolic power, is the notion of ‘who reports to whom.’ A change in vertical flux of reporting would then attenuate medical dominance, but also create internal confusion.

“That was a chaos [sic]. Things were really messed up and nobody seemed to have the answers. What was written in the guidelines seemed to find no place here. Doctors were responsible of admitting the patients into the new programmes, but they didn’t do what they had to; they just didn’t want to; many lost their rights because of that. We sent reports regularly to the coordinator of each programme and we were requested to... force things silently, such as filling the forms ourselves and persuading the doctors to sign them. Now I take a look back and I simply can’t understand how we’re able to overcome such a torrid chaos.” Senior Nurse.

The greatest challenge was the apathy with which doctors regarded the reform, advising not to use new guidelines and algorithms that would allegedly support patients’ treatments throughout the course of priority illnesses. How could an old, stagnated ship keep afloat, given this setback from within? How crucial a resistance may medical opposition actually be for managers to keep control over the helm and make the reform thrive?

Doctors’ apathy contrasted to nurses’ optimism, for instance, who took over increasing responsibility in office work, whose centrality in domestic
aspects of the reform would eventually inspire a sense of white-collar status rise, away from the patients, delegating most direct care to nursing auxiliaries (Author, 2014).

While office work meant a larger number of professionals reporting to nurses, the emergent implementation of new care programmes also opened an entirely new window of opportunities for other non-medical professions intending to validate their participation in processes definition and control. What is relevant to emphasise here is that those professional groups’ interests would conflate technical control with social control, as their centripetal role in a period of inoperative fragmentation and distrust – for want of a domination apparatus – would garner higher recognition within this new scenario. Extra-organisation interests reflecting a wider social movement (Arthur, 2008) indeed unfolded as fieldwork progressed and tracked back the different professional groups reporting the upheaval of the process to external parties (Arthur, 2008), such as their respective professional associations and trade unions. These associations, in turn, endeavoured to introduce their political agenda in the government board.

By using the organisation as a cultural platform for political interests, organisational changes bring non-medical staff to the front line and with them a fresh “disruptive potential” (Parkin, 1979; Wrong, 2003), for suspending their activities could bring the system into a halt, whereas medical professionalism and altruism appeared to experiment a status downward while being questioned by both State and society at large, as expressed by the now ex-Minister of Health:

“*Their attitude separate medical representatives from society, affecting their credibility*” (García, 2004) Public statement, extract.

In the middle of all the hustle and bustle of the social movements in action, it becomes evident that while the professionals supply the organisation with technical wherewithal, those same supplies were used as bargaining chips (Burstein et al., 1995) for their collective interests, scheming how to seek greater rewards as confusion and distrust grew (Seo & Creed, 2002). The organisation, in turn, suffered the strains of a ship that has just collided with an iceberg on a foggy, moonless night.
Reorganisation: stronger hands hold the helm

Having reviewed the labyrinthine imbrication of a ‘cultural reform,’ it is necessary to discuss whether the denouement of this process lead to the re-stabilisation of the system’s functioning.

Nurses and other professionals continued to attend training sessions on the functioning of the new processes and how to respond to patients about the effects of the reform. Meanwhile, doctors had private gatherings ever so often:

“When people begin to murmur instead of actually talk, you know there’s something going on out there. And then you see them all getting themselves to the meeting room behind closed doors. No premonition was necessary to know something was being plotted.” Senior Nutritionist.

While there was a general optimism about imagining a new hospital order, that optimism seemed to vanish in the wake of a medical strike convoked by the Chilean Medical Association across the country towards the end of 2002, and then again repeatedly in subsequent years, claiming that a reform of the sort was untoward and awkward (Lenz, 2007). It was not until several years later that it would be demonstrated how the medical profession’s claims had been disregarded by the legislative body, commanding to proceed with the reform as planned, at both organisational level and bedside level. That intervention, which came to be known as ‘a process reengineering,’ may well be considered as a defeat for the reform detractors.

The field setting, as most major teaching hospitals in the country, was then rearranged by ‘responsibility centres’ which would provide more accurate and trustworthy accounting on hospital managing, diluting medical specialities as its organising principle, which focused on rather curative aspects alone. In spite of internal resistance offered by dominant groups, the progression included a two-pronged external intervention aimed at altering the organisational regime – one up-down legal instruction imposing procedures and deadlines, and down-up exigencies from the citizens, empowered by media advertisements promoting rights and benefits, reported elsewhere as monitoring performance of public services (Milewa et al, 1999).

Even though analysing the technical, therapeutic side of the rearranging is not pertinent to the present discussion, it was noticeable a decentralisation of decisions along with the establishment of coordination mechanisms,
often supported by fresh clinical personnel brought from the private sector serving as consultants.

Throughout the process, non-medical groups learnt how to adopt less attention-getting strategies for their purposes (Creed, 2003; Arthur, 2008), possibly because strikes may feed fears of invasion from competing groups – overlapping roles among healthcare workers often threatens one profession’s specificity of function. Lacking a domination apparatus and discarding the choice of a forcible progression, they had no means other than adopting persuasive and manipulative tactics to handle their environments, which would eventually lead to an internal balance. The dynamics of modernisation have thus meant the deconcentration of authority and a redistribution of collective power (Davis, 2003; Scott, 2004) with formal organisational training outranking mere seniority (Abbott, 1991).

According to my observations, most ‘dos and don’ts’ in an organisation still refer to the existence of social processes, which in turn reflect cultural expectations of the organising. Similarly, the existence of numerous restricted-access doors is explained at times technically but most times symbolically. While I would have expected this when attempting to reach high-rank executives and elite professionals, I witnessed something unexpected, as registered on my field diary:

- Observer: May I speak to the physiotherapist, please?
- Secretary: But… who are you?
  (She looked surprised, as though I was breaking an unwritten rule).
This evoked earlier situations in the wards, witnessing a newer authority structure in action:

- Observer: Could I possibly talk with the Ward Nurse, please?
- Auxiliary: With the Ward Nurse? You ought to wait until she has time – The dryness of her tone contrasted to the air humidity.
- Observer: Then, may I see the Shift Nurse, please?
- Auxiliary: She’s busy now – Her tone became dryer.
- Observer: She knows me.

- Auxiliary: Okaaay, I’ll let her know you’re here. What’s your name? – She came back after a while accompanied by the nurse who kissed me welcome. The auxiliary looked at me apologetically.
While mapping the use of organisational space (Arthur, 2008), it becomes evident that less-qualified workers act as ‘doorpersons,’ separating those who can access the professionals from those who cannot, and at the same time being exposed to the public; otherwise stated, separating those who are ‘available’ to ordinary people from those who are not. In my example, these restrictions referred to the new power investiture of non-medical professions, consequently to a redistribution of ownership and function of organisational spaces or, rather, ‘spatial hierarchies.’ The centrality of professional paper work has indeed become key in upholding organisational order, which now consumes a great proportion of some professionals’ day, as earlier reported by Jervis (2002). This redistribution reflects the abandonment of some spaces, such as the patient rooms, favouring the adoption of new symbolic territories, such as offices and desks; such is the case of nurses, whose role has become highly organisational rather than patient-centred, as earlier reported by Allen (2007). Again, this is an indication of how changes in the organisational culture shape the landscape that social actors inhabit.

Through the disaggregation of this titanic journey to a modern hospital, one can fruitfully appreciate disorganisation as an essential requirement for further progression, and how social processes are translated into manoeuvres, explicit or subtle, within social movements, but above all into an ‘organisational capital’ (Abbott, 1991) that makes the application of expertise more effective. Healthcare workers, and particularly professionals, have not necessarily adapted themselves to the environment but rather adapted the environment to their necessities and aspirations, and in the process prevented a reform from becoming the deadliest disaster in the history of modern medicine in the country.

**Conclusion**

In this ethnographically informed account, I analysed the history of a specific aspect of the health reform process as constructed culturally by professionals across the organisation of a hospital. Although I have used a major change to develop my argument, it may well echo other minor-scale
changes and thus be useful in the understanding of gradual changes in organisational cultures.

In studying organisations, researchers usually refer to a static snapshot and its internal structuring using linear logics. However, analyses of what an organisation becomes rather than what it is (Scott, 2001) may more usefully provide a focus for understanding change as a cultural process. Accordingly, I have disaggregated the transformation of the internal organisational structuring (Abbott, 2009) of a hospital and the exchanges professionals have among them and with the organisation itself.

As shown, ecological interactions account for adaptation processes in light of the interests and aspirations of different occupational groups mediating, in turn, in a necessary disorganisation. If state policies are regarded as purely economic and technical in intervention, the analysis would then consider action and skills in a vacuum, overlooking crucial coexisting elements in interactions, such as affiliations, influences, competitions and struggles. This focus may indeed uncover a more nuanced picture of organisational regimes.

Professionals seeking status and rewards are key in reforming internal logics, therefore it would be misleading to consider their involvement in the process as a result of a moral credo alone. Grounded in the research data, their progress is in fact negotiated in exchange of a stronger identification towards the organisation, while established groups may risk an under-identification (Stiles, 2011). This analysis illustrates how the reorganisation in the practical arena has not necessarily been patient-centred, but rather politically centred, with institutional cultures shaping roles and struggles. By rethinking the organisational change in light of professionals’ interactions and interests, the gap between the two separate traditions will become narrower and in the process offer a more coherent picture of organisations.
For any researcher interested in the functioning of a profession, a series of articles may be easier to evaluate than the series of consequences arising from the profession’s behaviour. As a response, I have attempted to depict via a rare analysis a vivid picture of the nursing world in Chile and the continuing socio-political transformation of its profession building. With certainty we may assume that, far from being finished, such transformation is an ongoing process.

The initial research question was simple, but resulted in complex ones as to complicate the analysis further and understand entwined dynamics of the nursing profession. The systemic theory of the professions (Abbott, 1988; Abbott, 2001; Abbott, 2010) enables to explore the ecology in and through which an occupation builds itself, in this case the nursing occupation, conceptualised here as a research field – the field of sociology of nursing. In light of this theory, one can identify exchanges with the environment and relationships among the system components, making up an interacting setting where the constituents parts have mutual implications. This is not to say that a profession’s course depends solely on that of other professions,
nor is to say that it relies exclusively on its own internal forces; it depends equally on the social forces intervening in the system, becoming clearer that profession building is not a profession-centred phenomenon. Rather, there are parallel forces shaping and reshaping the professions.

Abbott’s perspective informed the research questions I explored in each chapter, and structured the data gathering process and the way I approached the data. His theory is revelatory in the course of the sociology of the professions, and it may account for most problems arising from interprofessional competition I was interested in. Parsons’ (1950) seminal work claimed the social construction of the ‘sick role’ in the functionality and effectiveness of the professional-client relationship, while Freidson (1970) underlined the professions’ attainment of extended training to master esoteric knowledge and language, and the dominance of some professions in the labour division, while Larson (1977) illustrated the professions’ conquest of status through that knowledge, becoming “naturalised” power-centred, organised groups. More generally, Abbott’s idea of jurisdiction comes to expand notions such as internal dominance and exclusive power, highlighting interprofessional relations as an evolving arena of permanent boundary dispute, not in a metaphorical sense but in reference to actual work. That actual work defines a permanent jurisdictional contest implies that change is the fundamental force of the system. This is a shift from a structural-functional perspective (a basic picture of society as an orderly, stable scheme) to a social-conflict perspective (highlighting inequalities, and conflict as necessary for social change) I discussed in Chapter 1 with some adaptation for a nursing audience.

Nonetheless, some theoretical adaptation was necessary as the research process progressed, in the belief that combining it with other concepts would enhance the analysis of this particular case. Among these concepts were, social reproduction (Bourdieu & Passeron, 1970), social class (Wright, 2005), gender relations (Davies, 1995; Adkins, 1995; Davies, 2004; Acker, 2006), academic credentials (Collins, 1974; Collins, 1990), Chilean social identity (Barr-Melej, 2001; Larraín, 2001; Keen & Haynes, 2009; Herrera-Sobek, 2012) and social closure (Larson, 1977; Evetts, 2013), which converged in the systemic approach where I positioned myself.
Building on this theoretical positioning, I elaborated on the internal and the external boundaries of nursing, the strategies it develops with regards to the interaction with environing groups – namely the auxiliary nurse, the medical doctor and the midwife – as well as the areas in which political action takes place, and the devices, strategies and alliances utilised as a means of strengthening the profession. As illustrated, the nursing profession is shaped socially to a very large extent by the ever-changing setting and by the professions ‘out there,’ though it also imple-ments its own strategies to manipulate its environment, both technically and rhetorically, with a view to defend its particular interests from outsiders. By bringing this systemic interrelatedness to the fore – highlighting landscape transformations, internal logics and interprofessional contact – it becomes evident that nurses’ behaviour is heavily regulated in nuce by unwritten rules and that those rules become crystallised in ‘a code’ as nurses are socialised into their professional culture. Of utmost relevance, this nursing code becomes the core element of the profession’s social-closure project, one that enables monopolisation of opportunities and resources as well as exclusionary mechanisms to control its power base. Nurses’ profession building seems in fact to be equated with a socially constructed apparatus which would ensure increasing symbolic rewards.

In this chapter, I conclude by presenting the study’s contribution to the field of sociology of the professions in Chile by drawing upon the findings of the present case analysis. There sure is much to say about the technical transformation of nursing; though the development of a profession is as much technical a process as it is social (Abbott, 1988). Here I focus on its transformation as a social process. The conclusions are four-fold:

(1) The system and its changes – which I refer to as landscape and landscape transformation – being idiosyncratic to this particular case, have opened up room for how nursing developed in several ways, challenging the nursing profession to display sophisticated adaptation abilities as to remain within the evolutionary loop of the healthcare system. As I flesh out below, this conclusion questions earlier approaches to the professions in Chile.
(2) The internal functioning of nursing as an evolving species has successfully functioned as an adaptive whole with regards to landscape transformations through a social closure project. Whereas nursing has progressively been concerned with its name and reputation, it has also pursued a monopolising contest for highly-valued symbolic attributes, obstructing in the process what may threaten its prestige, including elements associated with nurses’ social background.

(3) The types of interactions with other constituent parts of the system (mutualism, ammensalism, commensalism, predation, etc)

And (4), the ability to adapt to landscape transformations is complemented by an ability to manipulate the landscape. These abilities seem grounded on a larger mechanism of professional functioning, best understood as an ideological device. While Abbott might regard this device as internal to the professions, it is useful to conceive it as a specialised medium between the adaptive unity and its environment – as with many actual living beings, once reproductive structures have been broadcasted into the environment, they serve as a communicating means between it and the originating being, carrying encoded information for propagating the species.

Insightful on their own, the conclusions of this research may well illuminate the understanding of other professional groups in the same locus and in comparable ones. If the functioning of a given occupational system may mirror the traits of society more broadly, then the acting bodies of other systems may be mapped with reference to these patterns found here.

1. The system and its changes: landscape transformations

Changes that are external to the professions may be analysed with reference to what Abbott (1988, p. 91) named “external sources of system disturbance.” It may be meaningful to treat these changes as both landscape transformation and changes in the immediate ecology of the profession’s settlement – whereas ecologies seek to reach a balancing point and are diversely researchable, landscape transformations tend to be cumulative over time and can thus be traced historically.
Technological and socio-political particulars have been extensively discussed in Chapter 4 as sources of system change. Historical frictions between midwives and nurses escalate to overt disputes for jurisdictions periodically, disputes intertwined with an increasing technologisation of healthcare unchaining an assimilation process, both for skills and for status – horizontal expansion. Likewise, that process of technologisation has opened up areas for nursing to advance into various medical jurisdictions, as well as into an increasing managerial domain – vertical expansion.

What I should want to emphasise here is that, insofar as nurses seek steadily new ground, they become more and more vulnerable on ‘rearguard’ areas, likely to be occupied by other occupational groups, such as auxiliary nurses – a firm referential group for identity formation through detachment – whose training also goes hand in hand with technological changes. Coupled with a continuous process of delegation from one profession to subordinate ones (Dingwall, 2008), this ‘disturbance’ may well prompt major evolutionary adaptation within the internal structure of the system in the coming decades, if they are to continue to evolve into the same direction – nurses becoming either physician assistants (inexistent to date in Chile) or healthcare managers (also inexistent), or both; and auxiliary nurses becoming actual nurses.

On the other hand, a new socio-political ambient has risen over the past thirty years, in the midst of a State reform and, as I have noticed, in the subsequent restructuring of healthcare organisation. The adoption of a market-oriented scheme for public services, an accountability approach to public administration, universities’ widening educational offer to achieve self-funding, all three come to open a unique window of opportunity for nursing and other professions, and, with it, a newer political consciousness emerging from this scenario (Chapters 3, 5 and 6). Whereas landscape and ecosystem give professions opportunities, progress comes from utilising them judiciously.

Natural and cultural particulars. Evident (mostly) natural changes, be they physiological or epidemiological, have not been explicitly addressed in this work, as it would inevitably lead to a technical analysis, and they can certainly cause changes in the nature of a profession’s scope. That is where my expertise ends, however.
Cultural factors, nonetheless, have very much had repercussions for the professions. As discussed in Chapter 5, the socio-political order shaped by ethnic backgrounds, with European ascendancy and appearance as a mark of social rank, permeates relational patterns. Hence, verticalism becomes an organising principle of social life as much as it connects professional groups with one another hierarchically, a relation amalgamated by the masculine, normative influence of the armed forces and the Catholicism. These synergic forces might lead submissive groups to either prolong the status quo of domination or to engender a competing sense of status elevation, such as the class struggle illustrated earlier in this work.

In this case study, nursing has benefitted from an increasing awareness of women as subjects of work, along with the rise of the middle classes, the success of the healthcare ‘industry’ – with demographics undeniably playing in its favour – and an open market of academic credentials. These cultural threads fuel an active questioning of established relational patterns, although inequalities (Chapters 2 and 3) are yet far from being bridged. It may be anticipated, however, that this increased consciousness will lead to an increased conflicting interaction among interest groups, with negotiation abilities becoming key in change processes.

All in all, it becomes clearer how landscape modifications mediate in the expansion or contraction of jurisdictions, beyond any spacial or functional separation between an area of work and society at large. However loose this mediation may seem on the surface, it helps understand that even seemingly stationary occupational fields are in fact dynamic, and, importantly, that they evolve as their environment evolves – one mechanism of this co-evolution is by facilitating the creation of new species of occupations; another, by challenging pre-existent ones.

These conclusions bring the understanding of the professions in Chile to a whole new level of awareness, and their theoretical value lies in this incremental contribution. The mainstream thought, disconnected from current debates, takes for granted that the development of a given profession is ought to a common pattern of professionalisation, and that through that process each profession evolves independently based on its institutional form. This work may thus remedy that defect in the sociological thinking in Chile.
Applications of this “landscapal” perspective are rarely seen outside the English-speaking world, and this work based in Chile suggests theoretical compatibility for studying the functioning of systemic environments for the professions elsewhere. This compatibility may be explained mainly by the liberalisation of the economy allowing an indiscriminate number of professions to self-regulate, and the mutually-fuelling pairing of self-regulation and the access to ever-expanding entryways for advanced degrees. It is thus anticipated that other systems in the Latin-American region may not bode equally well for nursing, in which nurses would need significantly more sophisticated strategies to incorporate their professional agendas into the political discussion. Charting the futurity of the healthcare system, for example, may offer critical junctures for that.

2. The internal functioning of nursing: evolution

Although purposefully focused on interacting aspects, my research devoted some attention to the internal logics of the nursing profession. And yet, it was not its structure or its traits that I should account for, but rather the mechanisms with relevance to its ecological functioning. In this section I substantiate on how nursing has successfully adapted to landscape transformations, mainly through a monopolising process of closure. Its particular ideological device I referred to earlier on will be discussed separately in Section 4.

First, the increasing process of academisation of nursing education (Chapter 2) may be regarded as platform to propel development and reputation. Begun as an apprenticeship model in the early twentieth century, nursing education has grown in length and scientificity, with abstraction as the landmark of the profession’s control of its knowledge base. By controlling its knowledge base, nurses have developed new skills, matching the continuous evolution of the healthcare system more broadly – advanced medical techniques to face medial scarcity (Chapter 4) and managerial skills that eventually put them in a good position to run internal process of change in the wards and climb into the health hierarchy (Chapters 5 and 6).

Expectedly though, this academisation process cannot be regarded as a purely technical one; it has served to strengthening symbolic aspects of the
profession, fuelling in the process the claims of nursing’s professionhood. Also symbolic is the component of nursing credentials being prompted through the relatively new postgraduate programmes in nursing, which has led to aggrandising allegations of a unique contribution to society, for they always seem to promise something impossible – the satisfaction of human needs from a holistic biopsychosocial approach to healthcare.

Rules can exculpate, however. We now know that professionalisation may be discarded in its most elite sense of identity superiority, that of a gradual progression of an occupation’s course from a simple craft to a mark of social lineage. Most today’s occupations require esoteric knowledge and skills, and may thus be spoken of as professions. Then nurses’ sense of status elevation may be justified by a larger phenomenon of labour complexity as society gives rise to a necessary ‘professionalisation’ of the qualified workforce. Similarly, aggrandising claims are a common resource used by the professions in different degrees by conceptualising an area of work and constructing solutions rhetorically; just as artists assuring to bring people into enhanced sensory experiences, and gigolos fantasy into the realm of possibility. By this token, professionals induce in their audiences a sense of loyalty and exclusivity, one that legitimates the profession-client relationship. However, that academisation works as a factory of social differences based on the eliteness of the (so-called “real”) professions, and of vilification of the excluded needs to be critically interrogated.

Secondly, and this is not exactly to take a look back to the old notion of structure, I shall revisit the internal organisation of nursing, as it enhances and indeed consolidates the profession’s jurisdiction as well as the understanding of its relations with the environment. Important from an ecological perspective, I noted that levels of organisation of biological species (Stearn & Hoekstra, 2005) may apply to professions as social species: separation, cohesion, hierarchisation, ancestry, and distinguishability. In fact, nursing’s evolution seems to me a textbook progression:

a) Separation: or speciation, the formation of a profession as a new species, different from others regardless how, originating in a critical juncture that gives rise to a bare area of work. Nurses in fact tend to construct discourses of differentness that, ultimately, refer back to the contradiction embedded in their raison d’être: “We do something that the rest do not, and
we do it differently”. While separation organise the profession around what it is and what it does, it is often encompassed by moralistic mandates, creation myths or other rhetorical constructions of “someone above” (Dingwall, 2008) who underlines separation but guarantees cohesion.

b) Cohesion: By no means can separation go without cohesion. Clearly, that is a concern. Nurses very much fear for their internal cohesion. Suppressing conflict and stressing a sense of class integration prevent internal split from occurring, regulating internal order and ‘protecting’ members from rebelling and drifting apart. While conflict suppression homogenises the group as to interact with similar ones safely, especially in early stages of separation, it raises its standards of internal organisation as to align – as consistently as they possibly can – their interests in appropriating symbolic rewards with their promises of high standard performance. Cohesion thus makes the profession more efficient both technically and socially.

c) Hierarchisation: While nurses are busy suppressing conflict, they are far from suppressing behavioural patterns that lead to hierarchy formation. There is a sense in which nurses have escalated into the hierarchies, gained a more respectable position as their training evolves, and enjoy a closer relation with doctors (at least one disguised in that form; Chapter 5). Internal logics, however, seem to remain very much attached to old forms of hierarchies – not flatten, but they certainly reproduce relational patterns. Such is the case of the pattern through which university-trained nurses and auxiliary nurses have continued to be estranged, ever since they first interacted (Chapter 2). Another example of nursing hierarchisation is the asymmetries among nurses depending on their social background. In both examples, however, the socially constructed otherness seems to be more social than technical, with closure as a mechanism of self-validation. The pattern resembles that of the doctor-nurse relation in the old days, where the oppressed group strived to gain legitimacy for its knowledge and practices. It is thus reasonable to infer that university-trained nurses have come to occupy the position of their former oppressors.

d) Ancestry: Of considerable help can be the knowledge that nurses’ linear ascendency becomes a multiplication mechanism of culturally transmitted values. Once achieved control over their own training, doctors vanished from view in nursing classrooms. Nurses’ line of descent then made
up a level of organisation that aids nurses to bind together more tightly – while cohesion is as a horizontal force, ancestry is a vertical force. Unexpectedly, the nursing ancestry is a very closed one, and this seems to be a part of the private furniture of most nurses: No nurse can derive from professionals other than nurses; nurses can be considered as other nurses’ archetypes, mentors and spiritual mothers. Similarly, no auxiliary nurse or midwife or doctor can be expressly trained as a nurse, and attempts of universities to provide such training have been seriously censored by the nursing community. This results in little or no horizontal mobility for career reorientation despite the common ground they may share, which in turn fuels discourses of exclusiveness.

e) **Distinguishability**: By this I do not mean the Bourdieusian idea of distinction. Rather, the members of a community are able to recognise one another by judging their values and behaviours. Being distinguishable is important to preserve ancestry and cohesion; it is in presence of fellow *specimens* that reproductive codes of behaviour become active.

Leaving aside their obvious uniform, could nurses be mutually recognised?, could they be recognised as different from midwives or auxiliary nurses? Although the bolder medicalisation of a sector of practising nurses (Chapter 4), there is a generalised increase in managerial roles at the expense of clinical ones (Chapters 5 and 6). The one possible sphere nurses might mutually recognise is thus the organising role, and yet there is an important overlap with midwives that nurses are determined to disinter.

By looking at the levels in which nursing is socially organised, the comportment of the professions seems more closely related to the comportment of biological systems than expected, while the ecological theory of the professions and evolutionary ecology seem, too, to be close relatives. This may well be another aspect in which the contribution of this research may embed its incremental value.

3. Types of interaction with other system components

In the previous section I discussed intraprofessional organisation. Here I present relevant conclusions concerning interprofessional relations.
Interprofessional competition is caused by the constant reshaping of jurisdictions. On the basis of a competitive exclusion principle, professions struggle to define the ownership of knowledge and the right to exercise, which to an extent limits the number of professions in existence. Co-evolutionary interaction of closely related groups in fact proved to be effective, even if the two species do not evolve at the same pace or in the same direction. Even though some relations are often perceived as predation or ‘ammensalism,’ (borrowing ecology terms) through which some dominant professions may unidirectionally harm to or feed on less-empowered ones, mainstream literature describes interprofessional relations as competition.

Unlike Abbott’s, my observations lead to the idea that competition is not the only possible logic in systemic interactions. Competition is in fact most commonly recurrent (Profession A affects Profession B, and the other way around), though I would suggest some forms of mutualism (Profession A benefits from the interaction as much as Profession B does) in the very process of delegation from one profession to another. As medical doctors become interested in newer technologies and specialisations, they leave bare areas that are occupied by nurses, whose bare areas are in turn occupied by others. Changes in one profession’s jurisdiction may thus turn into a beneficial chain, as long as it is not perceived as jurisdictional invasion. Without a subordinate profession taking on bare areas, the process of growth might in fact become difficult to develop. Likewise, the existence, and more clearly the functioning, of umbrella organisations for a range of health professions embeds this mutualist principle.

Additionally, a less noticeable type of interaction seems to be used, that of commensalism – one profession may benefit from another unidirectionally without affecting it. Such may be the case of those that use the progress of successful professions as an existential argument for equalisation of privileges and rights, but do not share tight junctions with them as to become contenders. It would be intriguing to explore the nuances of this type of interaction further, seemingly connecting professions such as physiotherapy to nursing and dietetics to social work.

Interestingly, the professions seem to develop specific repertoires of interactions for different environing professions, depending on the actual or perceived jurisdictional conflict arising from their enactment – or the effect
of connectivity, systematisation, residuality and dominance, in Abbott’s words. It is expected that professions within a specific field will have a certain degree of conflict. That conflictual nature is given by common technical pathways of differentiation (or lack thereof) they seem to have followed since the rise of scientific medicine and hospitals as medical organisations. Those pathways can now be mapped through professions’ morphological similarities and their assimilation strategies – medicalisation of nurses, nursification of midwives, nursification of auxiliary nurses. In other words, within a particular ecology, one profession’s behaviours can possibly be recognised in other profession’s behaviours; just as pathways are traceable through the shared social code they seem to respond to – social class, ethnicity and gender levels of hierarchies, for example. Similarly, relational patterns of one ecology can possibly be recognised in another ecology.

By bringing together the overlap of parallel pathways of evolution and the various types of interaction professions develop, interprofessional relations become much more complex than previously thought.

4. Deciphering the Social Code of Nurses: An Ideological Device

I conceptualise nursing’s functioning in terms of an ideological device – namely a behavioural code – structuring the intricacy of its underlying principles and dynamics. As stated on earlier pages, although some might consider this code as a constituent part of the internal structuring, I thought it deserves a special treatment, as I rather see it as an interphase between the profession and the environment.

There are founded reasons to conceptualise the nursing apparatus as a code. Foremost among them is that language and behaviour are used both for conveying the contents of the profession and for obscuring them, becoming a part of a ciphered communication among its members and with its audience. Second, in order to read the profession’s contents, one must learn how to discern its keys and symbols, senses and nonsenses, ‘presents’ and ‘missings,’ and how to decipher them. Lastly, and importantly, the apparatus is not a self-generating device, but rather a machinery purposively constructed for attaining the profession’s aims.
The unrestrained emphasis on ideological convergence – rather than divergences – purports to consolidate consistency of nurses’ predicaments and impose conformity on the community, that in the process permits the implementation of an agenda of cultural politics. In a sense, consistence is necessary to hold an ideological discourse, then it is easier to comprehend why elements considered at variance with the mainstream stance are systematically filtered out. The most evident way to uphold the reached convergence is to transform predicaments into either laws or dogmas, therefore excluding voices that do not fit in or that question the nursing ideology: the result, a doctrinaire internal culture. In such context, agreement may be considered as a simplifying model of thinking, as for a group lacking academic literacy on the whole it is easier to agree than it is to disagree – whereas disagreement must have some form of contra-argumentation, agreement must not. Seen in this light, the community members may simply respond “so be it” to predicaments posed as inherent, abiding truths. Examples of this are the ideas that nursing unquestionably is a profession (in the old-fashioned, structural sense), that society recognises the role of nurses in the form of laws (not in a metaphorical way), and that nursing is the only piece without which no hospital can function properly (an hypothesis as difficult to accept, as it is to assess).

With this picture in mind, the nurses ideological device operates through seven different components:

a) Behavioural rules: Norms, usually unwritten, about what to do and what not to do. There is a cultural convention which holds that, as members of a graduate profession, nurses must join to either equal or superior professionals socially (friendship – family relations), which makes up an unspoken agreement on social behaviour.

b) Affirmation of principles: All professions have principles, and those principles tend to be more overt than the code as a whole. This is not to say that nurses’ behaviour is conflicting with their principles, as the one thing nurses’ put in first place is their patients’ safety, and that seems to be above every political interest. Their (formerly Christian) moral code is in fact an integral component of the totality that is nursing. Very rarely, for example, do nurses leave the wards to engage in industrial action. Their principles
come to complement a longstanding codes of ethics, which is beyond any momentary strategy of status pursuit.

c) **Statements of ideals**: Nursing is full of great – naïve, some might say – idealism. Nurses’ earnest ideals can be traced through their rhetoric of vindication, voicing that their aptitude to govern the system is greater than others’. Though in essence their ideals respond to the logics of social movements.

d) ** Creed forms**: What nurses believe they profess. The creed helps separate their fundamental beliefs from other types of stances, and constitutes *the* truth, which must thus be agreed on by all nurses – those who do not, are not nurses or do not deserve to be called a nurse. Examples of the nursing creed’s content is the so-called Nightingalean vocation and the claims of a paradigmatic shift in nursing, which eventually might embed their community’s greatest myths.

e) **Fellowship commitments**: Commitments reinforce both linear ancestry and cohesion. Examples of these commitments, overt or covert, are that only peer fellows can enter their community, one of a graduate profession, that they – and only them – can be called nurses, that this title can only be reached through university-based training, and that their community cannot accept anyone else except for university-based nursing students to whom nurses must support in their practical training on a master-apprentice relation. Through my observations, it also becomes evident that nurses are committed to report professional problems to the Chilean Nurses Association, rather than to other immediate professionals with whom they work.

f) **Collective interests**: Status, autonomy, higher rewards, social recognition, professional image in society, a substantial change in the patterns of power, all the same, form part of nurses’ interests. They engage with one another in the hope that it will further interests they suppose common and that individual interests will be best assured collectively: while most exert their profession, a group engage in lobby activities. And given the ecological nature of work, nurses’ collective interests are, to some measure, opposing to those of other professions.

g) **An ordered language**, capable of amalgamating a professional body and conveying a new form of symbolic capital. Nurses understand that language can create particular images in people’s mind and have learnt the language that works well with politics and squares their interests. While that
may not be a language that best describes reality as it is, it has been helpful to change the way the audience perceives reality.

Equally, although ordered, their language may not be fully systematic. The heterogeneous use of the vocabulary – academic, practical and political – suggests some internal atomisation of the nursing collectivity, mixing randomly esoteric concepts with their practical jargon, letting sense a political undertone that reveals a larger narrative (Chapter 5). Nonetheless, language has followed a progression, partly deliberately crafted to gain public credibility, partly reflecting evolutionary changes in the nature of the profession (e.g. from “we take care of the sick” to “we do management of care”).

**Conclusion**

Deciphering a code and its normative and political nature is seeing the shape of a chart guiding the transformation of the profession. I currently make no attempt to forecast nursing’s futurity. Rather, I stress that its interaction with the environment, its internal organisational levels, the effectiveness of its political apparatus, the comportment of and the interaction with the neighbouring professions, and the landscape transformations functioning altogether may account for nursing’s success – its development does not unfold by pure chance.

More important than deciphering a profession’s functioning, however, is where to move from it, and that is the biggest challenge nurses will have to face. Meanwhile, I can safely say that we might now begin to understand the sociological puzzle that is nursing.
Critical appraisal and related work

Recognising the limits of my work

The systemic theory of the professions (Abbott, 1986; 1988; 2001; 2010) has generated intriguing insights into the evolutionary aspect of occupational groups and their efforts to protect group closure (Larson, 1977). Starting life in an era of great criticism towards professions’ dominance, Abbott’s work advanced the field, largely attached to structuralist views. Some critics have pointed to his failure to fully engage with Larson’s theory and to his inability to clearly differentiate his work from the structuralist/functionalist stream (Macdonald, 1995). Be that as it may, its contribution to the field still is a turning point from the mono-group professionalisation theory to a multi-group conflict approach. The strength of systemic analysis lies in showing that profession building is not a profession-centred phenomenon and that professions are defined by the actual work they do.

Abbott’s work seamed best fitting for the setting of my research. A process of cultural assimilation between Chile and the historical context he researched has installed the professions at the heart of social dominance, and with them an obsessive race for attaining university status and advanced degrees. Academisation has, as I have illustrated extensively, reinforced constructs of an undesirable social standing around other trades and crafts, and, importantly, the allocation of wages and symbolic rewards accordingly.
His work’s weaknesses can be the same as those of my own. My exploration of the nursing profession has been based on a range of techniques, of sources and of concepts, which enabled a thick description of the findings and enhanced their reliability. In addressing the systemic relations between occupations, nevertheless, my way of approaching them may have resorted to a structural basis more than to a conflict-driven basis. For example, when analysing the evolution of the institutional devices used to wield power and the patterned affiliations of individuals to hierarchical social compartments, purposive attention to ideologies and multiple affiliations was not devoted until the last chapters. I did pay attention, however, to the dangers of functionalist accounts, arguing consistently that functional relations between groups every so often benefit some while eroding others. I underlined this perspective while discussing internal as well as external boundaries of the professions.

Methodologically, my approach might also become an object of criticism for retaining the reproduction of institutions under my ethnographic lens for too long, and for – as in any other ethnographic enterprise – the problem of representativeness. While structures where at the base of my observational scheme, the analysis moved the focus forward once a certain scaffolding was built. This perspective was certainly helpful guiding analysis of absent traits in one or another interacting profession and of how those differences in fact referred to larger dynamics. Any criticism to ethnography might begin with “its problem of representativeness…” – this is an important concern. Without aiming to achieve topic representativeness, my work was deliberately concerned with realities socially constructed in everyday lives in their natural settings, as to account for the whens, the hows and the whys of the actors’ actions. This work may thus stand as a reaction to the limitations of representative accounts.

Yet while collecting stories, observational data, documents and archives, and encountering the informants in and out of the hospital, my participation in the field aimed at allowing information to speak for itself. In reality though, my own participation might have somewhat informed the construction of data, for those who joined me in my field research were willing to speak to me, and to give me access to their views on the subject, had perhaps some affinity with my own. My presence in the field might have out-
placed a wider variety of informants should I have over-identified with a cer-
tain mindset and over-relied on my informants’ willingness. To what extent,
then, might I have seen my own expectations or, further, my own inner self
mirrored in the dazzling reality of the field? Most reassuring was to test and
discuss preliminary ideas with unknown nursing and sociology audiences as
the analysis progressed, and to engage a field assistant as to compare and
discuss data. While any researcher claiming scientific neutrality can be sub-
jected to critical scrutiny, and I make no attempt so to claim, in the study of
subjects and their realities at least personal neutrality was maximised.

Access to the field raised a number of issues. My position as a former
nursing lecturer surely catalysed agreement with both the Head Nurse and
the Hospital Director. Background to that decision was the idea that I was
able to guarantee sufficient specialised knowledge and skills not to trans-
gress regulations of hospital work while observing. I thus rapidly gained
‘right’ to free movement throughout the hospital, sharing a number of their
day-to-day activities, from coffee breaks of clinical staff to meetings of high-
rank managers. Freedom of movement was in fact reinforced by internal let-
ters sent by the Hospital Director to the wards. Despite that few seemed to
fully understand the nature of ethnographic observation and that an imposi-
tion from above could have resulted in an additional barrier to building rap-
port with the workers being observed, they seemed mostly keen on cooper-
at ing. Micro-negotiations, however, were necessary as the staff changed
from shift to shift; in some wards my assistant and I were requested to wear
a white smock on the grounds that this helped them distinguish us from the
public while handling confidential information. We expressed our reticence
by explaining that unnoticeable observation was preferable. While we also
considered dressing like them would induce an undesirable sense of natural-
isation of their practices on our part, I rapidly learnt that accepting their
requirement was an important token to benefit from an inside view of hos-
pital culture, as if hospital uniforms activated codes of more intimate, out-
spoken communication styles. The wallpaper role soon evolved into a par-
taker one thereafter.

Analysing retrospectively, accessing the hospital in this way – and I still
strive to envisage a better one – might end up in the instrumentalisation of
the observer as a collection agent for the management board as to map loy-
alties, workloads and the like, undermining both trustworthiness as an insider and independence as a researcher. Yet the interest of the Head Nurse in my research helped greatly to put its purposes in first place from the outset; she introduced me to the Hospital Director and the Nurse-in-Chief of each ward, to whom my research was explained as to clarify it had nothing to do with supervision of any sort, a notion that consistently surfaced in the wards until the personnel became familiar with my work.

By the time I began my field research, I had not set foot in hospital in over two years. That period was long enough ‘to render the familiar to unfamiliar’ so as to have to re-learn its social codes and the way people react to them, a process that along with cross-observer discussions enabled enriched descriptions of the setting and of the way I approached the data.

With the exception of few, my articles claim to use Grounded Theory. While for some Grounded Theory may constitute a method, I rather see it – and use it – as way of approaching data and building theory from it. In my research, Grounded Theory was helpful to organise the voluminous amount of data resulting from the diverse sources I explored. The analysis moved gradually from an open coding strategy to a selective coding strategy, a process informed by both secondary data provided by the hospital board or found in libraries and archives, and primary data produced on my own. Throughout the process, it was crucial to interrogate discourses in light of my observations, especially to overcome the risk of interpreting a priori that what people think equals what they do. Codes and categories thus suffered a constant process of adjustment until data cohered together in view of key sociological concepts.

In the final part of the coding-and-making-sense procedure, however, it was important to connect the categories to the concepts I was drawing which theoretically. Thus, I cannot make any claim whatsoever that my work is a grounded theory in the sense of new, revelatory theory. Rather, my research identifies with a Grounded Theory orientation – theorisation from data arose within a social theory frame, as stated in my articles.

The constituent articles of this work also tried to make their way through, somewhat understating excessively formulaic recurrences of the writing referred to as ‘academic.’ For me, being an ethnographer, it was important to find my own voice in my writings, and in so doing I attempted
to induce a mood that connected with the reader, and myself, more easily, instead of making up a tone that sounded like someone who has just come out of the ivory tower. Equally important was style – without being chatty, I hope; although not sure at times; too often, perhaps; well, it is the reader’s to say – not too indirect. I used mostly accessible language, though I do recognise some esoteric terms of my repertoire as well; this effect is partly because of the different audiences to which the articles were addressed: practically and theoretically minded researchers within sociology and health sciences; and also partly due to my theoretical inputs in other languages.

There is a conceptual continuity, nonetheless, as one advances from one chapter to another. The argumentative line becomes evident by making clear that the aim was to explore the social construction of healthcare professions in their interacting environments. While the relatively high number of articles may well account for the phenomenon I was interested in, it would have been intriguing to further the analysis by using a single set of concepts in the whole series of articles. This, however, did not seem convenient.

**Engaging with related work**

Committed to account for professional development as a constant dispute between professions, my research was concerned, on the one hand, with professional structures, their organisation, functioning and remodelling, and processes, ideologies and devices, on the other. Conflict between groups begins in structural arrangements – it was thus important to explore both spheres, that of structural-functional concerns and that of conflict-based concerns. I could not, however, catalogue my work as a conception of social functioning based on unmoving functions given by social positions. On the contrary, I studied structures and functions of the nursing profession to move from there to an exploration of intra and interprofessional dynamics. Structures were in fact much less significant and insightful than what they hid.

By using a systemic perspective, change as the fundamental force of the professions’ dynamics became central to my focus, and I investigated the
problem of interest accordingly. A lively long-life debate has closely accompanied nursing regarding its professional nature, a debate that advances as the profession and society change. Admittedly, the largest part of that debate corresponds to nurses writing in reference to themselves, which suggests both an enduring area of interest and a conflicting process of social identity construction. As for the rest, nursing is often used by sociologists as a case in point to compare against its closest neighbour – the medical profession – to some measure, an inevitable comparison as these two groups, along with others, change simultaneously. Though very few works can serve for comparison.

Allen’s (1996) major research is possibly the one with which my own shares more similarities. Her work was inspired by Abbott (1988), Hughes (1988), Strauss (1978) and Dingwall (1979; 1983; 1990). By doing ethnographic research in a hospital in the United Kingdom, Allen took effectual means that she would analyse actual nursing work, rather than nurse’s rhetoric. She focused on sources of tension in shaping the profession – the definition of internal nursing hierarchies through the delegation of tasks and roles perceived as a threat to nurses’ identity, the devolution of tasks from doctors to nurses, and the delegation of certain tasks to patients. That delegation of extremely routinised, boring, distasteful and unchallenging tasks, she argued, becomes central to the reshaping of nurses’ jurisdiction. And yet, she did not emphasised the conflictual dimension of jurisdictional reshaping as much as she did the division of labour. She argued, moreover, that a boundary-blurring phenomenon prevented negotiation from occurring and, likewise, minimised potential interprofessional conflict.

Hers was in fact an exploration that looked intentionally for conflict in doctor-nurse relations, which she would eventually not find. Unlike Allen, I addressed interprofessional relations based on a seemingly more ecological approach than hers, therefore I looked purposefully not for conflict alone but for any type of relations that species may have, and that was a useful resource. Different levels at which relations work, based on the expansion of jurisdictions either vertical or horizontal, in some cases led to conflict, in some others did not. Even though we both looked through a conflict-based lens, ecology as applied to sociology can facilitate other possible results to surface.
Roles and tasks in my filed research seemed to mark a bold boundary between professional fields, to the point that legislation was used to legitimise the nursing jurisdiction and keep expanding it into medical and managerial fields at the expense of nursing roles proper. Allen’s data seemed to speak of a great defence of care as an element used not for identity building but for keeping control of boundary shaping, whereas mine suggested that nurses absorb increasingly more ‘professional-looking’ roles insofar as they turn away from the caring role they contradictorily use to induce trust in their audience. Both cases, however, highlight care as a rhetoric of professional building more than as an organising principle of nursing work.

Allen (2007) goes further, illustrating that, despite dominant disciplinary claims, nursing is best described as a bundle of activities overshadowing nursing’s caring roles; she concludes – nursing is not a patient-centred profession. My research, in turn, shows that, despite dominant disciplinary claims, nursing is best described as a set of organisational tasks emerging from environmental changes; I conclude – nursing development is neither a profession-centred phenomenon, nor a caring-centred one. Intertwining the findings from these two research sites, actual nursing practice seems poorly connected to its disciplinary base, though rhetorically attached to a larger narrative of caring professionhood. This is additional empirical evidence consolidating the premise that claims over a disputed jurisdiction are often not consistently sustained with actual work (Abbott, 1988).

Abbott (1988) himself, too, drew great attention to conflict as a source of the mutual reshaping of jurisdictions, and that is an unchallenged assumption of his. He claimed to conceive the system of professions as an ecology. Perhaps though, other types of interaction were overshadowed by such a focus on conflict, as much as the levels of internal organisation and properties that, as ecological units, professions may have.

Dingwall’s (1979; 1983; 1990; 2008) outstanding interest in the nursing profession led to a prolific body of literature. His is a sociological account based on historical resources, illustrating the shaping of professions – nurses, health visitors, doctors. While he highlighted the evolution of health visitors into nurses in England and the partnership between nurses and doctors, rather than the widespread idea of the ancillary position of the former, his writings inspired to some measure my own exploration of conflicting
relations when professionals have no or little actual contact at work. Then historical methods can greatly serve to solve this problem. Dingwall and I had rather different purposes, though methodological similarities connected through social history.

Lattimer (2000; 2003), in another sociological ethnography in UK, concludes that the nurse-patient relationship is crucial for identity formation. As she puts it, “patients are nurses’s key materials for the performance of identity.” While this may in principle be equally so for the setting I investigated, an argument like such would be unsuitable. Although nursing students spend a great deal of time of their practicum with patients, professional nurses, as I have documented, have largely distanced themselves from bedside roles, a distance that continues to increase as they concrete their project of healthcare management as the star of their political armament. This process is consistent with the physical displacement of nursing spaces, once conveniently placed within patient rooms, now rather to be found in offices, likely a result arising from the little social distance between nurses and patients, and nurses and subordinate groups. Allen (1997; 2007) reported a certain move of nurses into managerial tasks, though keeping in practice core roles of sick nursing. American literature on nursing practice often differentiates between clinical nurses and managerial nurses, without a generalised shift into management. It would thus seem that Chilean nurses are evolving into a rather unique form of clinical-management professionals, while, at the time of writing, new disputes with auxiliary nurses erupt on the grounds of jurisdictional ownership of bedside tasks understated by professional nurses. Similarly, none of the above-cited studies seemed to have uncovered clues of nurses’ political enterprise or of effective social-closure projects.

All things considered, my work advances the field of the sociology of the professions in Chile, meagre in fruits and disconnected from leading debates over the past three decades with the demise of its last survivor (Gyamarti, 1984), leaving many apparent dead ends. It then disappeared from the sociological agenda altogether. This is in fact a rare piece of research reviving an area largely eclipsed by the sociology of work. The field is thus endless and open for research of any form.
The case I report on seems, in the main, connected to a larger functioning of the broader professional system in the Chilean society. Again, without aiming topic representativeness, it becomes clearer that both the making of a political device and a closure strategy refer to social inequalities that have pervasively existed in that country. Science is available more than ever before in that country, and the professions look to science to face better their clients’ risks – or so they claim – and to make themselves – idem. It is anticipated that the debate addressing the professions will expand as a larger number of occupations begin to question professional dominance.

Ideas for future research

By no means should I suggest that this research has exhausted all possible aspects of the nursing profession. There are indeed a number of other questions arising from this work that, due to time constraints, were not studied. While those questions can be deduced from the limitations of my work, there are some areas on which I would insist when developing further questions:

a) Relevance: As I have elaborated, whether nursing is a profession becomes an irrelevant question, and it would be misleading to continue to use it. Researchers studying the nature of an area of work might begin with examining the notion of professionalism in that area, which is quite another thing. No constellation of traits can properly define what it is to be a profession and what it is not. Today it seems more fruitful to consider all occupations as forms of professions, as the old-fashioned divide between professions and crafts has, I argue, led to the reproduction of the same inequalities pursued by professionalization projects: historically disempowered groups have taken on the same exclusionary strategies implemented by long-standing groups. I have also suggested discarding the notion of ‘semi-profession,’ which refers to the same divided, although it is commonly found in mainstream nursing textbooks. This same preoccupation has led nurses to over worry about issues of status, creating persuasive discourses that may become a source of dissatisfaction in the long run.

This type of questions, likely a reflection of aspirational ideas, has not only pervaded nursing research but also translated into political effects, as
the ‘eliteness’ associated with the professions has lead to the monopolisation of titles by university institutions.

Other researchers wanting to study other professional groups may well benefit from the framework I developed. However, the landmarks defining professional jurisdictions may change from area to area. I studied the case of healthcare, where the impossibility to fragment the human being produces a great overlap between professions and under certain circumstances roles and tasks of different professions are, not officially, but practically exchangeable. Healthcare professions are not separated by clean-cut borders, and other areas such as civil engineering may find bolder limits separating contiguous groups; this information might be useful for exploring more strict forms of delegation and, importantly, more subtle strategies of negotiation.

\[b)\ \text{Manageability:}\ \text{Nurses, as I have noted, enjoy a privileged position in the hospital, accessing, collecting and keeping confidential information, and controlling flows of work. While this position is usually used to favour their cultural agenda, the information may also become a source of data for complicating the analysis, either of the professions or of the organisational functioning. Documents and archives are underused resources for understanding work in healthcare, just as much as the behavioural patterns I studied ethnographically. These are sources of data that healthcare workers are very familiar with, participate in their construction, and can systematise through associative research. Manageability of data is in fact an attribute every researcher values.}\]

The particular healthcare system I studied is often discussed ‘from above,’ ignoring the dynamics operating in actual work. While my participants might have been distrustful towards being observed, as the hospital had never served as a setting for ethnography, as fieldwork progressed there emerged greater rapport, therefore further explorations would benefit greatly from this cooperation. I have learned that healthcare professionals, when given the opportunity to appreciate the potential contribution of the social sciences to an understanding of their work and realise the advantages of field research with them and about them, they become very keen on sharing their practices. Without claiming a messianic message, this window of opportunity can have a transformative potential for further research in
health and for the involvement of health professionals in projects of this nature.

c) Comparability: Like in most countries in the region, nursing in Chile has long been influenced by theory bodies developed in the U.S. Cooperation projects implemented in the mid-twentieth century allowed nursing scholars to access South-North mobility programmes, to the extent that current versions of nursing in Latin America emulate US nursing. However, cultural differences affecting this affinity, although evident, have been rather neglected in analyses of nursing across countries. Claims idiosyncratic to a single culture have long been assumed as universalistic and future research, in nursing and in healthcare more broadly, would need to overcome this assumption. It is anticipated that differing versions of nursing coexist across cultures and that the conclusion of this research or of research produced elsewhere need not to be transplanted just as they are, for the national and supranational constituent parts of the systems can modify the functioning of the healthcare systems, therefore that of the professions.

Doing comparative research seems to be the obvious step for having referential points, though comparison has a greater analytical purpose: facilitate to discover the ‘presents and missings’ in each of the units subjected to analysis. With this in mind, there seems to be a need for greater availability of channels of cooperation, and this is possibly the biggest challenge for newer generations of researchers.
ANNEXE

From question to field, from field to narrative: A note on methodology.

I found no plausible reason to provide the methodological details of my research as a typical ‘third chapter.’ Since most details are explained in the respective section of each constituent chapter, interspersing repetitive information among them would thus seem meandering, as much as it would interfere with the roundness of tone and register of the narrative. The intended reader of this thesis is foremost concerned with its contents, and less so with the making of them, unless turning the attention purpo-sively to methodology. I should like to suggest that methodology can be read as a book within a larger book, and I have proceeded accordingly. Aside from the explained details, there are a number of issues which need further problematisation, and merit, therefore, closer attention. This section is devoted to three of those issues. And although minor might seem, they must be stated and addressed nonetheless.
This research took place at a time of fierce struggles among occupational groups in healthcare, arising from the remodelling of roles and responsibilities in the context of major State reforms beginning in the 1990s and repercussing on the professions more specifically from the 2000s onwards. One aim of the study was to gain an understanding of how these professions are connected to one another socially in the dispute for status and recognition.

Avoiding to become mesmerised by and over-reliant on the first fine-sounding theory I found, I went through various different approaches. The perspective I actively decided to use brings together issues of social construction of prerogatives and of interaction in the field, and it was its re-emerging notion of ‘system of professions’ that motivated me to ask questions that would overcome the limitations of structural accounts: How is a profession a socially organised group? What professional groups participate in shaping the jurisdiction of nursing and what are their dynamics? How do professions relate to one another in my particular setting? How is my setting different from or similar to those where main literature bodies come from? What explanatory potential do these theory bodies have for my case study?

In developing these types of questions, I decided to challenge mainstream approaches to the problem of nursing as a profession, analysed mainly from the standpoint of nurses – that is, what nurses think nursing is. By that time I had become familiar with newer criticisms of some nursing scholars towards the fixation of nurses for professional status, and the disappointing, though realistic, acknowledgement that nursing theory has had little repercussion outside the U.S. With this idea in mind, not only did I put aside the continuity between nurses’ rhetoric and their explanatory models, but also found myself asking questions concerning to what nurses do, as their actual occupational activities began to emerge as the primary focus of my interest, and their field of work became the field of my research. This enabled an account of nursing from its own internal dynamics. These dynamics, I have argued, are the means through which flows of powers and relations come into circulation – more than they do through rhetorical constructions – for behavioural patterns disclose what the rhetoric hides.

The concern here is to discuss the methodological choices involved in this process of investigating how profession making is embedded in day-to-day practices. Before I became a sociologist, I had myself a short career in
nursing. This helped my understand on one hand the intricacies of hospital work, and on the other hand empathise with the group of nurses engaged in my field research. My aim, nevertheless, was not to scrutinise the quality of the care these nurses provided. In fact, nursing roles were not analysed as a set of technical tasks, but rather as a strategy.

Research of practices implied my own involvement in the setting as a participant observer, a requirement that benefitted from my background, looking for the construction of first-hand experience resources of unspoken principles and logics behind social action, considering that the research would explore aspects people do not normally think of and uncover conceptual interrelations people may not have words for. Ethnographic observations were indeed used for intensive cross comparison between data constructed discursively and data embedded in the social action, especially through the relationships among nurses themselves and with other professionals.

One may argue that my familiarity with hospital work could have represented and obstacle rather than an advantage, for it might cause overlooking naturalised patterns of relations. Engaging an assistant – who was an anthropologist unfamiliar with hospital work – was surely helpful, as cross-disciplinary observations and discussions assured quality data and an enhanced interpretation of them from an internal perspective and an external perspective. In order to prevent ‘getting dazzled’ by the complexity of the setting, we agreed on an observational guide (Fig. 5) with which to map firstly trajectories of the nurses in the wards, and secondly relations (and lack thereof) connected to those trajectories. We first paid more attention to nursing handovers, teaching-learning situations, decision-making processes, meetings, routine activities, and any activity involving inter-disciplinary contact. In a later stage, we focused the attention on gathering specific pieces of data, relevant for the specific questions addressed in precedent chapters.
Along with this observational guide, notes were kept on a diary in a two-column system, one column devoted to descriptive notes and one to reflective notes, and a line containing the chronology of activities. When possible, descriptive notes were recorded as we observed, though our participation in the field not always permitted so to do – for example, in deference to someone talking about a sensitive issue – in which case some passages might have been slightly paraphrased or reconstructed afterwards. However, the specificity of each observational fragment was not the focus of the analysis, rather the emergence of patterns embedded in organisational practices.

What should become clear is that while studying a familiar setting may raise legitimate controversies, my methodology benefited from that internal perspective shortening the acculturation time and facilitating rapport with
the participants, and dealt with the certainties of familiarity by doing strategic adjustment.

**Sampling heterogeneous versions of nursing**

This research was concerned with the construction of relations and concepts. Accordingly, it seemed appropriate to design a semi-structured sample (of sub-settings and of informants) that enabled covering a range of theoretically meaningful professional roles and tasks performed in different sub-settings, but that at the same time were flexible enough as to develop and refine the emerging categories by adjusting the sample. This adjustment was not meant to increase the sample indefinitely, rather to refine ideas and relations between them as they surfaced during the constant comparison of data involved in the Grounded Theory approach (Corbin & Strauss, 2008; Charmaz, 2006).

The theoretical sample (Burgess, 2002) was initially aimed at balancing opposing conceptions of professionalism in nursing (for example caring-oriented nursing and technically expert nursing) and different degrees of seniority at work, and exploring the dynamics between them in the assumption that professional groups are heterogeneous entities. This heterogeneity justified that the sample was structured considering degrees of interventionism and length of stay in the hospital (ranging from emergency room and intensive car unit to chemotherapy and dialysis to general hospital wards to management units), which assured the highest possible variation of cross-disciplinary contact between professionals and the greatest possible degree of professional role overlap. The dynamics among them in fact facilitated to observe delegation practices from one profession to another and disputes, covert or overt, for an internalised notion of ‘ownership’ of tasks seems to be at the core of interprofessional work in healthcare. By exploring the borders of professional jurisdictions, this work eventually did not only explore the dynamics of nursing work alone; it also involved healthcare work more broadly.

The construction of data involved typical ethnographic activities: extensive in-site observations while adopting varying degrees of participation (Burgess, 2002), informal talks, semi-structured interviews (see guide
below) and hangouts with nurses. As field research progressed, it also seemed necessary to involve other actors that were important for an understanding of the systemic relations with neighbouring professions, such as academics, medical doctors and midwives, and extend the observations into other sub-settings.

During the field work, however, I also sampled and compiled a significant amount of institutional documents and archives connected to the topic of concern, which would provide fresh insights into conflicting interprofessional contact. Although not previously considered, documents and archives helped further interrogate observational data and the contents of the interviews in substantive areas, and suggested to go back to particular respondents. Throughout this process, the sampling method was compatible with the Grounded Theory approach, as refining the sample structure evolved from certain openness to a rather selective choice of participants. Important for integrating these documents into the data and contextualise them in the period and context in which they were produced was the adoption of a social-history approach. Combining this approach with the frame of Grounded Theory enabled an interpretation of professional relations as part of key socio-historical processes that would later enrich the creation of narratives.

**Interview guide**

_Time planned: 60-90 min._

1. Let’s start by talking a bit about your experience as a nurse (physician, midwife, student, etc.)
   - Where did you go to college?
     (This part was meant to be a warm up question, just to get the interview underway, and can be followed up with a few other “small talk” questions, like “Where is that?” etc.)
   - How would you describe yourself in your job when you became a nurse?

2. Can you tell me how you became interested in nursing?
   - (Exploring further) Could you talk about some of the experiences that were important for you to become interested in your studies?
3. Tell me about your experience so far. How have things worked?
   - (Exploring further if they don’t provide details): In what ways?
4. Can you take me through a typical day for you here at this hospital?
5. I’d like to ask you about your job experiences you’ve had since you started here.
   - Have you had experiences that you would describe as particularly good? Can you tell me more about that? So what was it that made this a good experience?
   - Have you had experiences that you would describe as particularly bad? Can you tell me more about that? So what was it that made this a bad experience?
6. I asked you earlier to describe the nurse you were at the beginning. How would you describe yourself as a nurse now, one (or ten) year(s) later?
   - (Exploring further) Talk me about your professional judgement, and the best experiences from which you’ve learnt.
7. Let me ask you to think about the other nurses you’ve met here. Would you say that in general they are more different from you or more similar to you?
   - (Exploring further) How are they similar/different?
8. Do you have much contact with non-nursing workers (not only “professional” workers) here at the hospital?
   - (Exploring further) How do things go with them?
   - How would you describe these relationships?
   - What happens when there’s a complex situation and a decision has to be made?
   d. How do you recognise what you have to do and what others have to do?
9. What would you say has been the most difficult situation with non-nursing workers so far?
   - (Exploring further) How did you handle (or how are you handling) that?
10. Think of your colleagues here at the hospital. What would you say they think it means to be a good nurse?
   - (Exploring further) How does that fit with your own image of a good nurse?
11. Knowing what you know now, as you look back to the time that you’ve spent here, is there anything that you would do differently in relation to nurses [to yourself as a nurse]?
12. Here’s a scenario I want to ask you about: There’s a new graduate nurse who’s interested in your job place. This student comes to you for advice. Knowing what you now know, what advice would you give her/him?
- (Exploring further) What situations would you suggest to avoid, and why?
13. Here’s another scenario I want to ask you about: There’s a producer who is interested in filming a movie about a typical nurse work life. If you could whisper in his ear, what advice would you give him about what he mustn’t miss?
(Question 13 is partially redundant with questions 4 and 10; ask if time permits.)
14. Is there anything that I haven’t asked you about that you think I should have? Anything else, relevant to an interview like this that you would add?
15. Do you have any questions you’d like to ask me?

Ethnographying sick nursing and primary care nursing

Nursing is a broken-up world. Two differing groups with rather separate occupational profiles – that of the visiting nurse and that of the sick nursing – mingle today under the umbrella term ‘nursing.’ Although the primary resources of this research came from observing sick-nursing activities, the theoretical interest was concerned with the nursing profession more broadly. Initially, the sample design considered primary care as a sub-setting on one end of the continuum of interventionism/non-interventionism and of long-term stay/ambulatory care. Data gathered in this sub-setting, however, were not amply used, due to the number of important issues of theoretical interest arising from observations in the hospital wards; observations of primary care in fact constitute row data, available to be used in further examination.

During the field research, I uncovered a general agreement holding that primary care nurses enjoyed a high degree of autonomy in comparison to hospital nurses, and it would appear to be partly so. To a large extent, primary care institutions are organised around flatter organograms that functionally obey to the logics of ‘care plans’ (programas) developed by the Ministry of Health, bringing together different areas of expertise around priority health problems and vulnerable groups, and defining the jurisdiction of
each disciplinary group. This called my attention, and I understood the care plans with reference to the concept of ‘commodity,’ discussed in Chapter 6. Commodities function as reservoirs of knowledge and expertise when there are no experts available to cover all the needs of the system, or when involving experts would become prohibitively expensive, therefore unsustainable. Other examples of commodities used in primary care are guidelines, protocols and high-tech equipment.

In the view of primary care nurses, these improvements (read ‘commodities’) would enable to apply judgment and knowledge dispensing with medical control, and this seems to be at the core of the persuasive discourses of an alleged autonomy of nurses working there. During the analysis, however, it was difficult to discern whether this can be considered as autonomy as such, as in a given case scenario one could argue that the ownership of that knowledge is not what has been transferred to nurses, but rather the application of that knowledge to the cases defined by the centralised care plans. The supposed higher autonomy of the primary care nurse may thus be restricted to the practical arena, which – again – puts the nurse in the place of a ‘knowledgeable doer.’

Further analysis may well shed light on how the commodities might have crystallised professional roles and in the process medicalise an area of the practice of nursing that is often claimed to be devoted to social matters. However, united culturally and academically by their university-based training, both hospital nurses and primary care nurses ultimately seem equally committed to political action, using new knowledge as the base of claims of vindication.

**Facing research ethics: significant moments**

I regard ethnographic fieldwork as an experience rather than as a data gathering technique. No fieldwork evolves as a perfectly textbook description, not that I know of. We, ethnographers, in fact deal with a number of challenges arising from researching a social world we become a part of, and reflecting about others we mingle with and ourselves in the research sites. To complicate the reflection further, ethnographers are pressured to conceal their decisions with an inconsistent body of literature of how ethical
principles ‘should’ be applied, especially while doing ethnography in healthcare settings, an area dominated by the cannons of medical experimentation poorly applicable to the nature of ethnographic inquiry. Not being able to draw a clear separation between researcher and participants, my engagement in the process embedded the complexity of personal ethics, which deserves special attention here. I refer to ethical issues as arising at significant moments.

Hierarchies seem to be very important in hospital culture, and it could have been naïve on my part not to think of my observing role as fitting that structure at its highest levels. I was fully aware that my access to the wards was facilitated by the hospital leads, and that the people I observed understood this too. I decided to code the names of the personnel and those of the wards being observed, for managers might have wanted to use my field notes to track their staff’s performance. The system I adopted for taking both observational notes and reflective notes also allowed me to ‘mask’ actual facts as if they were my own thoughts, in ways that protected the informers from being identified, scrutinised or – although unlikely – harassed. The staff understood that I was in a sense indebted to the leads, just as the leads understood that I enjoyed a position to which they normally do not have access. I thus actively decided to write my notes in English and use sociological jargon as a means of making this information available to few, in case my diary was misplaced and read by accident. This decision was crucial not to feel overprotective towards my notes; I needed to build rapport in a natural fashion, and any hint of distrust would have just interfered.

Likewise, giving access to my field notes would have interfered with cultural conventions allowing (or not) a flow of information from one level of the hierarchy to another. Most strategic decisions in organisations are made at a certain level alone and behind closed doors. In the same way, some pieces of information of sociological interest flow in various forms of organisational knowledge (e.g. graffiti and gossip, along with other much less maligned non-verbal codes of social life, such as thumb-downs, gazes and winks) usually at lower levels of the hierarchy. The back-and-forth movement between levels puts one in an uncomfortable position, ‘between a rock and a hard place,’ having to choose between pretending not to know any-
thing about what happens on the other side of the border and being ‘too’ honest even with information that may seem trivial to one’s eyes. I regarded this situation as one of the significant moments when one must choose between good and good, an ethical undertone of decision-making that would surface again at several stages of my fieldwork as well as in the process of writing the ethnography. It could have been problematic for the organisation should I have violated the cultural conventions of the group, as much as it would have threatened the completion of my research project in that particular site. And so I opted for the good. Protecting information that I considered did not belong to me was mostly assuring for minimising the effects that my own presence in the field might have had.

The moment I realised that my presence had ‘social effects’ in the wards became the second significant moment. Most nurses were manifestly interested in my sociological views about nursing and felt they had something important to communicate with regards to the future of the profession. Experienced nurses were particularly keen on talking to me – and I am very grateful for that enthusiasm – in and out of the hospital, and quite a few of them invited me to unscheduled interviews in their workplaces which often lasted over an hour. This was very indicative of the degree of autonomy these nurses held to reorganise their day, but made me wonder whether my observations were withholding them from duty. I understood that enthusiasm and disremember may be kindred, and thus from then onwards I decided to invite participants to after-office encounters to interview them at length – some of the subsequent interviews indeed lasted over two hours.

A third significant moment was marked by informants not wanting to be recorded during interviews. This happened sparingly throughout the fieldwork, specifically with one nurse and one auxiliary nurse on the grounds that they were afraid of not being completely grammatical while speaking, because they felt embarrassed for having voices they thought were annoying, or – important for the focus of my research – afraid of having to be too careful as not to say something compromising for others or for their own reputation. While I was reluctant towards the idea of missing important passages and tried to negotiate consent by explaining that the digital files of the interviews were password stored, it was preferable not to force
A practical solution for this was to take notes during meaningful fragments of the interviews, enriched with comments of mine and slightly paraphrased quotations immediately after. While this is common for casual conversations in ethnographic fieldwork, my textual material relied on a mixture of memories, notes and recordings with which I reconstructed their views on the topics being explored. During the data analysis there were moments when I forced myself to recall their exact words as I analysed a specific topic, almost as though I was trying to mentally replay a field tape I did not have. Relying on memory alone, however, can be a chancy enterprise – one can evoke any number of memory flashbacks; that does not make them true. For this reason I decided to meet some informers again several times in my subsequent visits to Chile and via online conversations, contrasting my on-going analysis against their version.

I still identified a fourth significant moment becoming evident when I realised I had access to confidential information and sensitive data of patients. Although I did not primarily aim to work with data from patients, they were circumstantially present in situations I observed to the extent that I became somewhat familiar with the cases and needs of some of them. This was a concern later discussed in comparative reflections with other hospital ethnographers, who had been requested to obtain informed consent from each person present in their settings before observing. My procedure did not consider this step, as the hospital had not served as an ethnographic site before and ethics committees tend to recommend informed consent mostly for registering interviews – I was innocently unaware of other practices that can best ensure confidentiality and, above all, the right to decide whether to participate in a scientific initiative, and the extent and the way people are willing to contribute. Although this omission simplified the access to the wards, by taking a look back to the field experience one can conclude that this is an area where my post-hoc understanding may contribute to the site by recommending devices to enhance the standards of rigour requested by ethics committees and hospital boards of management, protecting in the process the rights of vulnerable individuals.
For all these reasons, I sustain that my experience on a research site whose history is that of a blank slate in terms of exposure to ethnographic research can be beneficial for strengthening the canons of quality of future experiences. That hospital became the laboratory of my research – though not in terms of actual experimentation – and those in ‘captivity’ should be protected from potential exploitation and misconduct. No report can stand as a promise of solution for the complex problem of ethical misconduct. However, researchers may use their intimate knowledge on the social life of their settings and their privilege of literacy to write about it as to recommend actions to compensate the imbalance between the position of the observer and that of the subjects being researched. Or at least, this is the path I have chosen.

**Doing participant observation**

I have claimed in precedent chapters that my approach to field research was that of participant observation. However, this is an umbrella term that comprises a wide range of possible roles, from totally passive (complete observer) to totally active (complete participant), including others somewhere in between, such as the participant-as-observer and the observer-as-participant. My participation was possibly more aligned with the latter type. 

Ever since I first negotiated access to the field, I emphasised my research focus on gathering observational data, and that full participation looking after patients would hinder that focus. I was interested to know details of social life in the hospital, and those details are often embedded in practices away from the bedside. I thus proposed to participate in nurses’ activities as to build rapport with them and the rest of the personnel, and to have a hands-on ‘refresher’ experience, solely to the extent that I could record my observations and impressions as well as reflect on my data and discover meaningful connections between them. My role in the field was not thus tied to strict routines; I had freedom to choose between wards, alternate observations with interviews, move from the patient rooms to the nursing station and from there to the staff rooms whenever I needed to record some relevant event, and schedule visits to nursing managers alternatively.
Equally, as this was a teaching hospital, I had the chance to observe and exchange points of view with faculty nurses and nursing students who where later engaged in in-depth interviews.

Participating in nursing activities merely as a lay helper not only did reduce the risk of becoming caught by the rush of hospital work; it also protected me and the institution from eventual legal charges – I had no contractual relation with the organisation to officially provide care – and patients from being looked after by someone with no proven skills. While adopting a complete participant role would have meant a failure in protecting patients’ safety, retraining oneself only for purposes of this research would have been time consuming. The only circumstances in which one might exceptionally decide to turn into full participant are those implying vital risk for patients without possibility of immediate help from trained practitioners; and yet this can also be a matter of scrutiny and should thus be discussed with the hospital board in advance. In some others, however, one might – and I in fact did – turn into full observer when taking notes or recording may seem inappropriate, disrespectful even. In short, the construction of the observer role is often an inconsistent mixture of sub-classifications, though my own was mostly that of an observer-as-participant.

The lay helper role I filled involved minor tasks, such as answering the phone and carrying some supplies. Yet my involvement in activities that did not relate to care was rather active, such as spending time with the nurses and other professionals at the nursing station, in offices and in the staff rooms, especially in handovers, teaching activities, filling some forms and attending meetings. In some occasions I was suggested jokingly by nursing aids and auxiliary nurses to take on part of their tasks, though ward nurses made clear that my job was of a different sort. This allowed me to gather quality data and prevent the aforesaid damaging effects from happening, but at the same time achieve a deep understanding of the social worlds of the hospital and their culturally constructed meanings.

**Engaging a field assistant**

Engaging an assistant – who was an anthropologist – was a reasonable solution for the problems of observing naturalised practices of one’s own
world. Observational tasks were distributed between the two of us, intentionally planned as to have one observer per ward at a time, in the assumption that the averseness of some members of the personnel to be observed would have increased with multiple observers. It is healthcare providers who usually do observational work in hospitals – they keep patients ‘under observation’ – and forcing them to switch roles seemed on one hand to make them feel anxious, and devolve inappropriate data for the research, on the other. It was their role enactment in their natural settings that I was interested in, not their response to external stressors.

Our activities in the field stuck into a standardised form, including observational notes, reflective notes, spatial patterns of activities, as well as the chronology of events, in ways that facilitated data integration. Although the types of activities we observed differed greatly, they did not refer to differing views on the patterns developing from raw data that we discussed later on. In fact, the standardised data gathering and overlapping reflections enabled comparisons as to facilitate the process of coding that I would later begin. Disagreements on certain matters – such as the degree of autonomy of nurses in some areas compared to others – were left open for further observations. We learnt soon after that those differences were not a matter of reasoning or interpretation, but rather differing conceptualisations we held, which were eventually concealed in light of the theoretical framework I used. A case in point is primary care; whereas my assistant considered primary care as an example of autonomous nursing practice dispensing with close medical supervision, I saw guidelines and technology used by primary care nurses as ‘commodities’ – a term that in sociological parlance refers to devices embedding somebody else’s knowledge – which seemed to limit nurses’ application of their own discernment.

It is always questionable, nonetheless, that both field researchers pertained to the educated middle class and therefore exhibited particular cultural traits, possibly generating as a result a stronger identification with some particular informants, disregarding categories of discourses and views that might have been of interest for this research.

On the other hand, in-depth interviews were undertaken entirely on my own by using a standardised guide for the first encounter, which functioned as an elicitor of information rather than as a questionnaire as such; as I was
interested in their own views about their work, the subsequent encounters were based on recurrences of their discourses rather than on the match between their answers and the interview guide. Yet observational data were used to contrast nurses’ actual work – the focus of my research – against their rhetoric.

In analysing both the corpus of interviews and the observations, the assistant acted sporadically as a consultant, as I visited the site again several times and met the informants to adjust my coding process and refine my analysis. This facilitated the integration of the core categories on which I elaborated in my articles with key sociological concepts.

**Corollary: giving back**

Ethnographers are often criticised for much to be taken away to build their careers and too little to contribute with to the researched people. It is this misbalance that puts researchers in an advantageous position, for their knowledge about the group and their scientific literacy to understand it create a relation of an exploitive nature. At this point of this dissertation, it should be self-evident that the purpose of my research was ultimately political. In this respect, it is safe to say that the issues I have raised through ethnographic discussion may well increase awareness about the constraints affecting the participants’ realities. While the raw data I constructed during the fieldwork may be of scant interest for the participants, there is always the chance to contribute with an influx of ideas, especially when built upon shared experiences – the insights I gained did not come out of pure observation or imagination; my informants were extremely generous in explaining the meaning of what I observed.

In a sense, they have benefitted from being asked about key issues as constructed in their day-to-day activities, which is itself a form of unintentional intervention as it makes people reflect on things one does not normally think of or whose existence one has not even realised. However, providing them with reports of the organisational functioning from the point of view of someone who has taken time to observe it externally might best meet their needs; that means a commitment to ‘translate’ scientific findings into a practical language, in ways that fit their vocabulary and expertise. Although
large organisations are – thankfully – unlikely to change by virtue of one report alone, the leads might find helpful to count on an external view for their decision-making processes and the planning of organisational strategies; they may also consider this researcher as a consultant.

All in all, these ways of thanking anonymous informants set the bases for future endeavours and nurture mutual relations, and in the process highlight the collaborative nature of organisational ethnography.
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