University of Southampton

Community Nurses' Talk of Equal Opportunities and Anti-Discriminatory Practice

A Postmodern Analysis

Kay Aranda

Doctor of Philosophy

Sociology and Social Policy

Faculty of Social Science

June 2001

This thesis was submitted for examination in June 2001. It does not necessarily represent the final form of the thesis as deposited in the University after examination.

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCES
SOCIOLOGY AND SOCIAL POLICY

Doctor of Philosophy

COMMUNITY NURSES TALK OF EQUAL OPPORTUNITIES AND ANTI DISCRIMINATORY PRACTICE –A POST MODERN ANALYSIS

By Kay Aranda

The pursuit of equality has been an explicitly stated social and political goal in Western democracies. In Britain, this has led to various initiatives in the National Health Service and practitioners are charged with a responsibility to promote 'equal opportunities' or develop an 'anti-discriminatory practice.' However, the increasing experience of inequality and disadvantaged in health and health care indicates the failure of these initiatives to respond to difference and exclusion. This has led to questions about the feasibility of this goal and equality is now in doubt. Postmodern critiques have played a key role in challenging these goals and the theories upon which the modern liberal democratic promise is based. These critiques imply there are serious *limitations* to modern forms of equality and infer its demise.

However, this study argues that these critiques also imply the *possibility* for re-thinking equality in health care and more specifically, in community nursing. Postmodern theories are a resource with which to re-imagine a postmodern emancipatory project in community nursing. In this empirical research project, I begin this task by examining the discursive constitution of 'equal opportunities and anti discriminatory practice', evident in the talk of twenty-eight community nurse students and practice teachers from two Universities. I explore these narratives through the use of interviews and documentary analysis. I contend that initially, this talk appears to be consistent and coherent with dominant, liberal equality discourses. However, re-interrogation of these narratives reveals any coherence with liberal equality to be superficial. Upon closer examination, there is a complexity and diversity that both competes with and contradicts liberal equality discourses. I argue these features of talk are critical to an understanding of the discursive constitution of 'equal opportunities and anti discriminatory practice' in health care. I propose that alternative narratives and discursively constituted selves produce an ambivalence and ambiguity that is indicative of the possibilities for re-visioning equality. Together, these diverse narratives and selves provide different grounds upon which to begin to develop a postmodern emancipatory project and politics in community nursing.

CONTENTS

ACKNOWLEDGEMENTS

Firstly, I would like to thank my two supervisors, Susan Halford and Clare Ungerson for their invaluable guidance and support. Susan generously devoted much time and energy, providing me with intellectual stimulation and debate and much needed help and advice. She offered constant encouragement and support and a commitment to my development and progress that I greatly valued. Clare contributed her considerable experience to this task and supported my efforts with many words of encouragement. She became a greatly valued critic and in our discussions together, encouraged me to think beyond the obvious.

I would also like to thank my colleagues in INaM at the University of Brighton. They have encouraged my efforts to continue and finish this thesis with understanding and good will and have supported my studies financially.

My thanks also go to Kathy and Ann for their hard work in proofreading these chapters.

I would also like to thank all my friends for their constant encouragement and support. My love and thanks go especially to Kathy and Mary, who were always ready to listen and were there when I needed them.

Finally, I would like to say thank you to my family. They have provided so much love and support throughout these years. My love and thanks go especially to my sister Mandy and my mother, Doreen, for their love, encouragement and continual words of wisdom. My love and thanks also to Jack, Sandra, Richard, Kathryn and Chris, for the laughter and fun and many necessary and enjoyable distractions.

CHAPTER ONE
EQUALITY AND HEALTH CARE: AN INTRODUCTION

1.1 Introduction

Equality has long been a key political objective of modern liberal democracies. This is evident in and indicative of modern political struggles for social change and increasing demands for egalitarianism. Therefore, any study of equality becomes an enquiry into the nature of modern democratic society (Turner 1986). The pursuit of equality and egalitarian ends has resulted in legislation that promises equal rights, equal representation and equality of opportunity. Thus, policies endorsing equal treatment and equal pay in employment, or equal access to public services, like health and education, have become core features of Western democratic societies. One outcome of these demands for equality has been the development of egalitarian values informing the education and practice of those *providing* public services and, more specifically, health care (Thorne 1999). The National Health Service (NHS) and the nursing profession now attempt to ensure a service that promotes equality and minimises discriminatory behaviours and attitudes in order that health care become more accessible and inclusive.

However, enduring social and economic inequalities appear to refute the modern democratic promise of equality (Turner 1986, Meehan 1992, Sevenhuijsen 1998, Phillips 1999). For example, the continuation of class, gender and ethnic inequalities in health suggest that there are limits to the liberal principles and promises enshrined in the NHS (Townsend & Davidson 1982, Whitehead 1987, Smaje 1995, Bartley et al 1998, Annandale & Hunt 2000). Research has demonstrated the culpability of nursing and the NHS in actively perpetuating these inequalities. Explanations have been sought and include the perpetuation of oppressive health care through individual discriminatory attitudes and behaviour, to institutional discrimination, maintained through daily work practices and the structures of nursing and the NHS (Foster 1988, Ahmad 1993, Bowler 1993, Gerrish et al 1996, Gerrish 1998, Thompson 1998, Vydelingum1998).

In addition, recent postmodern critiques of modern social and political theory propose serious challenges to questions of equality. These critiques interrogate not only the

means to equality but also its ends. In raising doubts about the feasibility of equality, the grounding of political action upon these modern ideals becomes problematic. Therefore, these critiques have implications that go beyond the traditional debates on inequality and discrimination. Implicit in previous debates was a relative consensus regarding the goals of equality. As Turner (1986:18) suggests, it was *inequality* that required moral justification, not equality. However, postmodern critiques throw this consensus into doubt. As the fundamental core values and objectives of modern politics have come under intense scrutiny, liberal democracy is revealed to be premised on an inherent inability to deal with difference. This has left the pursuit of equality upon very uncertain grounds.

In this thesis, I intend to explore these postmodern challenges to equality. More specifically, I examine the implications of these debates in relation to equality in community nursing and more generally within the NHS. This is an urgent task in health care when, as the evidence shows, discrimination is endemic and nurses are implicated. Moreover, the strategies used to promote equality have reached a stalemate; with no one approach deemed able to effectively address inequality. With postmodern theories challenging the very feasibility of equality, the relative merits of these practical strategies are, therefore, in doubt. In nursing, these strategies include promoting 'equal opportunities' and/or developing an 'anti-discriminatory practice'. Postmodern critiques imply these strategies are not merely limited but are also more fundamentally flawed. Thus, the modern theories upon which 'equal opportunities and anti-discriminatory practice' are based are defined as incapable of tackling inequality, and as such, appears to reaffirm the demise of equality as both a political vision and a practical goal.

However, postmodern critiques suggest not only the end but also the possibility for re-imaging equality. These arguments provide a valuable analytical resource with which to rethink equality in health care. This is important as, currently, a number of questions remain unanswered. It is not clear, for example, whether community nurses work with, endorse or reject these modern strategies of equal opportunities or anti-discriminatory practice. Furthermore, it remains uncertain as to how community nurses construct their own accounts of these strategies, or of equality more generally. Nor do we know how they talk of promoting equality and/or including those excluded, nor how that work

might involve them, both professionally and at a more personal level. In addition, there is an enormous amount of evidence documenting how discrimination occurs in health care, implying the presence of vested interests perpetuating a status quo. There is need to investigate whether there is a similar inertia in community nursing and whether all community nurses are defending and protecting a status quo. There is also relatively little research on how equality might be developing in community nursing and more generally in health care. This lack of knowledge, together with the damning postmodern critiques, implies there is an urgent need to identify how equality may or may not be constituted and a need to clarify what form of equality is being endorsed, rejected or reworked. Undertaking this investigation would reveal whether modern forms of equality are predominant and whether this dominance is complete. If it is not, then the reasons for this and the possibility of 'other' constructions of equality need to be clarified. This could indicate different grounds from which to begin to re-think equality in community nursing. In this thesis, I intend to begin this task and respond to these challenges by conducting an empirical study into community nurses' talk of equal opportunities and anti-discriminatory practice.

I have chosen to focus on community nurses for several reasons. This is a group of nurses who are based in primary care and have an extremely influential role in promoting access to services and access has become one of the major objectives of policies and programmes aiming to promote equal opportunities in health care. Community nurses also have an individual *and* community focus to their work and would seem ideally placed to tackle inequality and promote social inclusion. Like all nurses, community nurses have a remit to meet the different needs of the diverse communities with whom they work (ENB 1995). Yet, for many community nurses this is often work with people who are the most marginalized and excluded. For example, health visitors and district nurses can be found working with homeless people, and refugee and asylum seekers, while community mental health and learning disability nurses work with clients who are considered among the most vulnerable groups in society (Luker & Orr 1992, Littlewood 1995, Twinn et al 1996). Community nurses also have a remit to be proactive in their work with clients, patients and their families and they have a responsibility to promote health and prevent illness and disease. Their role is additionally unique, in that they have a considerable degree of independence in

their day-to-day work and often work alone. There is, therefore, a continual need to develop partnerships and collaborative working with the rest of the primary health care team (Sines 1995). They often develop ongoing relationships with individuals and families over periods of time, which requires respectful and reciprocal forms of practice, especially as community nurses often work with people in their own homes (Twinn et al 1996). In addition, this focus on community nursing stems from the need to develop specific knowledge about the community nursing response to demands for equality, as their work is a valuable but considerably less visible part of the NHS. Indeed, much previous research into the inequality and discrimination experienced by clients, patients, and nurses themselves, has tended to focus on the more numerically dominant groups of nurses in pre-registration training and/or hospital or secondary care settings(see for example Ahmad 1993, Gerrish et al 1996, Iganski et al 1998). It is for these reasons I have chosen to focus on community nursing. Their daily work brings them in to direct contact with clients who experience the worst effects and consequences of inequality and disadvantage; they work within diverse communities, with clients, patients and their families, many of whom have immensely differing needs. Furthermore, these are nurses who are at the forefront of a primary care led NHS, as government policy now dictates, and are ideally positioned to promote equality and social inclusion (DOH 2000).

I have divided this chapter into several sections so that I may review the relevant literature and substantiate the aims and structure of my thesis. In section one of this chapter, I begin by examining the premise for modern political initiatives, such as equal opportunities, in order to establish the nature of the foundations for these practices. I review the philosophical foundations and key concepts of modern political theory in order to establish the nature of modern equality. I identify the modern epistemological and ontological assumptions embedded in the two main approaches to equality and discuss both the aims of liberal and radical strategies and their respective limitations. In section two, I then evaluate how the NHS and nursing generally has sought to respond to questions of equality. I assess the modern foundations to these strategies and the respective success or limits of such initiatives. I conclude these programmes are predominately liberal and though partly successful, have been mainly limited in effect. Section three of the chapter discusses the limitations of NHS' policies and initiatives, and the possible reasons for the resulting inequalities are discussed. I argue that *modern*

responses to this may in themselves be limited, as they too are founded upon modern epistemology and ontology. I show how these approaches to equality may now be considered inherently flawed and consequently imply the demise of equality as a goal within the NHS and nursing.

However, whilst this is one possible outcome of postmodern theorising, I reject this pessimistic scenario. I suggest there is an alternative conclusion to postmodern theorising of equality and politics. These theoretical limits may offer the *possibilities* for new ways of thinking about equality and practice. Thus, the very tools used to deconstruct theoretical certainties are, I argue, capable of creatively constructing new visions for a postmodern, emancipatory politics. I argue that postmodern critiques engage in a critical interrogation with modern theories and concepts not only in order to deconstruct and critique, but to reuse and re-deploy and re-vision the political (Yeatman 1994). I conclude by arguing that *postmodern* and *poststructural* critiques developed by feminism, offer a valuable resource (Flax 1990, Nicholson1990, Butler & Scott 1992, Yeatman 1994).

1.2 Equality & Democracy

Equality is a complex concept to define It is often conceptualised as a 'value and a principle' that is quintessentially modern and progressive. Indeed, it is taken as a measure of what it is to be modern (Turner 1986:18). Thus, the mark of a civilised society is argued to be evident in its attempts not only to eliminate the symptoms of inequality, but also to tackle its sources (Turner 1964:140). However, desirable though these aims are, equality is also a contested concept. There has always been a degree of controversy over the way the same term is used with different connotations. This produces a conceptual confusion that means that equality may be expressed as a moral belief; as an a priori principle; a right; and/or a means to an end or an end in itself (Meehan & Sevenhuijsen 1990). This varying conceptual use is evident in Tawney's (1964) claim that it is not equality of capacity or attainment that a democratic society seeks but equality of 'circumstances, institutions and manner of life' (1964:49). This conceptual confusion also has important consequences for how equality and difference are framed within current debates. The varying conceptual definitions and use of

equality tends to reinforce notions of equality as description, which serves to ignore its normative base. Even when this base is recognised, there is also a tendency to mix the two together. Thus, liberal conceptions of equality become associated with equivalence and fairness. This is a supposed individual equivalence of like with like, where individual but equal subjects are granted equal rights to equality. Yet, this use perpetuates taken for granted norms; norms which are revealed when the gendered subject at the heart of political theory is exposed (Pateman 1989). This normative and descriptive use also leads to the positioning of difference as non-equivalence, as a deficit of some sort, rather than as a valued attribute or virtue (Mens-Verhulst 1998, Sevenhuijsen 1998). Thus, conceptual diversity has produced a great deal of confusion and there is a need always to for clarify these various uses. Turner's sociological study of equality is useful as it has sought to identify frequently cited uses of equality. These include ontological equality, equality of opportunity and condition, and equality of outcome or result (Turner 1986:34). Ontological equality is an equality of person due to some essential nature or ontological sameness or worth. Equality of opportunity and condition are associated with the former concept, permitting equality through merit and the application of fair rules. The more radical notion of equality of outcome asks for the wider redistribution of wealth, income, social goods and resources, power, prestige and status. Together, this typology and Meehan and Sevenhuijsen's (1990) critique appear to clarify some of the previous conceptual confusion. However, as Turner acknowledges, this form of ordering is always an 'ideal type' and in every day use, definitions may overlap and become indistinct. Nevertheless, there is more at stake than semantics, for as feminists have shown; the disguised normative base to equality and the promise to include is, in fact, a key mechanism in perpetuating the exclusion of large numbers of people (Pateman 1989, Nicholson 1990, Butler & Scott 1992, Yeatman 1994).

1.2.1 Justice, Citizenship and Equality

While the concept of equality is contested, there is a consensus that the pursuit of equality is inextricably liked to modern notions of justice, citizenship and democracy (Young 1990, Phillips 1991, 1993, Lister 1997). Therefore, an appropriate starting point for understanding the various concepts of equality is that of early liberal democracy

from the eighteenth century. Forms of democracy at this time exemplify how modern political conceptions of equality were central to notions of modern citizenship and democracy and struggles for social change. As Turner (1986:18) suggests, equality is a modern value, arising from political egalitarianism and the aspirations for universal citizenship that grew with the development of the modern nation state. This was a notion of citizenship that presupposed egalitarian social relations, rather than those relations traditionally based on vertical hierarchies. Therefore, with the growth of the modern state, pressures arose to ensure these egalitarian values were translated into formal laws aiming to guarantee universal legal relations (Turner 1986:20). A modern form of citizenship, therefore, presupposes some commitment to equality and within such a framework, a certain amount of inequality is no longer to be tolerated (Turner 1986, Lister 1997, 1998).

At the heart of modern political democratic theory and citizenship is the political subject. Rousseau saw this abstract, rational, autonomous subject as an idealised and romantic figure, good by nature and yet corruptible by civilisation. Thus, Rousseau's 1762 social contract set out the principles for a democracy based on a notion of consent (Phillips 1991). This consent was to continue to guarantee the liberal freedom to pursue one's own interests and ensure freedom from unreasonable state interference. Therefore, consent was a key concept in understanding how free individuals came together as equals and subjected themselves to any political authority. Consent meant that all free citizens agreed to transfer their sovereignty to a central power in order to protect their own interests and in so doing constructed a 'general will' (Meehan & Sevenhuijsen 1992). This was a social contract premised upon the notion of an individual who had natural rights to freedom and autonomy, which would be surrendered to secure order and regulation.

Therefore, as Phillips (1991, 1993) argues, liberal democracy was initially a means to protect the free individual. Yet, it was at the same time a democracy based upon fear. These fears were initially of an excessive government that could potentially interfere with an individual's freedom, which later became fears of the apparently excessive demands of the people themselves. Thus, protection was argued to be a necessary constraint in order to safeguard individuals' freedom and rights. Rousseau argued that

man was born with innate rights to freedom because it was assumed he was capable of rational self-determination and independent action. As Phillips (1991, 1993) notes, the idea that rights were innate, implied a natural or ontological equality between people. This meant that modern forms of equality in liberal democracy were linked to the one's status as an 'individual,' with innate rights to equality.

In these early democracies, an individual's rights to equality were also rights to privacy and more importantly property. Those without property were deemed to be non - individuals and subsequently were without rights. Indeed Phillips reminds us that in original Athenian accounts of democracy, only those holding property were allowed to participate in politics. These assumptions excluded slaves, women and children (Phillips 1991). However, as Phillips (1993) argues, once political theory was premised on notions of individuals being essentially the same, others seeking to be represented as political subjects began to make claims upon the liberal democratic state. She argues that historically, therefore, equality was linked to a particular form of democracy. This was a link that needed to be constructed rather than it being an implicit part of the democratic ideal. Central to this ideal were notions of justice and citizenship.

The most influential framework for conceptualising justice is the distributive paradigm (Turner 1986, Young 1990, Sevenhuijsen 1998). Within this paradigm, the dominant conceptualisation of justice is with redistribution of goods and services. Citing Rawls' theories of justice, Young (1990) argues that this paradigm identifies justice with the 'proper patterns' of distribution. This allocation of social goods and benefits tends to refer to material goods, which narrows the focus of justice to end states or static, pattern-orientated notions of justice. However, as Young (1990:18) argues, these patterns should not be the only measure of justice. Non-material goods and the *processes* of justice, and social structures and contexts must be included in contemporary discourses of justice. These non-material benefits are significant as they include rights, opportunities, power, and self-respect (1990:29).

Rights to equality are now an important part of the democratic ideal (Turner 1986). Marshall(1950) argued that the eighteenth century oversaw the development of civil rights, with the extension of equality through representation for the wealthy few. The

nineteenth century saw the development of legal equality through an extension of political rights and suffrage. This became associated with an extension of opportunity via education and a focus on equality of condition to ensure equality of opportunity. The twentieth century witnessed the emergence of social rights with the development of the welfare state. The development of universal provision for basic needs included health care and legislation for social citizenship. This aimed to bring about a minimal equality of condition (Turner 1986:119).

However, these rights remained intimately connected to the individual who was able to participate in political and social life. Thus, equality became associated with participation brought about by the development of citizenship in Western democracies. The term citizenship derives from the Latin meaning membership of the city and with status or social standing. It was a concept connected to nationality but not always interchangeable with claims to human rights (Lister 1997). Only in Roman times did the association with membership and the state evolve. Now citizenship is linked to nation state status, enfranchisement and belonging to political and social communities. The subsequent extension of social citizenship has become inextricably bound up with social movements' demands for social change and equality. Evidence of these demands are to be found in the development of modern struggles for change, in which women, black and minority ethnic, lesbian and gay and disabled people began to make claims upon the liberal democratic state in the name of equality (Yeatman 1994).

It is evident from the preceding discussion that there appears to be an established link between citizenship and a range of rights to equality. However, this link was not inevitable. Therefore, to understand why this association has evolved as a key principle for ensuring the modern liberal democratic ideal of equality, it is necessary to examine the philosophical foundations to modern political theory. It is the development of modern liberal political theory from the historical period known as the enlightenment that reveals a particular epistemological and ontological form. This has shaped the type of theories and practices and strategies of equality within modern liberal democratic states.

1.2.2 Philosophical Foundations to Modern Political Theory

An examination of the philosophical foundations to modern political theory is essential for understanding the premise and logic of democratic concepts and ideals. The foundations to these ideas are derived from enlightenment thought and the ideals of humanism, rationalism and universalism. As a historical period, the Enlightenment reflected a number of beliefs about the modern world. These included a belief in the existence and use of a neutral yet emancipatory reason, the belief in an undetermined, autonomous rational subject and in the benign progressive logic to history. Given these tenets, there was also a belief that political life could harmoniously coordinate these autonomous selves but only through the exercise of an authority free of domination (Flax 1993:30). Thus the Enlightenment established the authority of reason. As subjects became more rational, they would become more adept at managing freedom and the need for constraining institutions would diminish (1993:82). Flax argues there were two tacit assumptions to this promise of progress and freedom. There was an assumption that reason was universal, could operate autonomously and that subjecting selves to reason's dictates was emancipatory. She shows how these assumptions rested upon a prior set of beliefs governing the constitution of the subject. These were beliefs or assumptions of an innate, homogeneous form of reason existing in all people, making everyone the same. Furthermore, there was a belief that reason could be split from bodily and social experience to ensure 'reason's purity'. This allowed reason to be undisturbed by other experiences in order to act as a reliable source of universal truth. These enlightenment premises became embedded in all modern epistemology and ontology.

The theories and practices of modern politics are imbued with these ideas and assumptions. The progressive and emancipatory logic of reason, together with notions of the autonomous, rational subject and the promise of benign governance provide the rationale and logic to modern liberal democratic theory. Therefore, modern democratic ideals and theories of a progressive politics and justice promised benefits to all citizens. Demands for equality of opportunity and condition or outcome were premised upon modern notions of epistemology and ontological equality. This has produced two main responses from modern liberal democratic states.

1.2.3 Liberal and Radical Approaches to Equality

Demands to be included into modern democratic society have produced two dominant responses, namely a liberal and radical approach to equality(Jewson & Mason 1992). The liberal approach to equality stems from the liberal democratic promise of inclusion. Within liberal states, there is recognition that certain forms of inequality are unjust, as unfair barriers; conditions or others' attitudes and behaviour are seen to hinder people's natural talents or ability to participate. Therefore, equality is to be achieved through the enabling of individuals to compete freely and equally for social rewards. This is ensured through the provision of equality of opportunity and the removal of barriers or rules that discriminate. In this way, justice is seen to be done (Forbes 1992, Jewson & Mason 1992, Phillips 1993). In health care, this equality of opportunity translates into guarantees or promises of equal access and equal treatment. More generally, these liberal responses can be found in an incremental approach to legislation, for example, the eventual extension of suffrage, the development of welfare services and the subsequent laws governing equal pay and sex, race and disability discrimination. These laws and policies have sought to guarantee freedom from discrimination in employment, housing, health care and education. Equality formally enshrined in law is known as procedural equality.

However, liberal equality is seen as a minimalist approach (Forbes 1992, Jewson & Mason 1992). It may offer people opportunities to participate but it leaves existing social relations and structures unchallenged and intact. Liberal conceptions of equality conceive of talent and ability as individual attributes. This fails to address structural sources of inequality (Jewson & Mason 1992:221). As Forbes (1992) argues, the removal of barriers or instating fair procedures does not ensure equality of opportunity, condition nor outcome. Rather, procedural equality is seen to legitimise a system that deliberately differentiates on the basis of desert or merit. In response to these difficulties and limitations, a competing approach emerged. Forbes (1992) describes this as a radical or maximalist approach. This differs as an equality strategy, in that it focuses on ends or outcomes rather than means. The key principle is to ensure a fair distribution of rewards rather than merely ensuring the provision of fair procedures as in liberal

conceptions. A radical form of equality recognises the indirect and covert forms of power involved in discrimination and acknowledges the power relations embedded in institutional practices. In this approach, there is an attempt to intervene more directly. It is only radical changes in the distribution of power and exposing the operation of that power that will eventually produce equality. Thus, Jewson & Mason (1992:223) argue that it is radical approaches that have revealed the normative base to liberal concepts like talent and ability. Furthermore, these radical approaches have done much to draw attention to the experiences of those oppressed or excluded and have focused on the mechanism or processes which produce inequality. Modern social movements and struggles to bring about social change have often been the result of a mobilisation around these more socialist or Marxist ideals. These approaches are commonly associated with different versions of democracy in attempt to overcome the limits of liberal representative democracy. For example, definitions of radical democracy often argue for the extension of more active political participation (Phillips 1993, Mouffe 1994). However, while radical approaches to equality have been premised upon substantial theoretical critiques of a liberal, capitalist society, the subsequent application of these approaches has been limited. Therefore, in terms of policy and legislation, radical equality has not been as significant to the majority of disadvantaged people in the West as liberal legislation and policies may have been (Weedon 1997).

Conceptual distinctions between liberal and radical approaches are, as Jewson & Mason (1992) suggest, ideal types that in practice and policy become blurred and less easy to define. This means that liberal and radical conceptions of equality are often compared and considered or discussed in differing ways. Jewson & Masons' typology of liberal and radical conceptions of equal opportunities policies clarifies important themes to these 'muddled' debates and conceptual slippage. They identify four elements embedded in discussions of equal opportunities policies. These include the principles of fairness and justice that underpin equal opportunities and the means of implementation used with these policies. Then there is often talk of the effectiveness of the policies and this refers to the ends and whether fairness or justice is achieved. Finally, there is the perception of fairness held by those participating in the policy implementation or policy-making process.

However, even with this clarification liberal and radical approaches are indicative of a further dilemma. For in addition to these theoretical limitations, there are normative assumptions embedded in both these strategies. Upon further analysis it becomes evident that to ask for inclusion or equality presumes an already defined norm. Thus, the demand for equality is premised upon a normatively defined political subject. Therefore, demands are made on the basis of a *sameness* with, or *difference* from this norm. Feminism's struggles for women's equality exemplify and reveal the dilemmas inherent in these two strategies.

Early liberal feminist arguments for women's equality sought to overcome barriers and to change attitudes and customary practices. Women were argued to be the same as men and were, therefore, as capable of self-determination and rationality (Phillips 1991, 1993, Weedon 1997). However, in appealing to liberal notions of justice, women were in turn arguing that significant differences between women and men did not matter. What became known as 'Wollstonecraft's dilemma' ensured that inclusion in the public sphere meant women's domestic responsibilities were ignored. Yet, women could not fully participate in paid work on equal par with men when they continued to have major responsibilities at home (Pateman 1989, Phillips 1991). Moreover, as bell hooks (1987) asked, it was not exactly clear with whom it was that women wanted equality. Yet, as in most cases this was men, she asked *which* men did women want equality with, given the many differences between men living in a patriarchal, racist, capitalist society. There was, therefore, growing recognition of the gendered and racialised norms of liberal equality. Thus, white, male defined norms underpinned these strategies and determined the parameters for inclusion. In response to these limits, feminists demanded radical strategies of equality. These approaches attempted to revalue women's significant differences. These differences were to be celebrated as virtues. Only by valuing these differences could women avoid being measured by any pre-given norms. Therefore women's lived experiences, their biological, psychological or emotional states were argued to be different, yet of equal value (Gilligan 1982, Sellers 1991, Grosz 1993, Weedon 1997).

However, these radical strategies of difference were, themselves, not without problems, for difference could be used, not only to demand equality, but to justify inequalities

between men and women. As Scott (1988) suggests, others can misappropriate demands for equality based on differences. These demands become arguments for innate, biological differences that can then be used to justify women's exclusion. Therefore, demands for equality premised on difference continue to imply some kind of common or essential nature. Even in its own terms, however, this strategy has become increasingly problematic. The assumption of common experiences has exposed substantial differences and inequalities between women. This diversity has undermined the core foundations upon which feminism, as a modern social movement, was based. Phillips (1991) sees this as a positive development. It has produced different priorities and alliances and is, what she identifies as, the continual movement between universal aspirations of equality and the assertion of difference (Phillips1991, 1993). These accounts have transformed feminism's understanding of taken for granted concepts and theories and the significant differences between women are now to be responded to and engaged with (Butler 1990, Sellars 1991, Weedon 1997). This was a politics of difference, which employed a concept of difference that made claims to equality based on an autonomy that sought to reject the terms by which equality is measured; this was a right to be equal *and* different (Scott 1988, Grosz 1993). Therefore, these feminist struggles with equality amply demonstrate the dilemmas of adopting a 'same or difference' strategy. They show how strategies of liberal inclusion have been questioned and diversity and difference have come to the fore.

Therefore, modern equality is a contested concept; it has many meanings and uses. Yet, there is a relative consensus concerning the particular ways in which equality is linked to modern democracy and notions of distributive justice and social citizenship. Paradoxically, liberal democracy also demonstrates an inherent inability to deal with difference or diversity. At the heart of modern political theory, with its claims of equality of opportunity, is an abstract masculine political subject. Therefore, excluded groups are required to make their demands for inclusion in the name of this subject. Strategies seeking to valorise difference, as a response to this limited liberal form of inclusion, were also shown to be equally problematic. Furthermore, these demands for the recognition of difference, and associated radical strategies, have had less practical success than liberal approaches.

Liberal equality is limited and has been shown to suppress or remain indifferent to important social differences. These social differences have led to significant inequalities in health and health care. It is therefore timely to consider the relevance of these theoretical debates for the practices and institutions of the NHS and nursing. These are welfare state institutions, whose founding principles were premised on those of modern liberal political theory, namely re-distributive justice and social citizenship. These principles sought to provide entitlements and rights to health care and were enshrined in the NHS through the principles of social insurance (Williams 1989). I will assess how these institutions and practices of the NHS and nursing have responded to demands for inclusion and for responses to difference and diversity. The persistence of inequality and discrimination in health care and nursing has led to increasing demands for change. The demand is for the delivery and provision of health care that responds sensitively and appropriately to the different and diverse needs of clients and patients, their families and communities. Strategies of inclusion, like those of promoting equal opportunities and those seeking to recognise difference, like anti-discriminatory practice, will be examined together with policy responses both past and present.

1.3 Equality and Health Care

The notion of equality in health care is distinct from the conceptual use in other contexts, in that not all people are, nor would they necessarily want to be, equal in terms of health or illness. Rather, the concern is with having equality of opportunity to access services and treatment when needed. Equity in health care can be defined as ensuring equal access and use of available health care for equal need, with equal quality of care (Kings Fund 1999). The aim is to achieve equitable, rather than equal health care per se. However, inequitable differences are those deemed unnecessary, avoidable, unfair and unjust. With the majority of health differences argued to be avoidable and unjust, health is seen as socially produced and mediated by peoples' social, economic, ethnic and gender identities and more widely by their de facto citizenship status (Whitehead 1992, Ahmad 1993). The World Health Organisation's (WHO 1985) strategy for 'Health For All by the Year 2000' and beyond, recognised these influences and listed *equal opportunities* as a pre-requisite for achieving health and the satisfaction of basic needs (WHO 1985). Thus, equality of rights, of citizenship, participation and the provision of

basic human needs are considered essential in moving towards equitable health and health care. In this way, issues of equal opportunities became a central part of the NHS and health care agenda.

As the major provider of health care services, the NHS obviously has a key role to play in either reducing or perpetuating inequitable differences and inequalities in health and health care. Though criticised for being an, 'illness' rather than a 'health' service, the provision of publicly funded health care provides an important source of welfare. The founding principles of this service were to ensure equal access for all, and since its inception the NHS has seen an increase, rather than the expected reduction in use (Williams 1989). The popularity of the NHS means the form that services take and the way they are delivered greatly determine people's access to and experience of health care. The nursing profession has a similar influential role, given their work with patients and clients in all spheres of the NHS, from primary, through to secondary and tertiary levels of health care. Nurses greatly shape the experience of care that patients and clients receive (Twinn et al 1996). These positions and influential roles have been shown to contribute to the ways in which nursing and the NHS more generally reinforce inequality and inequity (Douglas 1992, Ahmad 1993, Smaje 1995). It is important, therefore, to assess how the NHS and nursing has responded to demands for equality and equity in health care. In the next section of this chapter, I review this evidence and the responses and evaluate the various strategies and programmes developed during recent years. Each of these strategies will be further assessed for the adoption of either a liberal or radical approach to equality.

1.3.1 The NHS Response to Demands for Equality

The founding principles of the National Health Service were those of inclusion, promising to provide equal access from cradle to grave, regardless of an individual's ability to pay. Yet, I will show there have been numerous claims of discrimination in access and treatment, and that responses to this have been relatively poor (Ahmad 1993). This suggests an inertia, the cause of which has been the subject of much debate (Doyal 1979, Oakley 1980, Roberts 1992, Ahmad 1993, Smaje 1995, Bartley et al 1998). Early debates have been influential in defining the initial problem of inequality as one of access to services and treatment. This has meant the process of care and the

involvement of health service providers, in particular nurses, was considered less problematic. However, subsequent numerous studies have amply demonstrated their involvement. These debates on inequalities in health and health care are reviewed in order to establish the overall framing of the problem of inequality and inequity in the NHS and nursing. I then examine the NHS and the various initiatives and policy responses to inequality.

1.3.2 Responses to Inequalities in Health

The literature documenting the link between continuing health inequalities and lack of access to health care is well established. In sum, the social divisions of class, gender and race are known to shape and determine both an individual's use of health care services and contribute to overall health status and levels of health inequality (Bartley et al 1998). Both the Black report, (Townsend & Davidson 1982) and Health Divide (Whitehead 1987) revealed the link between class, gender, ethnicity, and mortality and morbidity. More recently, the Acheson Report (1998) into inequalities in health confirmed the continuing effects of multiple disadvantage and social exclusion. The report continues to show that while poverty and unemployment are major determinants of poor health, access to appropriate care and treatment remains a key factor influencing health.

The Black Report was the first major report to reveal the systemic effects of class and gender on health, though little comment was given to the disadvantaged experienced by black people. The Health Divide confirmed these divisions and their role in perpetuating inequalities in health. Evidence from both reports confirmed Tudor–Hart's inverse care law, with those needing health care the most using it the least (Whitehead 1987). The Black report also confirmed that inequalities in health were inextricably linked to the availability and use of health services. Townsend and Davidson (1982) concluded that inclusion or access was a complex phenomenon, not easily reducible to any one factor. They commented that,

' Unequal usage will never be more than a partial explanation of the overall inequalities in standards of health[for]difference in health may be far more a function of variations in socio-demographic circumstances of a population than the amount and type of medical care provided and/or available[.] Nevertheless, any inequality in the availability

and use of health services in relation to need is in itself socially unjust and requires alleviation.'(1982:76)

More importantly, Townsend and Davidson did argue that the availability and quality of care was one explanation for the various use of services. Another significant reason was the normative, institutional base of the NHS, functioning predominately to meet middle class people's needs. They concluded that it was these two factors, the availability and quality of care, together with this normative base, that combined to generate and produce the inequalities in health the Black report documents. Thus, the demand to promote access to health care regardless of any other considerations became problematic. This was reinforced by the experiences of those using the services and those working within the NHS. These subsequent accounts have revealed the role of the NHS in perpetuating inequality and inequity. The organisation and activities of the NHS are said to reflect and reinforce wider capitalist, racist and patriarchal power relations in society. Therefore, arguments for inclusion perpetuate access to a service that is at best patronising and at worst extremely oppressive (Doyal 1979, 1995, Oakley 1980, Roberts 1982, Ahmad 1993, Smaje 1995, Hunt & Annandale 2000).

Further sociological studies sought to document peoples' experiences of health and illness and their experiences of using health care. Feminist research contributed a great deal to these debates and revealed that the extent to which class and gender shaped encounters with the health service. These patriarchal, classed forms of care were found to be especially prevalent in the areas of fertility or reproductive care. Women's experiences of contraception, abortion, their use of maternity services and their face to face encounters with the medical profession provided many examples of the power and control 'white medical men' had over women. (Doyal 1979, Oakley 1984, Roberts 1992).

Furthermore, while health care was sexist and classed, it was also racist (Pearson 1985, Mama 1992, Ahmad 1993). The NHS was never intended for a culturally diverse population. It was set up to meet the needs of an assumed homogenous British culture and services were to meet the expectations of the majority population, popularly consider to be white, middle class, and Christian (Ahmad 1993). According to Pearson, (1985) the assumption was that people's needs and priorities would be similar.

Therefore, existing services and policies were considered appropriate with different needs thought to be easily assimilated. The fallacy of this argument is evident in minority ethnic people's continuing experience of racism. Consequently, minority groups experience disproportionate levels of inequality in employment, housing, income, education and more significantly, health and health care (Hall 1990, Brah 1992, Skellington & Morris 1992, Ahmad 1993, Smaje1995, Solomos & Back 1996). More specifically, the racialisation and the pathologising of minority ethnic people's health needs or lifestyles has led to forms of direct and institutional racism being ignored and denied (Douglas 1992, Ahmad 1993). This status quo has ensured that racism is deeply embedded in the structures and practices of the NHS (Ahmad 1993, Smaje 1995).

1.3.3 Responses to Inequalities in Employment and Service Delivery

The NHS response to gender, ethnic and class discrimination has been slow. This is exemplified in the NHS response to racism. The inertia was possibly reinforced by policy initiatives in the 1970s, where the Commission for Racial Equality (CRE) focussed on education, housing and social security rather than on health care. Indeed, the NHS did not receive much attention until the mid 1980s (Johnson 1993, Ward 1993). Ward (1993) speculates that this may have been due to the bureaucracy of the NHS being more concerned with administration than with the management of change. The New Right's anti -collectivist welfare policy of the 1980s compounded this, with its emphasis on the internal market and providers and contracts. This meant the NHS began instead to focus on efficiency and effectiveness, although outside agencies did exert pressure to respond to the growing evidence of racial discrimination. Throughout the 1980s and early 1990s, the CRE demanded the NHS endorse codes of practice and develop equal opportunities polices in line with their guide to good practice (Johnson 1993). Initiatives such as the Kings Fund's Equal opportunities Taskforce (1990) encouraged NHS management to introduce equal opportunities policies and health authorities began to monitor and collect information on minority ethnic client groups. However, Ward (1993) argues, that while this centralist top down approach produced some action, it did not necessarily produce any commitment. Furthermore, this laissez faire, assimilatory approach to diversity and equality was complimented by the development of a multicultural approach.

Multiculturalism is an approach based on the principles of respect and recognition of ethnic diversity. However, this approach has been severely criticised for failing to account for the inequalities in power between major and minority ethnic groups (Williams 1989, Culley 1996). In response, the anti-racist approach has sought to correct this 'add in and stir' or colour- blind approach. Anti-racism meant focusing on inequalities in power by identifying direct and indirect forms of racism. Thus, racism was theorised as the product of individual as well as institutional practices (Dominelli 1988, Williams 1989, 1992). Gerrish et al (1996) note, however, that anti-racism was never a homogeneous practice and it was criticised, both on the left and right of the political spectrum for being strong on rhetoric and weak on delivery in practice. Ahmad (1993) and Dominelli (1988) argue that these policy responses in the NHS must be understood in the context of British nationalism and imperialism. These responses are linked to the historical aims of the welfare state, which was to create a healthy nation fit to work and ensure economic prosperity. But this promise never included black people. Indeed the fear was that black people would over use or abuse the NHS. This meant there were always doubts as to the legitimacy of black and minority people's claims or entitlements to welfare. Yet, paradoxically, the NHS relied heavily upon and exploited migrant labour to offset the rising costs of health care (Doyal 1979, Williams 1989).

These multicultural and assimilatory responses to minority ethnic clients and patients demonstrate forms of procedural equality. The main focus has been to promote further access, to equalise treatment, remove barriers and ensure fairness in procedural affairs. However, a further complicating factor to these official policy responses has been the overwhelming focus on employment issues rather than on service delivery. Therefore, employment initiatives have been far more evident than policies that directly address issues of service delivery, though the two are related. The recruitment of a workforce that reflects the cultural diversity of the population is thought to guarantee sensitivity to client and patient diversity in the delivery of services. Employment is a significant arena for equality, as the NHS is the largest employer in Western Europe (Culley 2001). Yet, nurses as workers within the NHS have only recently become the subject of research (Oakley 1984, Davies 1995).

Previously, traditional sociology focused on the doctor-patient encounter rather than nurse-patient relations and did not see nursing as a legitimate area of study in its own right. It was assumed that what applied to medicine would equally apply to nursing. Even early feminist studies of health care did not view nurses as an oppressed group of women whose position required feminist theorising. This is an oversight that was the one of the paradoxes of applying feminist arguments for equality to the NHS (Franzway et al 1989, Davies 1992, 1995). Arguments for women's equality were primarily concerned with inclusion through employment. Women in the NHS were in the majority as employees, so there seemed to be no need for feminist political action demanding equal representation. As Davies (1995:230) argues, the need to understand the processes *of inclusion* as well as exclusion is an important task, one which I discuss further, later in this chapter.

Within the NHS, the initial focus was on women who were already included but faced discrimination as employees in the NHS. The official NHS response was to launch the 'Opportunity 2000' initiative in 1991, which aimed to increase the quantity and quality of women's contribution to the workforce (Langridge 1993). The NHS executive's own survey had found that the macho working culture of the NHS militated against women with children, due to the long hours and inflexible working arrangements. The arguments were for flexible working patterns and improved opportunities for part-time or job-share workers (NHSE 1996). The NHS is also the largest employer of minority ethnic workers. The NHS response to these workers and its preference for more inclusive strategies, particularly the aforementioned multicultural approach, is evident in the NHS Programme of Action (NHSME 1993) and the development of an Ethnic Minority Unit. This unit sought to achieve equal representation in recruitment and employment of minority ethnic staff in nursing and at management levels. It also aimed to tackle harassment and to make the NHS free of discrimination. This also led to the development of various strategies, amongst which were the development of an ethnic minority women manager's network and the Mary Seacole Leadership awards for nurses, midwives and health visitors (Wedderburn Tate 1996).

Nevertheless, recent evidence suggests that despite promoting inclusion into the workforce, minority ethnic nurses continue to experience racial harassment from both patients and colleagues, and racism has been found to exist not just generally within the NHS but specifically within nursing (Kings Fund 1990, CRE 1991, Ward1993, Iganski et al 1998 Bagihole & Stephens 1999). As Pearson (1985) states, this racism was present in earlier nurse recruitment from what were Britain's ex -colonies. This resulted in black nurses being mainly recruited into the less prestigious enrolled nurse training, which carried less status than registered training and offered no opportunity for promotion. The evidence on the extent of racism and sexism in the NHS seems indisputable, yet a recent survey for the NHS executive revealed that many trusts were failing to put equal opportunities policies into practice. The survey of four hundred and twenty trusts revealed that most had policies but failed to monitor or evaluate these (Agnew 1998, NHSE 1998).

In response to the continuing evidence of racism and sexism, the current Labour Government has now made explicit commitments to tackle inequalities in health and in the NHS. These policies aim to address both employment and service delivery inequities and inequalities. An obvious example is the development of an Equal Opportunities Unit (DOH 1998). This unit aims to encourage the development of an active approach to what it calls 'equal opportunities.' One early initiative from the unit has been the development of a series of awards for examples of good practice. These are awards for examples in employment practices *and* service delivery (DOH 1998). In relation to service delivery, the awards are given for reducing health inequalities for those people, 'whose race, gender, disability, age, religion, sexual orientation, income or employment status may have affected the service they receive' (DOH 1998:1). Action plans to tackle all forms of individual and institutional racism now form part of the main agenda of equality in the NHS, seen in the shape of a new Equalities Framework (DOH 1997,1998, 2000). These are policy responses I discuss in more detail in Chapter Three.

Yet, even these extensive policy commitments to tackling inequity and inequality may still serve to reinforce and retain rather than challenge the structures of the NHS. For example, the ENB now requires all future practitioners to be equipped to work in multi-ethnic society. Moreover, community trusts are required to ensure staff are educated to

meet the needs of diverse cultural groups. However, the approach is that of a procedural liberal equality, ensuring a sensitivity that hopes to guarantee fairness of access and treatment. As Gerrish et al (1996) argue, one barrier to developing any notion of equality in the NHS has been the focus on needs rather than rights which has helped to individualise and de-politicise these issues. So, whilst the use of legislation may make it more difficult for individual cases of, for example, racial discrimination to go unchallenged, it is an approach that does little to tackle the broader patterns of inequalities between different ethnic communities.

The evidence suggests that the NHS has adopted a less than radical agenda of equality. Policies favour equality of opportunity and condition and this represents a liberal approach, mainly addressing issues of employment. Therefore, the NHS tends towards a protective rather than enabling response (Gerrish et al 1996). The impetus to respond to discrimination in service delivery and clients' and patients' experiences of health care has been rather slower. Overall, the main response has been one of assimilation and inclusion, in spite of numerous studies showing the NHS to be part of the problem. The evidence suggests these responses and policies are not working. The nature of those limitations and the implications for both nurses and patients and clients will now be assessed.

1.4 The Limitations of the NHS Response to Inequalities

The limitations of a liberal equal opportunities response are still much in evidence in the continuing inequality and discrimination experienced by clients and nurses. For example, several recent studies continue to provide substantial evidence of the persistence of sexism and racism within nursing (Beishon et al 1995, Gerrish et al 1996, Finlayson & Nazroo 1998). Men were still more likely to be found in the higher nursing grades and women are still more likely to work part time and in areas with little opportunity for promotion (Finlayson & Nazroo 1998). The report, 'Nursing in a Multi - Ethnic NHS' (Beishon et al 1995) showed that racial harassment remains widespread and unfair practices continue to operate in relation to recruitment, training and promotion. Minority ethnic staff were still more likely to be working in the less prestigious areas of nursing, with overall career progression for black nurses slower

than compared to white or Asian nurses. A further ENB study has found a similarly depressing picture concerning nurse recruitment. In examining the national pattern of applications for pre and post registration courses, Iganski et al (1998) found that a higher proportion of minority ethnic applicants were rejected at the short-listing stage. In addition, the whole recruitment and selection process was open to subjective and potentially discriminatory attitudes and practices. Moreover, a two-year ENB research project has recently evaluated the educational preparation of nurses and midwives for working in a multi ethnic society (Gerrish, Husband, & Mackenzie 1996). They found few educational institutions had little more than a minimal approach to these issues in their curricula. Furthermore, the overall approach to preparing practitioners to meet the needs of a minority ethnic society was haphazard and ad hoc.

This depressing picture and haphazard approach to meeting the needs of minority ethnic communities implies nursing work is extremely discretionary and implicated in oppressive health care. Furthermore, the lack of policy governing service delivery in relation to equality or equal opportunities perpetuates this tendency. This lack of attention is surprising when both the caring and controlling aspects of practitioner's clinical practice have been well documented. The most dominant theme in this literature has been practitioners' use of cultural stereotypes and their involvement in racism. This literature substantiates the extent to which policy responses in the NHS are not working.

This literature demonstrates the way in which nurses' personal judgements greatly influence interactions and decision–making. Furthermore, it has also revealed the significant impact of social divisions of gender, race, class and age upon the caring process. Even student nurses develop moral evaluations of patients that reinforce discriminatory processes. For example, Mackay (1989:146) showed how student nurses distinguished between 'good and bad patients'. These distinctions were related to gender. A 'good' patient is compliant and is often male, whereas a 'bad' patient is one who demands and complains and is often female, hindering rather than assisting the nurse in their work. Mackay noted that this was contrary to the common sense expectations of how men and women cope with illness at home. She states that,

'Women don't complain at home and men do. The men don't complain in hospital and the women do. Nurses prefer to nurse men rather than women'. (1989:147)

The extent to which racism shapes health care is evident in Bowler's (1993) study of midwives. She identified how in daily practice, midwives reproduced stereotypes of Asian women. The midwives constructed several areas of difficulty that reinforced these stereotypes. These were difficulties in communication, the women's lack of compliance with care, their 'abuse of the service', their tendency to make 'a fuss about nothing' and their lack of 'normal maternal instinct' (1993:160). Bowler shows how these stereotypes were used to make judgements about the kind of care the women deserved. Furthermore, although ethnicity was never directly mentioned, the women's ethnicity clearly had a direct role in their typification of bad patients. The full effects of these stereotypes were beyond the scope of Bowler's original study, although she argues these women were probably disadvantaged by these assumptions. How these midwives stereotypes contribute to, or indeed construct a racist nursing discourse was not discussed.

Bowes & Domokos (1993) found that when South Asian women were asked for their views on health services, they were more than able to identify instances of racism. The authors' study of twenty women of Punjabi Muslim heritage in Glasgow revealed that interpersonal and institutional racism impacts upon these women's health far more than any cultural differences. A few of the women were quite explicit about the way in which racism conditioned and even dictated their lives and opportunities (1993:613). In terms of using the NHS, there were problems of choice and variable quality in GP care and maternity services, due mainly to problems of communication. Interestingly, these communication problems were more prevalent between the GPs and the women than with their health visitor. However, the problems encountered overall by the women were either similar to the general population or different due to racism. Bowes and Domokos conclude that being part of a racialised minority certainly affects the health of these women because,

'They experienced different treatment in the health service, and were not , we have argued, enjoying full access to the quality of health care to which they were entitled.' (1993:622)

Bowes and Domokos' (1998) subsequent study of health visitors working with a group of Pakistani women, explored the potential for health visiting to challenge the social exclusion of disadvantaged groups. They concluded that health visiting was a

potentially socially inclusive force, enabling the access of excluded clients to health services. Exclusionary mechanisms were seen to be located at an institutional level and the health visitors were found to resist and challenge these exclusions in order to promote inclusion (1998:504). However, they also noted that those aspects of health visiting that enabled inclusion were also under threat due to management led changes.

Together, these studies indicate both the growing concerns with racism in the NHS and nursing and the limits to equality strategies. This is further substantiated in the studies documenting the oppression experienced by other user groups. As with racism, these studies illustrate the extent to which the NHS response to issues of equality and inclusion are failing. The use of stereotypes, individualising and depoliticising needs are endemic and the construction of difference as problematic allows ageism, ableism, racism, sexism and heterosexism to flourish. For example, health care practitioners, no matter how well meaning, collude in depoliticising disabled people's needs when they continue to define these as health or medical needs rather than social needs (Barnes 1992, Swain et al 1993, Morris 1996). Northway (1997) argues nurses are indeed part of the problem and actively contribute to disabled users' oppression. Northway argues that if nurses continue to view disability as an individual medical condition, rather than as a source of social oppression, they become the potential oppressors of disabled people through their uncritical practice, education and research.

Lesbian women and gay men and their families' needs are often overlooked, ignored or stigmatised when assumptions of heterosexuality dominate nursing care (Lawless et al 1996, Eliason 1996). The discrimination experienced by people with learning disabilities and people with mental health problems has been well documented (Pilgrim & Rogers 1999). Older people experience similar oppressive services and care. Old people are stereotyped, subjected to abuse and neglect. They often receive poorly coordinated personal social services and support at home relies increasingly on the informal care of female carers (Cameron et al 1989, Victor 1991, Lookinland et al 1995, Ungerson & Kember 1997).

Together these studies reveal the extent to which nurses are complicit in perpetuating oppression. These accounts do, however, tend to construct clients as passive victims

rather than viewing them as active participants in the care they receive. May (1992) has shown, for example, how clients have the ability to subvert or resist nursing interventions. The ability to subvert nurses' work interferes with their task of getting to 'know the patient' (1992:472). May shows how knowing the patient mobilises the nurse's traditional, listening caring role, but not without some difficulty. Knowing the patient was seen, at one level, to contribute to the clinical gaze or apparatus of surveillance argued to be endemic to all health care (Foucault 1976, Bloor & McIntosh 1990, Armstrong 1983, Lawler 1991). But this gaze was also productive rather than merely repressive, for it enabled patients to resist and subvert nurse's intentions to know them.

This suggests a more complex picture as to why policies may not be working. Thus, whilst discriminatory stereotypes and labels may indicate the limits to equality in health care it may also present opportunities for clients' resistance. This is an idea exemplified in the work of Bloor and McIntosh (1990). Their Foucauldian study of the power in therapeutic relationships illustrates the various techniques of client resistance to health visiting interventions. Various forms of surveillance are shown to produce equally diverse forms of resistance. As they argue, 'power provokes resistance, indeed there is a sense in which power creates resistance- resistance is itself it part of the disciplinary relationship' (1990:180). They conclude that the professional-client contest is a disciplinary relationship, whereby differing aims and goals will exist for both parties. These studies complicate yet illustrate the control that exists within nurse-client interactions.

Thus far, this review suggests equal opportunities policies or practices are continuing to fail. As the dominant approach to employment issues within the NHS, these policies are failing nurses. As a less than obvious approach to service delivery, clients and patients continue to experience inadequate and oppressive forms of care. The liberal procedural approach to equality promises an inclusion that is far from successful. It is evident that the development of equal opportunities in the NHS has been haphazard and ineffective. It is also evident that many forms of discrimination continue to be perpetuated through NHS institutional policies and nursing practices. Although many health authorities and

trusts have developed equal opportunities policies, it is equally clear that these responses remain inadequate. The reasons for these continuing problems are less clear. A common explanation for discrimination is that of individual attitudes and behaviours, be that an individual nurse or group of nurses. Therefore, correcting an individual's mistaken beliefs, attitudes or behaviours through more education and training is seen as the necessary solution. The assumption is that more knowledge or awareness will translate into behaviours, enabling practitioners to become more inclusive in their practice. Important practical measures are central to this and are indicative again of a more liberal approach. The value of employing trained interpreters to overcome language or communication difficulties has been essential and appreciated by clients and patients alike (Bowler 1993, Bowes & Domokos 1993). The emphasis here is to remedy deficiencies of some sort, be they knowledge and understanding or skills and competencies. The introduction of policies to protect and ensure equal opportunities is another key feature of this response. As in all liberal explanations, the promise of equality is dependent upon creating open and fair access and participation, removing barriers and ensuring fair rules and procedures. The limitations of these liberal initiatives are made all too clear in radical critiques.

1.41 Limits to Liberal Equality

Liberal approaches individualise inequality and there are implicit assumptions that state organisations, like the NHS, can be neutral. The continuing presence of inequality is indicative of the way liberal strategies in health care suppress social differences by depoliticising and individualise these inequalities, as health needs. This is further evident in the increasing trend towards multiculturalism both in practice and education (Culley 1996). Radical strategies concentrate instead, not on the individual, but on broader social relations and structures, as was discussed previously. This is an analysis that investigates how patterns of inequality are reproduced and sustained over time. Liberal accounts fail to tackle these features, and in so doing perpetuate the status quo. Marxist, Socialist and Black feminists have utilised the radical approach. Using a political economy or Marxist perspective, they have explained the continuing subordination and inequality experienced by black, white working class and minority ethnic women. They have identified Capitalism, Patriarchy, Imperialism and

Colonialism as the cause of women's oppression (Williams 1989, Brah 1992, Mama1992, Doyal 1995). This research shows how power becomes embedded in institutional structures and practices from which the NHS and nursing are far from immune. More practically, this approach demands challenges to the status quo, demanding more appropriate services, or tackling institutional sexism and racism directly. In relation to welfare and the NHS, demands are for major changes in the redistribution of wealth or power in society. Moreover, this approach to equality has tended to promote a notion of equality based upon difference (Williams 1989, 1992, Phillips 1993, Doyal 1995).

Interest and a demand for these approaches to be utilised in the NHS is evident in the body of nursing research now calling for institutional racism to be tackled (Gerrish et a 1996, Ignaski et al 1998). However, the demand for the development of this approach in nursing practice is less evident. The developments of an anti-discriminatory or anti - oppressive practice are practices based on these more radical accounts. However, these practices appear to be a less obvious presence in nurse education and practice than for example, social work (Dominelli 1988, Thompson 1995, 1997, 1998). A distinguishing feature of these practices is the demand to challenge the oppressive practice of others and to work at a structural level to ensure change (Razack 1999, Thompson 1997, 1998). Thompson (1997, 1998) has advocated for these forms of practice in health and social care. He defines anti-discriminatory practice as 'good practice'. That is, practice that does not tackle oppression and discrimination cannot be described as good practice, no matter how high its standards may be in other respects. (1997:11). Anti-discriminatory practice and anti-oppressive practice are practices aiming to provide more sensitive and appropriate services through a range of activities:

'Responding to people's needs regardless of their social status. AOP embodies a person centred philosophy; an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives; a methodology focussing on both process and outcome; a way of structuring relationships between individuals that aims to empower users by reducing the negative effects of social hierarchies on their interaction and the work they do together' (Dominelli 1996:171).

For Thompson, failing to recognise their potential role in the oppression of clients means service providers become complicit in perpetuating oppression.

1.4.2 Limits to Radical Equality

However, while these approaches appear to tackle the problems of dominant power relations, and aim to disrupt the status quo, these radical strategies have proved to be equally problematic. Wilson and Beresford (2000) critically assess the concept of anti-oppressive practice from the perspective of service users. They argue this form of practice has led to the perpetuation of oppressive knowledge about service users and an appropriation of their knowledge. This has reinforced constructions of clients as passive and masked professional power. This has led to a continuation and legitimisation of the controlling and problem-based approaches to social work practice (2001:570). Williams (1999) argues that conceptualisations of anti-oppressive practice are equally problematic because these practices produce a politically sterile debate. Under the cloak of anti -discriminatory and oppressive practice, oppressions are reduced to a sectionalist focus on "isms" which place differences into hierarchical lists. This implies differences are exclusive, fixed and static. Worse still, she argues, is the development of ambivalence to difference, where an acknowledgment of difference potentially descends into an inability to decide where to act. Furthermore, requesting that these practices be assessed, as they are in social work training, means they inevitably become a technical list of activities to mark off in practice. For Williams this never addresses the systemic forms of oppression and discrimination embedded in human services.

Thus, radical accounts are not without problems. While they appear to correct the focus of liberal approaches and expose the false assumptions of impartiality, they too are limited and appear not to have had much practical impact. This may be due to problems of implementation. This suggests, for example, if there were a serious commitment to redistributing power and resources oppression would be eradicated. This inertia undoubtedly plays a significant role in perpetuating the failures of both liberal and radical strategies. But these explanations do not provide adequate responses to more recent critiques. These critiques suggest that no amount of tinkering with the system, or sharing of resources will overcome the limits of either approach. Liberal and radical strategies are argued to be incapable of resolving the dilemmas between choosing an individual or structural approach or a same, or difference strategy. For each approach is premised upon assumptions that are fundamentally flawed. These faults imply the

demise of equality as a political and social goal and leave equality upon troubled grounds.

1.5 The Post Modern Challenge to Modern Equality

Modern concepts of equality are evident in the debates concerning the role of nurses and the NHS response to inequality. The predominant approach has been to adopt a liberal rather than radical approach, although both have been shown to be limited in terms of implementation. However, postmodern critiques suggest *both* these strategies are inherently flawed and this relates to shared modern epistemological and ontological foundations. Limits to liberal equality were evident in health care when the modern democratic promise of inclusion became increasingly unable to deal with the demands or needs of those who were excluded. As Phillips (1993) and Yeatman (1994) have argued, the more contemporary struggles of minority ethnic and indigenous peoples were preceded by similar struggles by women at the turn of the century. These struggles have made the specificity of liberal political theory and practice explicit, revealing the sexual and racial politics of publicly funded health care provision despite universal pretensions to the contrary. Feminism revealed the gendered and racialised nature of health and health care, while Pateman (1989) showed how political claims to universality ignored the normative concepts embedded in liberal theories of democracy and distributive justice.

Pateman (1989) went on to demonstrate that the individual at the centre of modern political theory was not the free and abstract individual of liberal democratic theory. The supposed neutral individual was in fact masculine in content and the assumed neutrality of the social contract was instead a fraternal contract that benefited patriarchy. This was the same individual at the centre of debates concerning social citizenship and rights to health care. In re-examining legitimate political obligation, she revealed how women were incorporated into the civil order differently from men and yet this difference and women's subsequent exclusion from public life, escaped the attention of political theorists. Pateman suggests that the political sphere in liberal theory was always defined in relation to the public sphere. This focus on public, political life meant paid employment became the key to citizenship and recognition as an equal individual.

This meant women's association with the private sphere was both ignored and made problematic. This analysis revealed the particularity of political theory and the gendered character of the political individual. These fundamental flaws to modern political theory have continued to be exposed and as Phillips concludes, these insights suggest that 'no amount of cleaning and dusting will make it (liberal political theory) suitable for use' (1991:38). Therefore, promises of equal access to health care and treatment become problematic.

To be included into the welfare state and health care is to always be measured against a gendered norm that is masculine in content. This much was evident in feminist claims of misogynist and sexist health care, as women struggled to be included into a male defined NHS (Doyal 1995, Annandale & Hunt 2000). For example, Phillips (1993) suggests that sexual equality has thus far privileged the male body and this means the male norm operates to define women as lacking or deficient. This phallocentric and ethnocentric discourse has pushed women into the uncomfortable 'either/or' choice in terms of arguments for equality (Scott 1988). Either they demand the same rights to what is essentially sexist or racist health care, or they demand to treatment on the basis of being different.

However, whilst the gendered character of health care services, and the welfare state generally, have been the subject of increasing feminist debate, Davies (1995) has noted that the emphasise on equality has been to focus on exclusions. There is, she argues, a need to understand the processes *of inclusion* as well. As she suggests, this task is all the more difficult, when to ask for inclusion is to ask for entry into a world already gendered (1995:230). In this gendered world, responses like equal opportunity policies, laws or practices are initiatives will never successfully tackle discriminatory attitudes and behaviour. Like other feminist analyses of the structures and processes of organisations, Davies (1995) insists that the NHS is located within a welfare state that is constituted by, and constitutes gender relations; these are gendered organisations in which gendering is maintained and reproduced (Franzway et al 1989, Pringle & Watson 1992, Witz 1992, Halford 1992, Halford et al 1997, Pringle 1998, Halford & Leonard 2001). Therefore, gender and the continual construction and reconstruction of gender

relations are built into the design and functioning of state organisations and these gendered power relations are enacted daily in organisational practices.

In this respect, feminism has revealed the ethnocentric and androcentric base to health care and subsequently to all modern epistemology and ontology (Nicholson & Fraser 1990, Barrett & Phillips 1992, Annandale & Hunt 2000). However, as Flax (1990) has commented, it is still tempting for those excluded to hold onto modern worldviews and promises. This is especially so when the increasing demands for inclusion began to appear to be recognised. However, to do so means retaining and accepting Enlightenment epistemology and ontology. These are foundations that aim to reduce difference and diversity to commonality or unity of experience. It would mean retaining assumptions of an abstract, unified individual, which is in fact gendered, and a desire for universal explanations and certainty in the face of growing diversity and uncertainty. These epistemological and ontological foundations fail to deal with the demand that difference and diversity be recognised and responded to effectively. This is difference expressed in the competing claims made upon the welfare state and the NHS and the limits to these responses are evident in this review.

1.6 A Post Modern Analytical Framework

These critiques of modern political theory stem from a body of work collectively referred to as postmodernism and poststructuralism. In this thesis, I draw on both postmodern and poststructural ideas, as developed by a number of feminists, who are seeking to engage with the challenges posed by these theories. The use of these perspectives makes for an eclectic approach but offers a valuable analytical resource. Postmodernism and poststructuralism are, like feminism, contestable terms. These two perspectives incorporate a range of positions that make attempts to define them difficult. Yet, key features have been clarified and this reveals mutual theoretical interests and concerns (Nicholson 1990, Weedon 1997). This compatibility is of value to the analysis undertaken in this thesis. Postmodern approaches question the assumptions embedded in modernist thought. Grand theories of progress, truth and science are 'broken up' and displaced and the loss of faith in these are said to mark the end of the modern era (Lyotard 1986). These once certain truths are replaced by small narratives, plural

realities and diverse voices. Like postmodern approaches, poststructuralism focuses on plurality and multi-vocality. Here the use of language is examined for the ways in which dominant meanings constitute rather than reflect reality. These meanings define and construct the actual and possible forms of social organisations and subjectivities available to us (Weedon 1997). These two perspectives also share a concern with plural and diverse conceptions of power. Centralised notions of power are replaced with an ascending theory of power that circulates and inheres in all discourse and interactions (Foucault 1979b). These shared interests in power, fragmented subjectivities and diverse truths and realities, make the combination and use of these two perspectives an especially valuable resource with which to investigate equality in health care. I will now examine these contributions in more detail.

I have referred to many of the postmodern critiques in my examination of modern epistemology and ontology. I have referred to poststructuralism in discussing the gendered nature of the welfare state. These insights have been extremely influential, showing that language does not merely reflect but constructs the social world (Foucault 1970, 1974, Derrida 1978). Linguistic terms have been shown to perpetuate relational hierarchal binaries, so that one term is always privileged or valued over another. Thus, binaries of male/female, objectivity /subjectivity, rationality /emotion, are seen to privilege male objectivity and rationality. However, in poststructrual theories, there is recognition of the plurality of meanings in language and the ways in which meanings are always deferred. This allows fixed and unified concepts like the subject/object and other related binaries to become decentred or displaced and opens up these concepts to further inscriptions and new meanings.

Feminism and postmodernism have insisted upon particularity, diversity and fluidity in meaning and understanding. This was a task already underway within feminist theorising. These critiques have had implications for key areas of feminist enquiry into subjectivity, identity, gender and the pursuit of equality (Nicholson 1990, Barrett & Phillips 1992, Weedon 1997). Yet, whilst these postmodern theories have been used to scrutinise modern concepts and institutional practices and discourses of modernity, feminism's major contribution has been to introduce gender into these perspectives (Butler 1990, Hekman 1990, Weedon 1997). More specifically, these postmodern

insights are being utilised to review modern social theories, especially political theory, where urgent answers to the questions of diversity and particularity are being sought (Butler & Scott 1992, Phillips 1993, Yeatman 1994).

Postmodern, poststructural and feminist theorising have revealed the troubled foundations upon which modern political theories and strategies are premised. Liberal and radical strategies are neither failing due to technical errors in implementation, nor because of universal or unified vested interests succeeding in maintaining the status quo. These strategies are more fundamentally flawed. They are inherently limited because they maintain rather than tackle hierarchal binaries, like those of same and different, inclusion and exclusion, and liberal and radical. These binaries have been shown to structure language and are contingent upon the devaluation, suppression and negation of their oppositional term. Furthermore, the grounds upon which liberal equality is based, namely humanism, liberalism and rationalism, are now so challenged, these foundations have become untenable. Paradoxically, it is because of these limitations that the specificity of the liberal democratic promise of equality is revealed, exposing the particularity of all political theory and practice. For these reasons liberal and radical strategies may never yield the type of equality modern theories promise.

This leaves equality on rather dangerous ground. If modern strategies are inherently limited then two possible outcomes are implied. One outcome would mean accepting the status quo. There have been some significant achievements to date but to effect further large scale change would seem improbable. The second outcome, however, is to view these limitations as the very pre-condition with which to re-visualise and re-think equality in health care, thus opening up new spaces for equality practices. Central to this task will be the deconstruction of equality and difference. Thus, it may be possible to use these critiques to move beyond modern ideas of equality. This may involve the fluid concept of equality evident in the work of Mouffe (1994). She argues that meanings and connections between people are always in a state of flux, constantly being constructed, articulated and maintained. Thus, meanings of equality may be thought of as *a process*, always being constituted and reconstituted rather than a rigidly fixed concept or as an end goal. Nicholson & Seidman (1995) suggest there is a need to recognise and make explicit claims of universality and to reveal their particularity. In so doing, the historical

and cultural context in which knowledge and meaning is constructed is revealed. They argue that postmodernism is not about celebrating difference and particularity for its own sake. It also involves acknowledging that difference represents a site of contestation and negotiation. Insisting upon difference is a political act. So there is recognition that when rules or criteria are applied, or conceptual distinctions are made, these moves are legitimising acts and such acts are political representations and moves of power. Thus, postmodernism is also a set of viewpoints of a particular time, not a set of timeless ideals. It is a political act. This means it is possible for these visions of a postmodern politics to root politics not in one identity but in multiple and contradictory aspects of individual and collective identities. As Lister (1997) suggests, what may be needed is a *differentiated universalism* that respects these shifting differences. Thus, an interrogation of modernism will retain modern concepts and even establish foundational criteria (Flax 1990, Yeatman 1992). These theories and criteria would have norms that were openly declared and have criteria that could be contested and challenged.

The analytical approach I adopt in this thesis utilises these particular versions of post modern and poststructural thought developed by feminism. These theoretical insights also provide a resource for investigating the work of those practitioners seeking to respect and work with difference and promote equality. I wish to argue that these theories are a valuable resource for three reasons. First, they offer a resource for critiquing or deconstructing modern theories. This entails a critical stance towards all meaning and demands we identify how particular meanings or stories remain dominant and others marginal. This involves revealing dominant and marginal stories, or narratives of equality in health care, and asing whether these are inevitable stories, or whether community nursing narratives of equality differ. It means teasing out the various meanings of equality and revealing the hidden oppositions. It means a refusal to accept or privilege any theory, or truth about equality, or truth about the egalitarian principles in health care or nursing, although this does not mean there is no truth. Instead, it means acknowledging that all theory is provisional, representing a perspective that needs to be exposed and its construction understood. This exposure reveals the particularity and specificity of modern political theory and subjects it to scrutiny. It uncovers not only its mechanisms of exclusion but also how these are maintained.

This introduces my second reason for using these critiques. For these approaches, reveal how power is embedded in all knowledge and circulates in all interactions. These insights are therefore useful for exploring how particular forms of equality become constituted and are sustained, both in community nursing narratives, and within the broader discursive fields that structure the context in which they work. Examining how power and knowledge come together within discourse permits the study of the way discourses constitute objects and the subjects of their intervention. This provides an insight into the way community nurses' narratives may or may not be determined by dominant discourses. It may reveal the ways in which they use and reuse dominant stories of equality in health care to construct their own accounts of equality. This use may be indicative of a critical dialogue or engagements with liberal equality, rather than a failure to work with or implement its dictates. Furthermore, in proposing a decentred subject, postmodern theories reveal the full extent of the plurality and diversity of identities and subjectivities. The presence of diverse community nurse identities and subjectivities will alter an understanding of equality in health care as conventionally understood. For it is this decentred subject that may allow for alternative political strategies and goals of equality to emerge (Nicholson 1990, Butler & Scott 1992, Flax 1990, 1993,Yeatman 1990, 1994).

Thirdly, I argue for the use of these insights for this *empirical* study of community nurses. A critique of modern political theory provides the means with which to critically assess the discursive foundations of equality. Such critiques are a resource for re-visiting equal opportunity or anti-discriminatory practices, because they provide both a theoretical *and* methodological tool with which to re-interpret talk of equality. For while there is much discussion of the discursive, there is relatively little empirical work to show how useful these theories are for developing practical strategies. Nor currently, is there much assessment of how relevant these insights are for understanding the realities of those who deal with difference and diversity in their daily work. In the final section of this chapter, I will summarise the aims of my research and outline the remaining structure of this thesis.

1.7 Aims and Structure of the Thesis

My thesis has four main aims. The first is to examine and assess the discursive constitution of equality within community nursing narratives. Given current critiques it is timely to examine how equality is talked about and constituted by, or for, community nurses. I achieve this through an *empirical* study of community nurse students' and their respective practice educators' talk of equality, discrimination, difference and practice. More specifically, I establish whether the discursive form equality takes in the NHS and community nursing is predominantly modern and liberal. I draw upon two sources of evidence. I examine the community nurse's narratives and establish the nature of the broader discursive field through an examination of relevant documents and policies.

My second aim is to consider whether this dominance is complete and whether it precludes 'other' discursive constructions of equality. I am interested in whether liberal forms of equality are an inevitable presence, or whether other discourses and narratives exist to undermine and/or challenge modern liberal equality discourses. I also wish to establish how those 'other' narratives or discourses arise. I contend that complex discursive accounts may be present as a result of a critical dialogue with liberal equality. This may present the possibility for moving beyond the 'sterile political debates' of modernism's construction of an 'either/or' choice regarding equality. This analysis would also imply that equality might be conceived of differently.

My third aim is to consider *how* the community nurses' talk and corresponding range of accounts are constituted. In other words, I aim to explore the grounds or foundations to these accounts. I aim to examine whether contingent foundations are present and to establish the form these take when discursively invoked through talk of equal opportunities and anti–discriminatory practice. I also aim to show how these foundations may influence the discursive construction of equality. Central to this discussion will be the involvement of variously positioned selves.

My fourth aim is explore the need for both a deconstructive and constructive approach to modern liberal equality. Postmodern and poststructural critiques argue for the need to move on from modern political stalemates. I wish to examine how relevant and feasible this is for community nursing. A twofold approach of deconstruction and construction

may be necessary to develop a viable political equality project in community nursing. Having deconstructed liberal equality, I ask whether a variety of practical strategies can be adopted in order to include those who are excluded. I aim to consider whether these approaches always contain totalising tendencies and therefore replicate the limits of modern liberal equality. I then aim to show how other conceptualisation of equality, which may not be measured by the total eradication of inequality, may offer opportunities or possibilities for re-imagining equality.

The remaining structure of my thesis will be as follows. In Chapter Two, I discuss both the theory and the practice of my research methodology. I review key stages of the research process and discuss relevant theoretical issues. This will include an examination of the postmodern/poststructural critique of modern research and how this applies to my research. I discuss why I selected a qualitative approach to this study, relating this to the nature of my inquiry. I discuss my methodological choice of interviews and documentary analysis. I look in particular at the processes of interpretation involved in interview data analysis and the reading of documents. I explore notions of data generation rather than collection and related issues of validity. I also explore the implications of my 'insider' status and notions of power in the research relationship.

In Chapter Three, I draw on two sources of material to show how the dominance of liberal discourses of equality within the NHS remains predominant in community nursing in particular. In the first part of the chapter I use documentary evidence to establish this argument and in the second part of the chapter I draw on the nurses' narratives. I argue that liberal discourses of equality are evident in the community nurses' narratives and that these forms of equality appear to be dominant. I show how these accounts are sustained by educational, professional and organisational discourses located in wider discursive fields.

In Chapter Four, however, I argue that this dominance is superficial. I show there is a liberal veneer, which upon further examination reveals a far greater complexity. Moreover, I argue this shows liberal equality to be less hegemonic but generating complex and varied narratives that challenge or displace this discourse through the

presence of 'other' narratives of equality. This I demonstrate through a detailed examination of these various accounts. I assess and evaluate these narratives for their discursive constructions of equality and their engagements with the limits of a liberal equality discourse.

In Chapter Five, I argue that these narratives are contingent upon various selves being invoked. In the telling of these other stories, I show the nurses can be found to position themselves differently in relation to a liberal equality discourse. These positions mediate the various narratives of equality found in the community nurses' accounts. In this chapter, I propose that these particular stories of equality are contingent upon the construction and interaction of different sets of selves. The various selves are invoked or suppressed and are dependent on context. These discursively constituted selves construct the particular stories of equality found in community nurse' talk and I argue that, together, these selves provide very different grounds for the construction of equality and an emancipatory politics.

Finally, in Chapter Six I discuss the implications of these various accounts of diverse selves for re-imagining equality. I conclude that these selves provide different grounds from which to develop a postmodern emancipatory project. I discuss how, in engaging with the discourses of modern equality, these selves challenge and displace liberal equality, making it a questionable presence within community nursing. I will argue these selves are positioned through this engagement and dialogue with liberal equality, and are indicative of the possibilities for equality in community nursing. I then outline the practical implications of this analysis for both community nurses education and practice. Finally, I demonstrate how possibilities exist for moving beyond modern debates. This will allow for a re-visioning of equality that may further the development of a postmodern emancipatory politics in community nursing.

CHAPTER TWO

METHODOLOGY AND THE IMPLICATIONS OF A POSTMODERN ANALYSIS

2.1 Introduction

In this chapter, I discuss and define my choice of research methodology and the research process involved in this thesis. This chapter also aims to develop the theoretical discussion I began in the previous chapter. In particular, I discuss the implications that postmodern and poststructural feminist critiques have had for my choice of research methodology. I will argue that central to this is the contested relationship between ontology, epistemology and methodology; that is to say, between who we are, what we can know and how we can research this. This chapter underpins the remaining chapters of the thesis.

I have structured this chapter around five main points. First, I explain how a post-foundational methodological framework can be used to investigate an empirical research project. I define a post-foundational approach as one that draws on the particular use of postmodern, poststructural feminism I outlined in Chapter One. Second, I show how these post-foundational propositions related to my methodological choices and decision-making and subsequent fieldwork. I demonstrate, for example, how postmodern, poststructural feminist ideas disrupt conventional or modern understandings of epistemology and ontology and how this impacts on methodology. I discuss more fully the theoretical assumptions I made when using these approaches and reflect on how these continued to inform my research throughout. Third, I explore what this means for 'doing' research and the tools or methods I chose. In particular I discuss the implications for conducting interviews and reading documents. This means I explore the notion of data *generation* rather than *collection* and assess the implications of this for the process of analysis. In particular, I focus on deconstruction and discourse analysis and I discuss the issues of validity and the charge of relativism. Fourth, I discuss some reoccurring issues that arose throughout, which included concerns of self-reflexivity and power. Finally, I evaluate my choice of research methodology. I discuss the respective strengths and limitations of this choice and reflect on possible additional approaches. I also assess whether these perspectives merely disrupt or contribute to

knowledge formation. I conclude that postmodern, poststructural feminist developments interrogate and deconstruct modern methodologies, but this crisis in representation is also conducive to a creative re-presentation of the social world.

2.2 Empirical Research and Postmodern and Poststructural Research

My reason for choosing to undertake empirical research might initially seem incompatible with my chosen theoretical framework. In disrupting traditional methodological assumptions, these post-foundational critiques appear to question the whole premise and feasibility of empirical research. These critiques challenge key assumptions of research, namely the ability to capture or reflect reality and to guarantee the validity of that knowledge (Denzin 1997). Yet, as I suggested in Chapter One, these approaches offer considerable potential for re-viewing the social world. Even though these critiques suggest a contested relationship between ontology, epistemology and methodology, they do not suggest empirical research is redundant. Instead, these post-foundational approaches generate new insights through the promise of 'diverse representational modes and devices' (Coffey et al 1996:2). These diverse genres and polyvocal texts are used to develop plural analyses and interpretations (Denzin 1997). However, using these perspectives means I must acknowledge that all empirical research, including my own, makes certain claims. By adopting this position I privilege research knowledge, understanding it to be derived from a process of formal enquiry and guided by a particular set of ontological and epistemological assumptions. These beliefs and assumptions shape and underpin all methodological approaches (Allen & Skinner 1991). Therefore, post-foundational approaches also rest upon a set of assumptions that must continually be made explicit and will be research work 'that insists on its own rigour and structure and is not arbitrary' (Traynor1997: 106).

In addition, my decision to undertake an empirical project was also influenced by the work of others attempting to utilise post-foundational ideas for empirical research. The focus of this work has predominantly utilised a deconstructive or textual discourse analysis of documents and/or interviews (Lather 1991, Kenway et al 1994, Nettleton 1995, Denzin 1997, Kendall & Wickham 1999, Silverman 2000). The use of these perspectives is, however, part of an ongoing debate, with respective advocates and

detractors. This debate is especially evident in current health-related and nursing research (Fox 1993, Henderson 1994, Cameron et al 1995, Fahy 1997, Lister 1997,Traynor 1997, Spitzer 1998, Crowe 1998, 2000, Cheek 1999, 2000, Seibold 2000). These authors draw heavily on postmodern and poststructural feminist theory to generate research for different purposes and understandings from those associated with traditional research. For example, these studies have sought to expose the discursive context of the nurse-patient relationship, or the discursive constitution of nurses' work and the performance of subjectivity in those contexts (Cheek 1999, 2000, Crowe 2000). I considered these uses and methodological intentions entirely compatible with my research aims. Furthermore, in drawing on this emerging body of work I concur with the view that these post-foundational perspectives promote 'ways of thinking' that profoundly shape research and the analyses made (Cheek 1999:386). However, as I indicated this decision is not without controversy as there is an equivalent body of work that refutes this view. Instead, the 'turn to the postmodern' is seen as destructive and/or futile for empirical research (Kermode & Brown 1996, Oakley 1998, Francis 2000, Seibold 2000). The relativism, nihilism and loss of agency implied by these approaches suggests, for example, that there is no reality to be captured by research, nor is there an ability to generate knowledge from which to speak or act with authority. However, I do not adopt this position. I argue that postmodern theories are compatible with empirical research. However, this will mean that I generate different stories or findings for different purposes but I argue that these are stories still worth telling. It does mean I make more provisional and contingent claims and this reflects the approach I outlined in Chapter One, in that I embrace certain aspects of postmodern and poststructuralism but reject the extremes implied above. These ideas are discussed more fully throughout.

2.3 Post-Foundational Methodological Assumptions

In this discussion of research methodology I must make explicit the theoretical assumptions I have already alluded to, as there are significant differences between these post-foundational approaches and interpretative and positivist research. Conventionally qualitative and quantitative research is premised on epistemological claims to represent reality or the truth and develop universal explanations. Post-foundational approaches challenge and displace these assumptions, destabilising the coherence and causality of

scientific rationality and replacing it with multiplicity, plurality, fragmentation and indeterminacy. Post structural approaches reflect many similar themes though there is more of a tendency to focus on textual analysis (Silverman 1997, Kendall & Wickham 1999, Cheek 2000). From a post structural perspective knowledge is never objective or value free, it is inextricably linked to power and this is evident through the formation of discourses (Foucault 1970, 1974, Sawicki 1991, Weedon 1997). Discourses are systems of statements or meaning that provide a frame of reference or way of interpreting the world. Dominant discourses draw upon bodies of knowledge and are able to assert more authoritative versions of events. Less dominant discourses then become marginalized. My commitment to feminism and my choice of feminist methodology meant I was prepared to uncover the effects of power and knowledge. For example, feminism has shown positivism's desire to disguise its gendered nature by making claims to objectivity and applicability across history and culture (Hekman 1990). However, my interest in, and use of post modern and post structural theories was precisely because these positions critique this partiality further. They do this by rejecting rationality as the ultimate standard by which to judge knowledge as valid or true. When the authority of reason is displaced then debate and the elaboration of additional criteria to assess the merits of an analysis can take place (Denzin 1997, Yardley 1997). This move towards heterodoxy has challenged the orthodoxy of both quantitative and qualitative research paradigms (Coffey et al 1996).

Thus, the established debates on the incommensurability of quantitative and qualitative research become redundant (Hekman 1990). These differences are thought to stem from the differing epistemological and ontological foundations of empiricism and humanism. However, postmodern critiques reveal that both paradigms form part of a dualism that stems from Enlightenment epistemological and ontological thought. From these perspectives, all knowledge, including that emanating from empirical research, creates subjects and objects, contains regimes of power and is involved in the construction of specific and partial truths.

In undertaking this research I therefore talk with provisional certainty about realities, recognising these statements are always contingent on context and are therefore plural

(Traynor 1997). In this way, I endorse Nicholson's view of the methodological implications of postmodern feminist theory; postmodern feminist methodology would,

> ' Tailor its methods and categories to the specific task at hand, using multiple categories when appropriate and forswearing the metaphysical comfort of a single feminist method or feminist epistemology. In short this theory would look more like a tapestry composed of threads of many different hues than one woven in a single color.' (199:114)

In using these perspectives, I reconsidered the claims I could make for my research. This means I have refuted the ability to 'uncover the truth' about a given situation and do not claim to represent or universalise a reality. Instead, my emphasis has been on the constitution rather than reflection of plural and diverse realities and I have no privileged viewpoint, postmodern or otherwise, on which to base an understanding of the world (Flax 1993). These post-foundational assumptions have underpinned the development of my research aims, hence my interest in the *discursive constitution* of equal opportunities. These theories suggest reality is an effect of discursive practices and that through statements or talk, texts are produced with which I can reveal the discursive constitution of meanings. These statements constitute meanings that are always in flux, never finally fixed but deferred and are meanings that are contested and culturally struggled over.

My decision to use post-foundational critiques was compatible with a qualitative approach to empirical research. Traditionally, the strength of qualitative research is thought to lie in its ability to explore the complex world of experience and the processes of interpretation and the production of meanings. Gathering data from inside, using Weber's notion of 'Verstehen' or empathetic understanding, means developing attentiveness to others' perceptions. The aim is to gather original stories and accounts to illuminate ways people come to understand or take action and manage their day-to-day situations (Bulmer 1984, Atkinson 1990, Hammersley 1992, 1993, Miles & Huberman 1994). This interpretative paradigm assumes a world less consensual, so there is a need to uncover the multiple meanings people give to their lived experiences and interactions. It is these processes that are said to constitute reality (Silverman 1993, 2000). These qualitative concerns overlap somewhat with poststructuralism and its emphasis on the socially constituted nature of those meanings and human experience as mediated through language. However, qualitative, like quantitative, approaches are

underpinned by *modern* epistemology and ontology assumptions. Thus, whilst I could find some similarities, there were fundamental differences to be engaged with (see section 2.2 for further discussion).

I also began this research assuming it would contribute in some small way towards emancipatory ends and this was compatible with my own feminist politics as feminism is strongly associated with emancipatory research. Indeed, most feminist research is premised on developing theories and practices which seek to overcome the oppression of women (Lather 1991, Reinharz 1992, Harding 1987, 1993, Stanley & Wise 1993). Furthermore, feminism's major contribution to research methodology has been to insist on the recognition of the political, historical and gendered processes embedded in all knowledge production (Harding 1993, Stanley & Wise 1993, Dyck et al 1995, Armstead 1995). Feminist research has shown, for example, that much research knowledge privileges scientific rationality, disguising its partiality through claims to universality and neutrality. Therefore, knowledge production is seen to be both phallocentric and ethnocentric (Harding 1987,1993, Bhavani 1993). I also wanted to use a feminist definition of methodology, namely that methodology is the theoretical and conceptual framework from which research proceeds (Harding 1987). This is because this acknowledges and makes explicit the epistemological and ontological foundations of all research methodology. Methodology is often associated with the technical processes of collecting data but this association often serves to obscure the theoretical foundations to all research design and tools. Therefore, all research methodology whether positivist, interpretative and, as I will argue, post-foundational, is underpinned by its own particular philosophical assumptions.

However, my allegiance to feminist politics and practice did not dictate or guarantee the methods or tools I should adopt. Feminist research has been strongly associated with a qualitative approach, as has nursing research, yet there is no one set of methods deemed to be feminist (Hekman 1990, 1996, Reinharz 1992, Stanley & Wise 1993). For example, Reinharz (1992) has documented the varied use of methods made by feminist researchers as ranging from quasi-experimental and survey research to ethnography, phenomenology and grounded theory. Moreover, there have been recent demands for

the continuing use of quantitative methodologies for feminist and nursing research and practice (Oakley 1998).

Therefore, my choice of a qualitative, feminist approach to methodology did not necessarily preclude the possibilities of questionnaires or a survey and did not, therefore, determine my use of interviews and documentary analysis. My decision to adopt these methods was influenced in two ways. First, my research aims and my intentions to explore community nurses' talk of equal opportunities suggested qualitative methods were more suited to this micro level of analysis. These were methods I assumed more capable of uncovering the discursive constitution of equality and difference in the community nurses' talk and in the texts of policies, educational curricula and professional guidelines or codes of practice. However, given the modern epistemological and ontological premises underpinning interviews and documentary analysis I needed to consider whether I could merely re-appropriate these tools, or whether my use and the claims I could make would need to change (see section 2.3 for further discussion).

Furthermore, my decision to use qualitative methods of interviews and documentary analysis also related to the literature I reviewed. As I argued in Chapter One, there is an established body of evidence documenting the continuing disadvantage and discrimination clients and nurses experience in their dealings with the NHS and health care. Many of these empirical analyses have documented the 'bigger picture' identifying the trends and the patterns of multiple forms of disadvantage and exclusion. This quantitative data has been extremely useful for establishing the 'facts' of discrimination as these designs seek to refine or confirm theory through deduction and thus describe or infer from observation and measurement (Allen & Skinner 1991). This approach relies upon a view of the social world as discoverable through the systematic objective development of argument, logic and evidence. The use of reason and the scientific process acts as a measure of validity and rigour, generating knowledge that exists a priori and can be discovered independent of bias or context. However, these positivistic beliefs assume reality is fairly consensual and undisputed. Empirical facts need merely to be collected, subjected to analysis and then generalised to other contexts and the

individual researcher is capable of being objective and detached in this process (Allen & Skinner 1991).

I discussed previously how this approach or focus has produced a great deal of epidemiological and sociological knowledge concerning the outcomes of discrimination and the subsequent effects on health in terms of mortality and morbidity. However, my reasons for choosing qualitative rather than these quantitative methods were not on the grounds of there being a relative paucity of qualitative research. Indeed, as I demonstrated in Chapter One, there is an equal body of work documenting the experiences of discrimination of patients and clients, and more recently nurses. This work tends to focus on the processes of discrimination and disadvantage, developing an understanding of the means by which clients or patients and nurses experience inequality and exclusion. There is, however, relatively little corresponding research on how equality in health care is ensured or promoted, nor is there work seeking to assess the views of those charged with the responsibility to promote equality in health care, namely nurses. For these reasons, my choice of qualitative methods seemed more suited to uncovering these processes of equality in health care. In choosing to use conventional qualitative methods, namely semi-structured interviews and documentary analysis, I assumed these tools were capable of uncovering the discursive constitution of equality and difference in the community nurses' talk and in broader discursive fields surrounding that talk.

Given my interest in the discursive constitution of equality, I decided to talk to both experienced practitioners and students. I interviewed fourteen community nurse students, each of whom is allocated a community practice teacher (CPT) for the duration of their time on a one-year specialist practitioner degree course for community nurses. This is a course validated by the English National Board (ENB) and recognised by the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC). This is a programme that allows already qualified post-registration nurses to gain accreditation for prior learning and experience (APEL) in order to undertake a one-year programme, which they are then able to exit with both a professional qualification in community nursing and an academic award. The degree programme provides a recordable qualification, and for health visitors, involves entry onto a different part the

UKCC register. These courses were, at the time of interview, relatively new as they were a direct response by the UKCC to move what was a post-registration diploma course to undergraduate level (see Chapter Three section 3.2.2 for further details). Completion of this course allows the nurses to practise as one of eight community specialist practitioners; this includes practising as a health visitor, district nurse, community mental health or learning disability nurse. All the students I interviewed were enrolled on this post-registration degree course, and as qualified nurses, all had previously worked in the NHS in a variety of acute, community and primary care settings (see Appendix One for further biographical details).

The community practice teachers were all qualified practitioners within their respective professional disciplines, ranging from health visiting, district nursing and community learning disabilities nursing. These nurses and health visitors were all qualified and their original and subsequent continuing professional development and education and training ranged from certificate and diploma to graduate level studies. I wanted to interview community practice teachers because they were qualified practitioners, usually with several, if not many, years of community nursing experience. They have a professional remit and responsibility, as teachers, to remain up to date in both clinical skills and professional issues in practice. Talking to practice teachers would, I felt, allow me to explore the impact of experience and everyday practice on these discursive constructions. Interviewing students, on the other hand, meant I could examine the discursive constitution of equality by those who were new to practice. In many cases, I was able to interview the student's own respective teacher of clinical practice. In a few cases, this was not possible and I then interviewed an experienced community practice educator from a similar discipline though this person was not necessarily allocated to a student for that year.

The final total sample consisted of fourteen students and fourteen practice teachers. The twenty-eight participants were evenly drawn from two university locations, fourteen from an inner city university and fourteen from a small town university. All of the students and practice teachers were women, and the majority of both students and practice teachers were white, with one student and two practice teachers from the inner city university describing their selves as 'black or Asian' and one practice teacher from

the small town university describing herself as Asian. The majority of students were undertaking the health visitor pathway, and together with the practice teachers, these seventeen were the largest group in total. This was not surprising as historically health visitor and district nurse students tend to form the largest cohorts on these courses. There were four district nurse students and two district nurse practice teachers, two community learning disabilities students and their two practice teachers and one community mental health student (see Appendix One).

I considered documents to be an additional tool, as these allowed for an analysis of the discursive constitution of egalitarian values and principles present in community nursing and in wider contexts. I wanted to identify the historical, political, and socio-economic discursive fields and establish the effects these might have on practitioners' talk of equality and difference. For this I turned to both current and archival documents. I arranged to view historical and archival material with two national nursing organisations, namely the Queens Nursing Institute (QNI) and Royal College of Nursing (RCN) and with the Wellcome Trust, whose library is dedicated to the history of medicine and included relevant nursing material. In order to gain additional material I contacted professional representative nursing organisations, such as the Community Practitioners and Health Visitors Association (CPHVA) and the QNI and related trade unions, the RCN and MSF. I obtained further documents from the UKCC, the regulating body for nurses, midwives and health visitors, and from the ENB who govern the educational preparation of post-registration nurses in England and Wales. This body also defines the learning outcomes of educational curricula. I requested relevant curricula material, including handbooks, timetables and practice assessment documentation, from the two university departments. I also requested and received equal opportunities policies from eight Community Trusts. These Trusts represented all the employing and sponsoring Trusts in which students were placed for their practice experience and in which the practice teachers were employed. In addition I collected national policy statements and documents ranging from government white papers and policy guidelines to Department of Health circulars and reports. Both the documents and interviews were collected and conducted over the months of July, August and September. This timing proved useful, especially in terms of the organisation of interviews, in that the students and community practice teachers were coming towards

the end, or had just finished what is an intense yearlong course. This meant the majority of assessments were finished and some students needed only to complete a period of consolidated practice before qualifying as community nurses.

I also made a decision not to undertake observation. Initially, I felt I would have to impose some form of criteria for deciding what constituted an 'equal opportunities or anti-discriminatory practice' which would in some way introduce bias. This imposition would have been necessary in order to observe 'its' presence or absence. On reflection, I obviously did have ideas as to what this 'practice' might be. This was evident in the type of interview questions I asked and my choice of documents, possibly influencing those I chose to look at and those I did not. However, on further reflection and in view of post-foundational critiques, I realised these concerns also reflected my modernist assumptions. I was assuming there was some notion of a real practice, awaiting discovery, which only required the application of the right technique or appropriate tool and I could uncover it. Furthermore, I erroneously assumed observation to be far more problematic than interviews and documentary methods, implying these chosen tools were in some way free of these inherent assumptions and would more accurately record what I heard over what I saw.

I also chose to interview nurses only rather than together with clients. My decision for this was partly pragmatic and partly methodological. Practically, given my timescale I needed to access a definable group and nurses were an easy population to access and locate. Community nurses were less definable as a group, but were nevertheless easier to access from educational courses than their respective dispersed groups of clients. My methodological reasons relate back to the gaps in the literature I established in Chapter One, namely the lack of available knowledge as to how equal opportunities or anti-discriminatory practice is being discursively constituted. At the time of this research, I felt there was already an overwhelming body of work that continued to document the exclusion clients experienced. I felt I did not need to re-establish this, but I wanted to build on this by developing a picture of how community nurses talked of promoting equality rather than how they did not. I wanted to establish how and in what way community nurses discursively constituted accounts of equality through talk of equal opportunities and anti-discriminatory practice, in order to assess the type of equality

being endorsed, rejected or reworked. In other words, were equal opportunities and anti-discriminatory practices inevitably liberal in content and form?

Thus far, it is evident that post-foundational approaches to research represent a major challenge to empirical work but are compatible with this type of research project. Nevertheless, these are important challenges that I have needed to consider in the process of my research. These challenges to research generally, and in particular qualitative research, can be summarised in two ways. First, in terms of ontology, the qualitative assumption of capturing lived experience becomes naïve and problematic, and second, in relation to epistemology, the traditional criterion used to evaluate the validity of knowledge, namely reason, is no longer seen as tenable (Denzin 1997). These two challenges will be explored more fully as I discuss how I proceeded to conduct interviews and documentary analysis in this post foundational context.

2.4 Data Generation with Community Nurses

Initially I conducted pilot interviews with a group of four community nurses who worked in a geographical area and community trust unrelated to my final sample. This proved to be an invaluable experience, as piloting my interview questions revealed significant limitations to my questions. These particular questions initially produced a very static 'official' or professional response only and this did not demonstrate any of the subsequent diversity of narrative I was able to generate. The 'broadening out' or development of my questions meant I was able to generate more in-depth narratives and discursive constructions of equality and equal opportunities. This I achieved by developing questions that generated general discussions on the nurses' day-to-day work and how this related to issues of equality and inequality, together with questions that 'allowed' the nurses to critique concepts like equal opportunities and anti-discriminatory practice.

As stated previously, I conducted interviews with students and practice teachers from two University sites. These students were registered on the same type of course, seven at an 'inner city' and seven at a 'small town' university. On the degree course, each student is allocated a practice teacher who acts as a mentor and assessor of practice throughout the year. The decision to interview two University student cohorts was

initially driven by the assumption that there would be some significant comparison to be made between the talk of participants from these two sites. However, I soon discovered that whilst I could decide on these Universities' location, practice placements were more widely located. There were, therefore, far more similarities than differences in terms of practice experience as the placements ranged from rural to inner city, as described by the community nurses (see Appendix One). There were, however, some differences. For the students attending the inner city university, community practice was more city based but ranged from areas of great deprivation to wealthy, suburban commuter areas. The small town university practice placements were similar in that there was a mix of deprivation and poverty alongside wealth. However, some placements were located in rural villages where levels of poverty and deprivation were present but less evident. Other placements were in relatively wealthy middle class areas but were again located in villages or small towns with a more dispersed, less concentrated population. The effects of these placements upon the discursive construction of equality or inequality were, however, evident throughout the community nurses narratives but there were none of the more discernible differences I had expected. I had, for example, assumed that possibly the inner city student or practice teacher would be more aware of equality issues, or have developed a politics that was reflected in their practice.

I offered everyone the choice of location for the interview and the majority took place at the students' and practice teachers' workplace. Only two interviews were held in students' own homes as requested. Workplaces ranged from purpose built community trust health centres to general practices. Each participant was asked again to consent to the interview and the purpose of the research was outlined. I also gave everyone an opportunity for further questions prior to recording. Permission to record was sought and each interview was taped. Using a semi-structured format to the interview, all participants were asked similar questions but not always in the same sequence, as befitted the conversations that followed (Silverman 1993, 2000, Morse & Field 1996, See Appendix 2). On reflection, the workplace setting appeared to have certain advantages for the participants. It certainly put the whole interview process on a more formal, business-like footing than those carried out at home. The practice teachers appeared very much in control of this environment. This was evident in small ways,

showing me in, telling others who I was and where they would be for the duration of the interview, diverting phones, or dealing with last minute enquiries with receptionists. Some of the students appeared equally at ease, having undertaken their community practice in a familiar surrounding, whereas others were less so. The unfamiliar and possibly temporary practice placement meant that, even though they had been in practice for nearly a year, it was not their environment to control. These issues are possibly indicative of the power inherent in all research relations, and were evident in my attempts to access participants.

2.4.1 Issues of Power and Ethics

Feminist research has insisted on making this power embedded in all research explicit. Consequently, there have been a variety of means to minimise a potentially exploitative relationship. This has led to developing reciprocal approaches, with 'give and take' methodologies being advocated. However, these innovations minimised but never really overcame the imbalances of power (Scanlon 1993, Stanley & Wise, 1993). In post structural terms, overcoming these imbalances in power becomes redundant because it implies a finite amount of power needs to be struggled over. Whereas, from a post-foundational view, power is seen as a relation that inheres within discourses and it is not possessed or owned by one party. It is diffused and dispersed, with its presence evident in its effects. These effects include constituting subjectivities, relations and discursive practices and where power is exercised, resistance to that power is to be found. This involves a radically different view of power in the research relationship.

In my own fieldwork, power did indeed structure relations in a diffused and less evident way. For example, gaining access to students and community practice teachers provided clear examples of how power potentially resided and shifted within the research process. In order to gain access to both students and practice teachers, I contacted the course directors of the degree programme in each university. Initially I wrote and then phoned to explain my research and explore the possibility of access. My anxieties here were twofold. Firstly, the students were on a one-year degree programme, which was due to finish in July. I wanted to talk to them about some of the input on this course, so ideally I needed to talk to them towards the end of the programme. However, delays in

access would jeopardise my chances of completing the fieldwork within my time scale, as I would have to wait until the following year. To track students once they left the course would also require a great deal of co- operation from the institutions and employing/sponsoring trusts and may not have been feasible.

My second anxiety related to the political and economic context of nurse education. The bulk of my fieldwork was undertaken in the summer months, from July to September. This coincided with the start of the contractual process for the degree programmes in community nurse education in the region where both sites were located. Bids were being drawn up for the tendering process due that autumn. Apart from it being an incredibly uncertain time for those working on these tenders, I also worked in a potentially rival institution, going through the same process, and wanted to ask research questions about the very courses due for tender. I feared my request for access would be seen as yet another demand, and possibly an extremely insensitive one at that, given the competitive nature of these contracts. I had no control over these outside forces shaping this contract agenda. My initial contacts as a researcher were positive. I offered to go to both sites to speak to the students and practice teachers to explain the research. However, at both sites, the course directors acted as gatekeeper to both students and practice teachers and lists of interested participants were produced, with one site requesting my research proposal be submitted before a research committee.

Furthermore, the ethical issues underpinning this research process became very evident as I made certain assumptions about gaining access to what I thought would be unproblematic stories or in gaining consent and promising particpants I would adopt an ethical approach to the research. For example, confidentiality and consent was routinely sought prior to interview but as many have argued, these can never be fully guaranteed (Morse & Field1996). Anonymity is easier, although when dealing with smaller organisations and practices it may be possible to identify persons by default. However, during the course of the interviews I encountered further dilemmas which involved listening to racist comments. My dilemma was that I did not challenge these directly as I would do in my work as a lecturer. As others have stated, when dealing with similar situations (O'Neal 1996), this can leave one colluding with such comments when pursuing one's own agenda of 'getting that interview'. This collusion reinforces a racist,

capitalist and patriarchal society. As a white, female researcher talking to both black and white students and practice teachers, all female, but from differing class backgrounds, this was disturbing. Furthermore, some comments were made after the interview. This was similar to the 'off loading' O'Neal identified when she interviewed lecturers and managers about equal opportunities in higher education. I wasn't sure if I should report these comments to anyone. At the time I thought this would undermine the trust I had built up, albeit brief, between participants and myself. This made me question whether my intentions were open and explicit. I suspected I really did have an authorial agenda that implied there were correct responses lurking behind my questions. I then wondered whether I really wanted to uncover these comments, would this not make the interview content more interesting or more tangible in some way? Ethically, nursing research should be guided by a desire to do no harm and I feared this research had the potential to do harm as colluding with comments amounted to condoning racist talk. However, I agree with O'Neal (1996), there seems to be no resolution of these dilemmas, only that they form part of this research and shape it deeply.

2.4.2 Generating Data through Interview and Documentary Analysis

I undertook the twenty-eight interviews over a three-month period. However, in view of postmodern and post structural critiques, I have had to deconstruct both the interview process and documentary analysis and the outcomes of these methods. Traditional methodological assumptions suggest qualitative researchers rely on two main methods of inquiry, looking and listening and:

'These technologies [interviews and observation] of representation crumble precisely at that moment when the representation is taken to be a measure of pure presence, pure interaction, and a window into human intentionality and meaning, there are no such measures; they are all textual constructions.' (Denzin 1997:36)

This suggests there is no 'true reality' to capture or discover in people's talk or behaviour or writing. Data is not collected but is *generated* through these research methods like the interview process. This implies what I heard and then subsequently read and analysed in the texts derived from the interviews was not lived experience but lived textuality, producing particular situated understandings (Denzin 1997). However, accepting these post-foundational implications reflects not only the destabilising affects upon epistemology but also the displacement of modern ontological assumptions. The

individual subject of liberal humanism, as transcendent, autonomous and rational, occupies a privileged position as the centre and origin of meaning in research. This is a subject able to use reason to legitimise knowledge as objective and true and produce knowledge beyond the power or influence of any one person or group. However, this individual unified subject is now decentred by the understanding of the subject and identity as complex, multiple and diverse (Butler 1990, Flax 1993, Weedon 1997).

However, there is still the question of how even these textual realities are constituted in interviews and this reveals a further problematic assumption. In interviews there is a reliance on memory recall that assumes memory can capture and reflect experience as *true representations* of the past (Sheurich 1997). Post-foundational approaches propose that what takes place within the specific context of an interview is not a reflection but a reconstruction or reinterpretation of the self. Recalling the past involves re- presenting the self, as meanings are co-constructed between the participant and the researcher. This constructs a particular version of reality. However, this was evident not just during my interviews but as I have indicated both prior to and after these events. Therefore, modern accounts of research are not external expressions of internal processes such as intention but are an expression of relationships among persons (Gergen and Gergen 1991, Sheurich 1997, Miller and Glassner 1997).

However, these interviews were premised on an additional problematic concept. The reflections of meanings collected during an interview rely on the authenticity of individual *experience*. These assumptions are found in feminist research. In interviewing women, feminists have sought to privilege marginalized voices, often arguing that such experience offered less distorted and even superior knowledge from which to develop theory and politics (Harding 1993). However, this assertion hides the assumption that experience offers the undisputable grounds for valid knowledge. This has been questioned and as Scott (1992) has argued, this appeal to experience as the basis for authoritative knowledge is limited. She argues that experience is not the origin of knowledge, nor does it provide authoritative evidence for what is known. Rather, it is experience that we need to explain, for what is counted as experience is far from self-evident, it is always contested and therefore always political. Experience is, therefore, contingent and constituted through differing processes and in this way the different

identities it produces become historicized (Scott 1992:37). This proposition deals directly with the subject matter of my research. The rationale for many of the egalitarian programmes, such as those developing in health care, are premised upon the authority of experience. The marginalized and excluded groups have voiced their experiences of discrimination and oppression at the hands of health care providers and demanded recognition and inclusion (Thompson 1998, see Chapter One for a full discussion). However, the notion that experience is constructed does not necessarily lead to discounting experience as grounds for knowledge. It does mean recognising the constituted and contingent nature of all knowledge production, even that drawn from experience. Thus experience must not be used in an ahistorical or transcendental way to generate totalising or universalising theories. These grand narratives of oppression and exclusion must be seen, therefore, as partial and contingent, temporarily fixing and totalising in effect but open to challenge and change.

Therefore, according to post-foundational perspectives, my use of interviews meant that I no longer expected to reveal hidden or authentic meanings, nor accurately reveal reality. Instead, I sought to understand how texts and discursive meanings shape the performances of subjectivity and to recognise the conditions in which these emerge (Denzin 1997:10). In making explicit the theoretical assumptions embedded in the tool of interviewing, I must acknowledge I am creating further texts. These interviews consist of verbal and non-verbal moments where joint construction of meaning took place and was sometimes resisted. Much of the content of these and any other interviews may shift 'between performed or censured statements and unperformed and uncensored statements' which represents a 'wild profusion' that possibly defies description (Sheurich 1997: 67). However, I have clearly decided to define and clarify the profusion of statements I generated in these interviews. The imposition of my definitions and interpretations is then a reflection of my theoretical, political and social background. This means that as I conduct research I am not describing but inscribing reality.

These processes of data generation were equally evident in my documentary analysis. My reading of documents meant I could not assume to merely reflect historicized or contextual accounts. The documents themselves, as texts, were not representing but

constituting those realities. Furthermore, in the process of reading I had already selected what I wanted to include and exclude so that I too was active in constituting this textual reality. I was engaged in constructing the summaries of texts or accounts I then re-presented as extracts to further develop the account I present in this thesis. What I did look for was the dominant and competing or 'reverse' discourses that shape the broader discursive fields in which the community nurses' talk was located. I discuss this in more detail in my analysis of the data.

Following the interviews I sent a full transcript to every respondent. My intentions were initially driven by a feminist commitment to share control of the research process, by offering an opportunity for participation or some shared ownership of one part of the research product. Though, when I subsequently reflected on this and why I had sent back transcripts, I realised I may have been looking to verify some true, accurate record or account. However no one wanted to comment on, or correct my account of our conversation and this lack of response has been argued to be indicative of the power and authority held by the researcher's text (Lather 1991, Stanley & Wise 1993). My account then becomes the authoritative reconstruction of the co-construction of meaning taken from the interview. However, the relationship between language and meaning is, in post-foundational terms, open to challenge and reinterpretation. Therefore, I cannot assume that even the final text is ever fixed or stable. My construction and interpretation of these accounts will be read and re- read and meaning will be re-appropriated or reconstructed accordingly. However, given the assumptions of postmodern or post-foundational approaches, I realised I had to reconsider the meaning of yet another stage of the research process, namely that of analysing the data I had generated.

2.5 Deconstruction and Discourse Analysis

I fully transcribed the interviews and then sought to analyse the data. I drew on an analytical framework to deconstruct and reconstruct both discourses and narratives present in these texts. I will now briefly define these frameworks before looking in more depth at discourse analysis and my overall approach to the analysis of my data.

2.5.1 Deconstruction

The most commonly cited research method stemming from post-foundational perspectives is deconstruction. To deconstruct, Lather (1991) argues, is to speak another way. She outlines three key stages to the process of deconstruction, initially defined by Grosz. First there is the need to identify binaries, second to reverse or displace these so that the negative value is placed where it can become the very condition of the positive term. Third, there is the need to transcend this binary logic by accepting fluid and less coercive concepts and organisation of terms. Therefore, the strategy of privileging the disprivileged no longer suffices (Hekman 1990, Grosz 1993). To undertake deconstruction assumes discourses create subjects and objects, contain regimes of power and construct specific and partial truths. This is evident in all research. For example, positivism disguises its gendered nature by making claims to applicability across history and culture, whereas interpretative approaches disguise their privileging of truth by making claims to describe unified subjective experience. Post-foundational approaches seek to deconstruct these claims and to privilege contingent truths and the decentred subject.

2.5.2 Narratives

Within the interview texts, I focused on the narratives generated by the community nurses and myself concerning the stories of equality and difference in their day-to-day practice. Narratives are described as the means by which people organise and communicate their experiences, and construct their world. They create meaningful identities and making sense of their lives (Somers 1994). Narratives exploit the dramatic form, telling a story by highlighting key points, selectively reporting events and enacting emotional content. Analysing stories involves identifying gaps or omissions or inconsistencies in the plot in order to understand the strategic use of these constructs. I have not conducted a conventional narrative analysis as such, but I have used the narrative form to identify diverse stories or accounts present in the community nurses' talk. In discussing the variety of narrative forms available in any text, Somers (1994) identifies four commonly used forms that were present in the community nurses narratives. These forms overlap considerably with the various stories the community

nurses drew upon and the broader discourses I identified. Ontological narratives are defined by Somers as narratives that define who a person is and form the basis of knowing what to do. They are considered especially useful for turning disconnected events into meaningful episodes. Public narratives are similar to discourses, in that they are located or attached to cultural or institutional formations, like those of families or workplaces or the mass media. These narratives often offer a legitimising context for ontological narratives. Meta narratives are the grand narratives now contested by post foundational critiques. These sets of organised statements tell stories of progress, decline, and crisis and often construct a political position. Conceptual narratives are those the researcher constructs. As I will show in the following chapters I identify similar narrative forms and discourses in the community nurses' talk.

2.5.3 Discourse Analysis

Analysing data or text in this way reveals the instability and ambiguity embedded throughout the research process. In modern research speech is transcribed to text and is then coded as a means to uncover truth. It is then assessed for the degree of relatedness to, or reaffirmation of, a theoretical position. However, this focus on the technicalities of analysis masks the 'unstable ambiguities of linguistically communicated meanings' (Sheurich1997: 63). Therefore, claims of valid representations through the use of techniques of line numbering, coding or creating categories tends to mask the 'absent presence of the researcher and her/his modernist assumptions' (1997:63). This would be equally similar with my reading of documents. However I am not arguing that modernist representations of interview data or documentary analysis are all fabrication but that all uncertainties have been erased and the complexity reduced to certainty and unity. These representations are not reflections of reality but reflections of the researcher's mindset. What is missing from modern qualitative accounts is any discussion of the 'irresolvable ambiguities of consciousness, language, interpretation, and communication' (Sheurich1997: 64).

Traditionally, qualitative analysis is seen as an active, sequential process of comprehending, synthesizing, theorising and recontextualsing (Silverman 1993, Morse & Field 1996) It begins with immersing oneself in the data and proceeds to

identification of key categories or themes through the use of rigorous techniques involving sorting, coding and classifying the material. There is then the development of an emerging theory, which is considered generalisable (Reinharz 1992, Morse & Field 1996, Silverman 2000). However, as Potter (1996) has argued, discourse analysis is different. As he states:

'Research conclusions are justified by reference to the correct and complete following of procedures such as operationalising variables, getting high rates of subject inter-rater reliability for codings, and so on. Discourse analysis is not like this. [.] A large part of doing discourse analysis is a craft skill, more like bike riding or chicken sexing than following a recipe for a mild chicken rogan josh.'(1996:147)

The aim then is to develop a particular "analytical mentality" rather than follow a recipe which, he suggests, involves highlighting patterns; a not too dissimilar technique from the more traditional method. He concedes that part of discourse analysis may even involve coding as an analytic preliminary to make the material more manageable.
My aim in this research was to interrogate the discursive meanings produced in the interview texts and documentary analysis. I wanted to identify dominant, resistant or competing discourses and the institutionally privileged meanings of equality and difference. I show these to be evident in the community nurses' narratives of equal opportunities in the next three chapters. This discourse approach to analysis was useful because it revealed how dominant discourses were sustained and offered possibilities for re-conceptualising aspects of nursing practice that are taken for granted. It also shows how nurses can assume multiple subject positions, as these are positions drawn from dominant and competing or subversive nursing discourses, which constitute the discursive field in which practice takes place (Cheek 1999). By evaluating discourses it is possible to show how definitions or shared truths sustain social action. It is also possible to see how different constructions result in various interventions and how these are culturally and historically specific and struggled over (Crowe 1998: 343).

Discourse analysis does vary in content and form. It is a method that has evolved from socio-linguistics, cognitive psychology and post structuralism (see for example Potter & Wetherell 1987, Gergen & Gergen 1991, Gill 1994, Marshall 1994, Potter 1996, Yardley 1997). The practical use ranges from a semi-prescriptive method, imitative of conversation analysis, to extremely ambiguous vague descriptions. There is, however, a guiding theoretical consensus, which suggests there is an emphasis on anti-realism and

constructionism on the part of both participant and researcher. There is also an emphasis on reflexivity. The understanding of discourse I draw upon is that of Foucault and utilises his definition of power and knowledge (Foucault 1974,1979b, 1980). This ascending analysis of power focuses not on who has power but on how power circulates. It is the capillary effects or the expression of power 'at its extreme points' that leads to the discovery of how subjects are gradually 'really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts etc' (Foucault 1980:97). It is power that constitutes subjects. As Foucault states, one of the main effects of power is that,

'Certain bodies, certain gestures, certain discourses, certain desires come to be identified and constituted as individuals [.] The individual is an effect of power [and.] it is the element of its articulation. The individual which power has constituted is at the same time its vehicle.' (ibid: 98)

This notion of the subject as an effect of power shows how power is not only repressive but also productive. However, this view of the subject displaces the enlightenment view of the transcendental, unified and self-determining subject. Discourses represent political interests and are far from equal. This means some discourses are marginalized, while others are more dominant, the medico-scientific discourse is a good example. It is through this nexus of power and knowledge that the objectification of the body occurs and the subject becomes the object of surveillance through various disciplinary techniques and the clinical gaze (Foucault 1976, 1979, Rabinow 1984, Smart 1985).

Prior to analysing these texts I considered other researchers' use of discourse analysis. I drew on advice from Marshall's techniques for discourse analysis in her research with midwives and health visitors (Marshall 1994). This meant that I initially read and reread the transcripts and documents. This enabled me to impose some order on the material and allowed me to make some sense of the detailed talk and text. I noted any similarities or differences in what was said, as she suggests, and placed these extracts or statements under broad categories, each titled to reflect a consistent theme. Again, as Marshall advises, consistency is not an indication of an underlying reality but is used to highlight the use of a particular narrative or repertoire. This was a process I repeated many times, with extracts being placed and replaced under these headings. Within these initial broad categories, further readings were made for the ways in which statements were being

used, that is, what function did they serve, or what problem did they solve? By using discourse analysis I wanted to identify sets of meaning, metaphors, images, stories or statements that in some way produced a particular version of events (Burr 1995, Cheek 1999, Kendall & Wickham 1999). Words or sentences do not belong to a discourse per se; the meaning given to any text is directly linked to the context in which talk or communication is utilised, including the participant and myself. There is, therefore, always a dependent relationship between what is said or written and the context in which it is produced (Burr 1995, Cheek 2000). Discourse analysis is an example of a reflexive methodology advocated by Gergen & Gergen (1991). They argue that discourses should be expanded upon in terms of meaning through dialogic procedures in order to generate new forms of linguistic reality. Thus, initially the researcher would generate tentative interpretations, descriptions, explanations and meanings. The next phase would be to open up the phenomena to inspection by others and these interpretations are then used to expand upon or question the initial tentative understanding, demonstrating its potential and limitations. There is no end point to this research, but rather the aim is to expand and enrich the vocabulary of understanding (Kendall & Wickham 1999).

In relation to my data, using discourse analysis has meant that I have looked for how language performs through the talk of community nurses. This reveals the historically variable ways in which knowledge and truth regarding equality and anti-discriminatory and equal opportunities practices are specified. It involves examining the meanings, the images and the stories which the community nurses used to construct their accounts, including how nurses positioned themselves, both in relation to each other as occupational groups, and their clients. It has meant that I looked for what was said and what was not said, interrogating the fixing of meaning for its function or use. For example, in examining how the nurses fixed meanings of discrimination or represented themselves, or clients, I needed to identify and examine variation in their talk. Then I had to ask how and when such variation occurred and what purpose it served. The aim was to locate and reveal the range of linguistic regularities or patterns available in their talk (Marshall 1994). Having identified shared meanings and conceptualisations used by the practitioners to inform their work, it is important to restate here that these meanings are not seen as emerging from the individual. This makes discourse analysis

different from the traditional subjectivism of qualitative methodology. Discourses are instead, culturally and historically located, generated and communicated. Linguistic resources already pre-exist and are available to participants. It is these they draw upon to represent their worlds. These forms of analyses are innovative and challenging. My analyses, therefore, aim to mount challenges upon, or to offer a continual disruption of, totalising views. This is seen to contribute towards redefining legitimised or dominant discourses or what is otherwise known as the 'truth' (Lather 1991:15, Traynor 1997:103). However, my acceptance of shifting grounds and loss of certainty means there are no external criteria, such as reason, I can use to judge between differing knowledge claims. This inability to decide upon criteria to validate research is, Denzin (1997) suggests, yet another major implication of these critiques for all research.

2.6 Validity and Relativism

Qualitative research was initially criticised for its supposed lack of validity and reliability or rigour. Subsequent responses, like those of Guba and Lincoln (1989) addressed this and produced criteria that established the 'trustworthiness' of qualitative research. Thus the rigour of qualitative work was defined according to criteria of credibility, transferability, dependability and confirmability. External and internal validity were measures concerned with controlling influences both inside and outside the research process. These influences were presumed to distort an implicit objectivity by introducing bias. However, feminist qualitative research has sought to reveal these methodological assumptions, exposing the 'doctoring' of the reality of doing research and arguing against the production of 'hygienic research' (Stanley & Wise 1993, Armstead 1995, Dyck et al 1995). Nevertheless, much feminist research retained unexamined modern epistemological and ontological assumptions. Moreover, the loss of faith in reason as some guarantor of truth now permits many forms of knowledge to be considered credible, trustworthy and valid.

However, with this plurality comes the charge of relativism, where if 'anything goes' in relation to knowledge production then it is assumed research knowledge is fatally undermined. But Lather (1991:114) offers an interesting insight into this fear. She argues it is only those in privileged positions who lament the loss of 'classical standards

and fear anarchy and cultural disintegration'. This is because they defined and shored up the standards in the first place. Thus relativism becomes a cultural dominant that masquerades as natural and necessary. Therefore, this fear, and its attendant nihilism, is nothing more than 'an implosion of white, male class privileged arrogance-if we cannot know everything-then we can know nothing' (1991:116). In a similar manner, Nicholson (1999:127) questions the charge of inevitable chaos following the displacement of rationality. She argues what is assumed to be frightening about relativism is the vision of complete 'indecision about the truth of a claim or the rightness of an act'. But this is, she suggests, the possible real-life situation. For it is only the continued assumption that rationality must be understood in singular terms that makes the plurality of truths or rightness seem implausible. Therefore, any success to convince others of the truthfulness of our claims is a matter of persuasive communication.

Even so, the loss of validity is a major challenge for research. In this uncertain context I had to decide how my research might make claims to be credible or trustworthy. As modern notions of validity are displaced, a range of additional criteria for judging knowledge comes into play. In his many examples, Denzin (1997) focuses on ethnographic texts to demonstrate different methodological representations ranging from new journalism, standpoint epistemologies to ethnographic poetics and narratives of the self. These alternatives present new possibilities for research and Sheurich (1997) sees resistance to these more novel ways as similar to the argument in the world of art, whereby realist representations held sway and there was resistance in moving to more abstract forms of art. These debates may not have made art per se any less valid but the controversies and debates as to what art is still continue. The concept of validity is then replaced with recognition of the power inherent within all text, as validity is considered to serve to disguise a text's claim for authority and legitimation (Denzin 1997). When using this definition it becomes possible to see how all text, mine included, is concerned with asserting its authority. The concept of validity becomes the means by which my text asserts its power. Therefore, my text seeks to assert its authority by claiming to be credible, by claiming to offer a rigorous and authoritative account in which I have sought to deconstruct and declare my theoretical assumptions and my authorial agendas. I have sought to expose my privileging of research

knowledge to ensure recognition of the stories I have generated and that these are in some way credible, capable of delivering a story worth telling. I claim a further measure of credibility is to be found in my attempts to incorporate a self–reflexive approach throughout this research process.

I have acknowledged that there is a need for self-reflexivity when using these perspectives to conduct research and I have already shown the reflection I have experienced throughout the research process and in writing up this account. To develop self-reflexivity is to put myself back into the research text. It means I remain critical of any imposition and reification of myself and I need to reflect on how my commitments to emancipatory politics become inserted into this empirical work (Lather 1991:80). This is what Denzin (1997) calls *'the baggage'* I bring to this research project and here I must acknowledge its impact more directly. I am researching a topic with people with whom I share a great deal of similarity in terms of occupational background and yet my work history also differs in significant ways. I trained as a general nurse some twenty years ago, but then left the NHS, studied a social science degree and worked for several years in the voluntary sector during a time of great political activity within the women's health movement. This meant I was involved in working with women's health groups and met and worked with women experiencing many of the worst effects of inequalities and often the most excluded and yet also included of service users. As a result of this work, my political commitment to feminism deepened and I returned to the NHS, initially through research and then worked in primary care. This led to my work in community nursing and in community nurse education.

To many practitioners these stories and these identities were important and/or significant in some way. Before most of the interviews, the students and teachers sought to clarify my position. This felt like some form of checking or evaluation of my credentials and myself. It may also have allowed participants to partially gain control of an unfamiliar situation, so they asked me questions rather than the reverse. Furthermore, whilst these similarities may have bestowed some advantage, this insider status may also present as many problems. It may be that in sharing a background I was too familiar with the worlds the practitioners inhabit, both in my role as teacher of community nurses and as a nurse. This may mean I have taken certain features, certain

talk or stories for granted. I may have colluded in a very particular co-construction of meaning during the interviews. As a teacher of community nurses for the last ten years I am also familiar with the programme the students and practice teachers were working on. Inevitably, this shaped my interactions, including the questions I asked and more importantly didn't ask or probe on. Being a white, heterosexual, able-bodied woman, from a working class background, with my concern for emancipatory political values and commitment to feminist goals has all meant that my differences, my politics, my background, my occupation as a community nurse lecturer have all had an impact on this research project from its inception. Furthermore, I must acknowledge all research efforts to liberate can perpetuate relations of domination, so even though I intend that this research contributes towards an emancipatory end; it may also serve to control and oppress.

2.7 Assessing Post-Foundational Research

To conduct research in a postmodern world means that I accept truth is always subjective, multiple and personal. Experience is evoked rather than explained and there are no stories waiting to be recorded, only stories yet to be constructed. Validity and reliability are marketing devices. The end result is reflexive, messy, open-ended methodology, where a performance based story-telling framework is privileged (Denzin 1997:264). My account of this research methodology has attempted to acknowledge the ambiguities, contradictions and inconsistencies present when listening to or reading a text. In this discussion I have tried to show how research and the interview context becomes the specific outcome of historical, socio-economic and political forces (Cheek 1999). I have advocated the use of these post-foundational positions because they provide detailed micro-accounts of how social worlds are constructed.

As Henwood & Pidgeon (1994) and Nicholson & Seidman (1995) have argued, these post-foundational perspectives are useful for their focus on the micro level. They have, however, neglected and need to be connected to more macro level issues in order to develop a fuller understanding. I would agree with this, though again as befits post modernism, the possibility of this link seems dependent on the version of postmodernism that is used. Social postmodernism, as advocated by Nicholson and

Seidman (1995) make these links feasible. This move towards the 'bigger picture,' is advocated by Henwood and Pidgeon (1994). They argue for similar links between textual or discourse analysis with more broad based and eclectic use of modern qualitative methodologies. In this sense there is a desire here to retain and utilise the best of both worlds. Strategically this might make sense as Stanley and Wise (1993) take up a similar position in arguing for a 'fractured foundationalist epistemology.' This would recognise the situated and competing nature of all knowledge claims and the need to recognise the interpretative aspect of all research in producing knowledge claims. They want to reject the foundationalist view of a single reality, existing out there, but they argue there are social realities, constructed by people, that have an objective existence (1993:8). Furthermore, many features of post- foundational perspectives are not completely new, as Henwood and Pidgeon (1994:12) argue, especially in view of feminist research. Feminist research has always recognised the multiple forms of subjectivity present in an interview and the cultural 'baggage' that shapes the research process. This includes the personal commitments, values and wider cultural assumptions for understanding and legitimising research. What does differ though is the insistence of a relation between these accounts to external events, a position indicative of feminism's modernist roots. However, postmodern feminist researchers acknowledge that experience or talk alone do not form the grounds for feminist knowledge claims. These claims involve talk plus different social positions, personal histories, cultures and unconscious and conscious processes (Hekman 1990, Weedon 1997).

Given the plurality of theoretical positions available the adoption of a plurality of methods would seem to be a credible and adequate postmodern response to research. Using a variety of tools may be needed to fully understand difference. Feminist research is in favour of utilising a multitude of methods as Reinharz (1992) illustrates. However, there are dangers in accepting or insisting on a plurality of method. It could mean a return to purely technical or pragmatic concerns. This could lead to the assumption that methods or tools are atheoretical, neutral and value free (Henwood & Pidgeon 1994). A further serious limitation is that these diverse theoretical positions do not appear to offer any serious prescription for politics or practice. However, given that I wish to draw more practical conclusions from this research, I agree with Yardley (1997) that

there is a need to relate these analyses to material experience. Indeed, the more practical outcomes of discourse analysis can already be found in nursing research in the work of Cheek (1999, 2000) Crowe (1998, 2000) and Traynor (1997). For example, in utilising post-foundational approaches for her study on toxic shock syndrome, Cheek examined the various sub-textual discourses present in Australian print based media and was able to assess the impact of these on women's understanding of the syndrome (Cheek 2000). In examining nursing discourses, Crowe (1998, 2000) demonstrates how nursing can potentially reshape and challenge more dominant and constraining discourses, such as medicine, governing their work. While analysing managerial and nursing discourses allowed Traynor to reveal the differences that led to managers marginalizing nurses' responses to managerial initiatives (1997:105). Therefore, the material consequences of discursive or post-foundational research are significant. As Yardley (1997:44) states, 'the very rationale for discursive research is to produce an effect'. This is the case with this research, as I seek to challenge existing practices, publicise suppressed discourses and narratives and create alternative interpretations.

In reconsidering my approach to this research I would assess alternative approaches and tools with which to generate data. I would seek to ensure further opportunities for greater participation of those I interviewed. This would mean sharing the results of the discourse and narrative analysis and asking for the joint interpretation of these tales or stories. This approach would also include the participation of other voices, like those of clients and the co-construction of meanings from observation. This would allow other stories to be constructed, which could be employed to construct further meanings and interpretations of equality in health care and nursing practice.

2.8 Conclusion

In this chapter, I have discussed the research process underpinning this thesis. I have also sought to examine a central concern, namely the implications of postmodern and poststructural feminist theories for research methodology. I have discussed the challenges these ideas pose for all research methodology and demonstrated this through an examination of key stages of my research process. This has meant revisiting the subject as the source of meaning and questioning the status of knowledge resulting from

techniques like interviews. It has meant deconstructing terms like validity and opening up spaces for new methods, like narratives of the self. With the loss of certain grounds upon which to base knowledge, there are no prescriptions for research but a recognition that research does not describe but inscribes reality. It was argued that these realities or stories are still worth constructing. Their usefulness lies in their strategic use but also in providing a fuller understanding of how stories are constructed and co-constructed. (Denzin 1997, Nicholson 1999). I have shown how these post-foundational theories have influenced my research methodology and I will now demonstrate how these influences shaped the meanings I have co-constructed in the following three chapters. In these three chapters I discuss the findings of this thesis. I draw on interviews with community nurse students and their respective practice teachers, together with the documentary analysis of current and archival literature relating to equality and to community nursing. My aim is to begin to explore the community nurses' talk of equal opportunities and anti-discriminatory practice. I intend to identify whether these discursive forms of equality are inevitably coherent or consistent with liberal equality. If the forms of equality being discursively constituted are liberal in content and form, this presence may infer the demise of equality work in community nursing.

CHAPTER THREE

TALK OF EQUAL OPPORTUNITIES AND ANTI-DISCRIMINATORY PRACTICE

3.1 Introduction

The dominant response within the NHS to discrimination and inequality has been to endorse a liberal equality discourse. In health care this strategy has produced an agenda that primarily focuses on equalising employment opportunities within the NHS for staff, while issues of equality and equity in service delivery have remained relatively marginal. In this chapter, I aim to assess whether a similar use of liberal equality is to be found in community nursing. I aim to establish whether community nurses are indeed endorsing, rejecting or reworking these dominant liberal forms of equality. I therefore intend to identify whether the community nurses discursively constitute equal opportunities and anti-discriminatory practice as consistent or coherent with liberal discourses of equality. Drawing on two sources of empirical material, namely interviews and documents, I explore how these notions of equality are discursively constituted, both more broadly within professional, educational and organisational and workplace discourses and within the nurses' own narratives.

In the first section of this chapter, I use documentary evidence to explore the broader discursive context in which community nursing is located. I examine the specific discourses that invoke, reinforce, compete with and sustain principles of professional practice and community nurse education. I also explore the organisational discourses underpinning the community trusts' workplace policies, as these offer local examples of the wider NHS equality agenda. I compare these 'official' policy responses with those of relevant community nurse professional and trade union organisations, and I seek to clarify the positions of these organisations with regard to equality and discrimination. Throughout this section, I aim to establish how these broader discursive fields or formations construct the context within which the nurses work and learn. This means I assess whether these meanings, definitions and/or uses are compatible and consistent with a dominant strategy of liberal equality.

In the second section of the chapter I draw directly upon the community nurses' narratives in order to reveal their particular talk and stories of equality. This is achieved through talk of equal opportunities and anti-discriminatory practice, as these are terms discursively available within the broader discursive context and constituted by the two different equality agendas of liberal and radical equality. I explore how the community nurses work with and rework these discourses, drawing on some and rejecting others from within this broader discursive context. My aim is to assess the degree of influence these discourses have upon the community nurses' narratives. Therefore, in examining whether a liberal equality discourse is a dominant and an inevitable feature of the nurses' narratives, I explore the consequences of these uses for the discursive constitution of equality in community nursing.

3.2 The Broader Discursive Context

Dominant discourses are argued to have strong institutional bases (Weedon 1997). Therefore, in order to examine the discursive context in which community nursing is located, I have chosen to examine professional practice, education and key organisations and the workplace; these form the key institutional locations or bases through which dominant meanings or discourses of equality will be constituted. Through the analysis of key documents pertaining to these areas, I examine this range of influential and dominant discourses. I explore a professional practice discourse, as reinforced through guidelines and a professional code of conduct. I identify a number of competing educational discourses, endorsed and legitimised through key professional bodies such as the English National Board for Nursing, Midwifery and Health Visiting in England and Wales (ENB) and the United Kingdom Central Council for Nursing, Health Visiting & Midwifery in England and Wales (UKCC). In particular, I explore the impact of these educational discourses for both the community nurse degree and its curricula and the two universities' policies and equal opportunities statements. I then inspect the equal opportunities policies, statements from the respective community trusts and those of relevant professional, and trade union organisations. I also assess these in relation to the wider health care agenda defined through current government policy.

3.2.1 Professional Practice

For every qualified and registered practitioner, the definitive reference and starting point for practice is the United Kingdom Central Council's Code of Professional Conduct (UKCC 1992). As a regulatory body whose foremost role is to safeguard the public, the UKCC governs the registration process, allowing only those practitioners considered safe to register to practise. Once qualified, registered practitioners are subject to the Code and are held accountable to the Council for their actions or omissions. The Code is the framework for professional practice and each practitioner is expected to, 'practise and conduct themselves within the standards and framework provided by the Code.' (UKCC 1992:3). The Code states:

'Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to: safeguard and promote the interests of individual patients and clients; serve the interests of society; justify public trust and confidence and uphold and enhance the good standing and reputation of the professions.' (1992:1)

With regard to clients, the Code seeks to endorse a client centred and individualised care approach, based upon principles of collaboration and openness. Practitioners are asked to 'foster independence' and client involvement in their care, and clause seven of the Code clearly states that each practitioner should,

'Recognise and respect the uniqueness and dignity of each individual patient and client and respond to their needs for care irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problem or any other factor.' (UKCC1992: 2)

Clause nine reminds practitioners to,

'Avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their person, property, residence or workplace'. (UKCC1992:2)

The Code is the foundation for post-registration practice and evolved out of a developing framework for post registration education and practice (Scott 1998). Additional guidance is available for developing these principles of practice endorsed by the Code. This includes the 'Scope of Professional Practice' (UKCC 1992) and 'Guidelines for Professional Practice' (UKCC 1996). The former document emphasises the need for relevant knowledge, skill, responsibility and accountability, whilst the latter document offers further details on the sixteen clauses of the Code of Professional Conduct. These guidelines for professional practice remind practitioners to develop a

sensitive, reciprocal relationship with clients, whilst empowering them to take control of health care decisions. Thus, client advocacy and autonomy is endorsed and is to be achieved through the principle of promoting choice. The guidelines insist the nurse is not to practise in a way that removes or denies these rights, either by 'thinking they know best, or by fostering dependency', which interferes with the right to choose (UKCC 1996:13). Moreover, these guidelines explicitly acknowledge that practice takes place in a context of limited or scarce resources. Thus, professional accountability is defined as the need to make and justify decisions in this context. More explicit references to equality and discrimination are evident but more in relation to the practitioners themselves, rather than to their clients. Practitioners are reminded that if they experience sexual or racial harassment they have the right to withdraw their duty of care (1996:12). Moreover, as workers, practitioners are entitled to equality and the right not to be discriminated against. All staff are required to be non-judgmental, as the UKCC states,

'Discrimination has no place in health care. This means making sure equal opportunities policies are in place, challenged and/or changed and ensuring that no one has to endure racial or sexual harassment. Each member of the team is entitled to equality and must not be discriminated against because of gender, age, race, disability, sexuality, culture or religious beliefs'. (1996:24)

The Code and these guidelines appear to constitute notions of professional practice as a practice and care that is premised upon a particular nurse-client relationship. This is a relationship that is based upon principles of equitable, egalitarian and non-judgemental care. According to Thorne, (1999) this is to be expected as nursing practice currently subscribes to a philosophy of equality. As she suggests,

'Professional nursing had typically worked toward distributive justice in health resource allocation, interrupting oppressive or discriminatory practices within health care, and articulating models of health service delivery that depict the recipient as a whole, conscious, and active agent rather than a passive recipient. Although these objectives have not been achieved, one can reasonably argue that they represent the dominant discourse within nursing scholarship, and that the discipline has had little tolerance for alternative perspectives. The principle of equal opportunity within nurse education and in the delivery of nursing services seems beyond debate'. (1999:17)

This implies professional practice, as endorsed in the code, should be compatible with the pursuit of egalitarian care. The code endorses a relationship premised on equity and reciprocity if not equality, which then becomes invoked as a principle of equal opportunity in the delivery of health care. However, this does not yet clarify the form or

type of equality being endorsed or used. Whether this drive towards an egalitarian philosophy in practice is indisputable, as Thorne argues, is debatable, but it is a philosophy that appears to apply not only to practice but to nurse education as well.

3.2.2 Education

The educational context of community nursing is greatly influenced by both the UKCC and ENB. Both bodies govern the design and implementation of post-registration education generally and more specifically, the educational programme leading to the Specialist Practice qualification. The functions of the UKCC are set out under the Nurses, Midwives and Health Visitors Act (1997). This organisation protects the interests of the public, not only through the aforementioned registration process, but also by setting standards for post-registration education. Thus, community nurse preparation and education is regulated by the UKCC, as it specifies the length and form post-registration programmes must take when leading to further entries on the register. The specialist practitioner programme is the post-registration programme that all nurses wishing to practise as specialist practitioners in the community must follow (UKCC 1994). A specialist practitioner is defined as a nurse who is expected to:

'Exercise higher levels of judgement, discretion, and decision-making in clinical care; [they will be able to] monitor and improve standards of care through the supervision of practice, clinical audit, the provision of skilled professional leadership and the development of practice through research, teaching, and the support of professional colleagues.' (UKCC 1994:9)

The UKCC specifies both core and specialist learning outcomes for this programme, the latter of which vary according to which of the potential eight pathways is implemented. As Scott (1998) argues, setting educational standards for such large numbers of areas is a complex procedure, however, these standards are extremely influential in shaping the overall structure and indicative content of the educational programme (see Table 1). In examining the standards for specialist practice, it is evident that the UKCC makes no explicit reference to equality. The core and specialist practice outcomes and recommended content are clinically focussed, though the indicative content includes 'sociology' and this has the potential to discuss discrimination and health inequalities. The overall emphasis of these standards is to endorse the Code of Conduct, as there is both a community-orientated approach to health as well as an individual delivery of

care. Specialist practice mirrors and reinforces a professional practice discourse that includes an emphasis on the support and empowerment of clients and their carers and facilitating partnerships in order to provide holistic care. An example of this is seen in the UKCC learning outcome 97.4. whereby clients are to be encouraged to become autonomous and independent so that :

'Individuals, families and groups must have a say in how they live their lives and must know about the services they need to help them to do so.'(UKCC 1994:31)

Learning Outcomes for Specialist Practice.	**3. Specialist Practice Learning Outcomes**:
1.Key Components: Clinical practice; clinical practice; leadership; practice development & care and programme management (1994:11).	To develop specialist clinical practice, care and programme management, leadership and clinical practice development (1994:31). Suggested content for these programmes includes:
2. Core Learning Outcomes: Assess health, health-related and nursing needs of patients, clients and their families and other carers (1994:13) Lead and develop clinical practice and ensure safe, effective and evidenced based care, which is to be delivered within available resources (UKCC 1994:14).	Health promotion, sociology, and social policy, law and ethics, clinical care, communication, research, and leadership and management (1993:33). **4. Specialist Practice Pathways:** General practice nursing; public health nursing (health visiting); nursing in the home (district nursing); community mental health nursing; community learning disability nursing; community children's nursing; occupational nursing, and school nursing. (1994:15-19) .

Table 1 Learning Outcomes for Specialist Practice Adapted from UKCC (1994) *The Future of Professional Practice- the Council's Standards for Education and Practice following Registration.* London: UKCC.

While there is no obvious endorsement for either an equal opportunities or anti-discriminatory approach to practice, the UKCC has recently made its own explicit commitment to developing, what it calls a 'valuing diversity and equality of

opportunity' approach to its work. Valuing diversity is to be integrated into every aspect of the organisation's business (UKCC 1999). As the UKCC states,

'Valuing diversity goes further than compliance with anti-discrimination legislation. It is about positively valuing the contribution of each individual, and treating them fairly, irrespective of their race, colour, ethnic origin, nationality, gender, age, disability, sexual orientation or family circumstance. This makes sense for employers and for society as a whole to develop and use the full potential of all people.'(1999:2)

Whilst diversity is argued to be more than issues of race and ethnicity, the UKCC has chosen to focus initially on monitoring the ethnic composition of registered practitioners:

'By developing an accurate picture of the ethnic composition of the register, we can help to ensure that workforce planning, recruitment and training strategies are non-discriminatory and targeted [.] This is about ensuring that all ethnic backgrounds have the same opportunities to achieve their potential.'(1999:2)

The UKCC is, however, only one professional influence on educational programmes. Another key source shaping post-registration educational provision is the ENB. The functions of the ENB are also set out under the same legislation as the UKCC. This professional body is responsible for the approval of educational institutions and programmes which includes the specialist practitioner programme. In the development and validation of post-registration specialist practice, the ENB(1995) guidelines are a considerable influence. The document, 'Creating Life Long Learners: Partnerships for Care' offered guidelines for the implementation of specialist practice programmes and clarified the required content for those Institutions wishing to gain approval to run this degree. This content obviously varies, according to the eight potential pathways, but common to all are the following elements; the assessment of the individual, individual families and communities' health needs, health promotion, inter-agency and collaborative working. More significantly, in relation to this discussion, the ENB insist specialist practice programmes directly address diverse needs by ensuring,

'That there is *equality of opportunity* for, and demands upon, students across and throughout the programmes and the diverse belief systems and cultural expectations evident in a multi-cultural society as well as an *anti–discriminatory practice* are addressed.' (1995:6)

The ENB insistence and emphasis on equal opportunities, anti-discriminatory practice and multiculturalism sounds promising. However, the concept of anti–discriminatory

practice is not defined and, interestingly, this request to address culture differs from previous ENB (1990) regulations and guidelines. These had previously suggested a more political and radical agenda of an '*anti–racist*' approach to curricula than that of multiculturalism. In reviewing the health care needs of minority ethnic clients, Thomas and Dines (1994) note that in 1983, the ENB began to insist on the study of a patient's culture, home and economic background. By 1990, the ENB had developed a policy on equal opportunities and anti-racism. It was recommending that the principles of holistic care and practice needed to reflect the needs of a multicultural society. This change was in part constituted by the broader shifts within professional discourses. There was a move away from instrumental or task-orientated care towards 'New Nursing' (Salvage 1992). This new philosophy of nursing meant a move away from the bio-medical model of health to endorsing a more social model, and this required a different relationship with patients and clients. As Salvage comments,

'The nurse's caring role should no longer be restricted to biological functions, but should acknowledge the subjectivity of nurse and patient in a two way relationship.' (1992:12)

This changing professional role is evident in these educational documents, as is the increasing concern that minority ethnic clients' health needs were not being met (Kings Fund 1990, Douglas 1992, Gerrish et al 1996, Gerrish 1998). The ENB also has a remit to commission research and it has examined the extent to which pre-registration programmes prepare practitioners to meet the health needs of minority ethnic communities (Gerrish et al 1996.) This study focused on pre, rather than post-registration courses, but found curriculum topics that related to minority ethnic peoples' needs received minimal coverage. The majority of courses claimed to address these issues throughout the curriculum, though there was no obvious commitment to these issues in the learning outcomes. As Gerrish, Husband & Mackenzie (1996) point out, there was also a general lack of opportunity in practice placements to explore and develop 'intercultural and cross-cultural competencies'. It would appear that pre-registration programmes struggle to fully engage with these issues and it is possible to assume that this is the situation for post-registration programmes.

However, while the educational curricula for post-registration programmes in the two institutions researched here did share a common foundation, the structure and content of

their respective curricula did vary. The Small Town University did indeed take a less defined approach as Gerrish et al (1996) suggest. The course handbook indicated that, whilst 'equal opportunities' were broad principles underpinning the whole course, these were not issues to be specifically addressed in the curriculum. There was no team statement, although there was a university wide policy covering both staff and students (Small Town University 1997). This policy was designed to ensure that no member of its community suffered unfair discrimination. The University stated that it had made a public commitment to equal opportunities through a 'Statement of Shared Values' and had a code of practice that gave guidance on how policy was to be implemented. Within this code, all course curricula were examined 'for their degree of sensitivity to equal opportunities issues' and the use of discriminatory language, actions and attitudes or exclusion linked to gender, race or disability was deemed unacceptable (1997:2).

The Inner City University's curriculum differed dramatically. In this specialist practice programme, there was a module that attempted to address issues of equality as 'anti – discriminatory practice'. Using social policy and sociological theories, the students were asked to analyse the nature and the impact of discrimination and the professional responsibilities and responses to anti–discrimination. The module aimed to prepare practitioners to 'recognise and challenge structural inequalities in health care provision and to develop an awareness of both personal and professional discrimination.' Students were also expected to demonstrate anti-discriminatory approaches to professional practice in their 'assessment of practice document' (Inner City University 1998a:1).This entailed developing relevant examples of where an anti-discriminatory approach be applied to practice. More specifically, the practice document defined discrimination at a personal and professional level and students were asked to record their responsibilities regarding anti-discrimination. However, whilst the curriculum used the rhetoric of an anti-discriminatory practice, it was an approach to practice that was defined as 'recognising the right of every individual to equality of care, irrespective of age, gender, race, sexual orientation, ability or class and also acknowledges the diverse beliefs and cultural diversity of modern day society' (Inner City University 1998a). When compared with the previous definitions, discussed in Chapter One, this approach differed remarkably from those of anti-discrimination derived from radical forms of

equality. Indeed this definition had striking similarities with the UKCC and ENB statements on equality.

This institution's course handbook had an extensive equal opportunities statement. This set out the course team's philosophy that included recognition of 'everyone as an individual and their commitment to a client-centred and student-centred approach' (1998a:6). Passive policies were recognised to be ineffective and there was an explicit commitment to an active approach, combating indirect and direct discrimination in the staff's own educational practices. This team approach was informed by a University wide equal opportunities policy that talked of the need to confront inequality and discriminatory behaviour (1998a:7). This educational emphasis on either a more general development of an equal opportunities, or a more specific anti-discriminatory approach to practice, has the potential to be further reinforced or undermined in the workplace.

3.2.3 The Workplace

All of the eight Community Trusts, in which both the students were placed and the practice teachers were employed, had some form of equal opportunities rather than anti-discrimination policy. However, only four out of the eight had a policy that focused on employment *and* service delivery issues. These trust policies tended therefore to focus on their responsibilities as employers. This meant in the first instance, claiming to offer protection against the worst excesses of discriminatory employment practices in relation to recruitment, terms and conditions of employment, selection for promotion and training and in performance appraisals and reviews. There were also clearly stated grievance, dispute and disciplinary procedures in place (Trust A 1998).

However, three inner city trusts' policies also referred directly to service delivery and mostly in relation to racism and 'ethnic health'. One Trust had an 'Ethnic Health Strategy' and had developed standards for access to services, treatment and care and the development of future services (Trust B 1998). Another Trust had made progress towards introducing ethnic monitoring, which the respective practice teacher discussed in her interview, having been involved with this initiative. The aims of the ethnic

monitoring process were to identify service and health needs and to monitor outcomes of health promotion and services (Trust C 1998).

Only one of the small town community trusts had a policy statement on service provision (Trust D1992). This Trust's equal opportunities policy was linked to notions of quality in service provision:

'[Trust D] is committed to achieving equal opportunities in quality service provision by breaking down the inequalities which may exist in the delivery of our services' (1992).

This Trust had a commitment to breaking down the inequalities in the delivery of services and wanted to encourage and ensure that 'no individual receiving care was treated less favourably or denied treatment or care because of the way services were structured or provided' (Trust D1992:3:1). This Trust also outlined the steps necessary to ensure that services were relevant to differing needs and that all staff were aware of the importance of equal opportunities. Key to the pursuit of equality in service delivery was the reduction of health inequalities, improved communication and the involvement of clients. Consultation with the community was felt to be a necessity in order to 'work in partnership towards equality' (1992:4.1.ii). Overall, these workplace policies did appear to offer commitments to promoting equality in attempts to ensure equitable care. However, a further significant source of influence, indicating a commitment to equality and the eradication of discrimination, can be found in the relevant professional nursing and trade union organisations.

3.2.4 Trade Unions & Professional Organisations

The Royal College of Nursing, as the largest professional trade union, is committed to the pursuit of equality in health care. It has officially stated that equal opportunities should be an integral element of the working environment of nursing (RCN 1996). This organisation has had an active role in developing advice for nurses on their responsibilities towards promoting equal opportunities and in developing an anti-discriminatory approach to practice. This advice has focused on specific groups and has included minority ethnic communities, people with mental health problems, lesbian and gay people, people with disabilities and older people. This advice details current research and suggest appropriate strategies for good practice. The RCN strategy

endorses nurses' political role in lobbying, arguing for their active contribution to debates on discrimination and encouraging them to identify service deficits. The RCN asks nurses to consult with local communities, lobby for provision of facilities, respond to harassment and develop care environments that reflect the needs of the diverse communities they work with. This advice in the more practical form of a series of advice sheets, has defined a proactive, political role for all nurses in relation to discrimination and oppression. There is an explicit emphasis here to move beyond procedural equality to tackle institutional change. These are strategies that clearly draw upon radical discourses of equality (RCN 1996).

More recently, following the McPherson Report, the subject of 'institutional racism' has become a key priority in the NHS (Macpherson 1999). This is evident in recent health union debates, including those of the Community Practitioners Health Visitors Association (CPHVA) and the RCN. At an RCN annual congress there was a turbulent debate concerning racism that triggered an emergency resolution to address the issue of institutional racism in the RCN (NT 1999). The then General Secretary, Christine Hancock, was quoted as saying 'I do not believe that the RCN is any freer of institutional racism than any other big organisation.' She went on to add, 'We find it hard to believe that that nurses–caring, compassionate people - can have anything to do with racism'(1999:9).

These commitments to anti-racism can be traced back to the earlier professional body for health visitors, the Health Visiting Association (HVA 1987). This organisation sought to develop a 'racial issue' working party that worked together with the Kings Fund Taskforce on Equal Opportunities. The HVA also had a radical view of equality. Racism was seen to be indicative of 'white power and supremacy' and the HVA argued for the development of an anti-racist statement, opposing direct and indirect racism. The working party aimed to develop a 'racially aware' service that would challenge racist practice in its own profession and other agencies. It was agreed that practice placements, or fieldwork were key to developing anti-racist practice. Indeed, the HVA was keen to address institutional racism by reviewing key assumptions embedded in health visiting practice. There was a clear commitment to tackling ethnocentric services, especially those services involved with the care of families. Stereotypes were to be

challenged and health visitors were to acknowledge their positions of power (1987:12). The HVA argued for health visiting courses to adopt an anti-racist stance and for all tutors to be anti-racist trained. A professional practice was argued to be one that did not discriminate and health visitors were to identify their own prejudices, racism and use of stereotypes and to share their professional power.

The successor organisation, the CPHVA, continues to have the Manufacturing, Science and Finance (MSF) as its affiliated union. This union advises community nurses and health visitors on issues of discrimination. Its own damning report, 'The Tables are Bare' (1997) reported on the status of ethnic minority staff in the NHS. It revealed there were low rates of returns from health authorities on the number of minority ethnic staff they employed and MSF argued this was indicative of a general state of apathy. This union has also argued for legislation that extends anti-discrimination law to provide a comprehensive approach to equality (MSF 1997:1). Evidence of this comprehensive approach is now evident in the NHS with the current government's agenda on equality.

3.2.5 The NHS

The reorganisations of the NHS during the last two decades have seen the prioritisation of economic and managerial concerns. This focus is also evident in the current Labour Government's major reforms to health care, aiming to ensure a modern and dependable NHS (DOH 1997). Many of these policy documents intend to ensure astute financial management together with improved quality, through increased collaboration, openness and fairness. This has resulted in an ever increasing range of measures, indicators, standards and frameworks for care. In the language of New Labour, modernising health services means responsible, accountable and efficient practitioners, contributing to the improved working of the NHS and involved in the reduction of health inequalities. There is to be improved professional self-regulation, continuing professional development and improved employment conditions through fair and just recruitment, training and promotion opportunities (DOH 1999). The Health Act (1999) and the NHS Plan (DOH 2000) formalise many of these major changes.

Within this new agenda, equality is an explicit target linked to notions of quality. The introduction of the Equal Opportunities Unit (DOH 1998) and the development of the NHS Equality Awards has culminated in the NHS Equalities Framework (DOH 2000). This sets a much broader agenda for equality work. In the document *'Vital Connections,* sub titled, *'working together for quality and equality'* the aim is to connect equality with quality and efficiency (DOH 2000). This framework requires the NHS to be accessible, able to meet the needs of different and diverse groups and communities and able to facilitate social inclusion. This document places equality at the centre of the modernisation programme in the NHS (DOH 2000). One of the three strategic aims is to develop a workforce for 'equality and diversity'. This is to be achieved by recruiting, developing and retaining a workforce that is able to,

'Deliver high quality services that are accessible and responsive and appropriate services to meet the diverse needs of different groups and individuals.'(2000:2)

A second aim is to ensure fair employment practices and equality of opportunity and outcomes in the workplace. Thirdly, there is a demand that the NHS uses its leverage to make a difference. Through the use of resources and influence, the NHS is to make a difference to the life opportunities and health of local communities, especially those disadvantaged or excluded. This forms part of a broader strategy to 'improve health and services and to promote fair employment and neighbourhood renewal' (2000:8). Therefore, this is a document that reinforces the notion of equality in the NHS with quality and the reduction of inequalities in health

3.2.6 Assessing the Broader Discursive Context of Equality

In examining this range of policies and documents, I have sought to identify whether this particular discursive field constitutes a specific form of equality. I now intend to assess this more fully in order to establish whether these formations constitute liberal equality. In Chapter One, I argued that the most dominant response to inequality in the NHS was liberal in both content and form, and a liberal equality discourse was argued to endorse a more procedural approach to equality. Within a liberal equality discourse, equality in health care is argued to ensure equitable health care through the application of fairness and impartial decision-making and through the promotion of equal access to services and treatment as and when needed. Liberal equality in health care is premised

upon an assumed equality of condition; individuals are assumed, in principle, to be equal and endowed with equal rights to care. These individuals are then assumed to be free and able to express their needs and exercise these rights, seeking access or inclusion to health care as and when necessary. Liberal forms of equality were shown to rely upon a strategy of inclusion, seeking to include those excluded through the processes of assimilation and integration and are strategies that are assumed to be unproblematic. However, it was apparent in Chapter One that such programmes and subsequent forms of care require the suppression of individual difference, or an indifference to social differences. Given that these strategies within the NHS not only reflect but constitute key features of a liberal equality discourse, I now intend to assess the implications of this broader discursive field within community nursing

In analysing the documents governing professional practice, both the UKCC code and the ENB were found to constitute a form of practice that was compatible with notions of liberal egalitarian care. This was evident, for example, in the code of professional conduct with its insistence on the promotion of a client/patient-centred form of care based on the principles of re-distributive justice and equitable and non-judgemental care. This produces a discursive constitution of practice as a sensitive, reciprocal and empowering form of care that seeks to promote client autonomy and choice. This promise of egalitarian care was also evident in an individualised approach to care, where the demand to recognise client/patient needs were to be ensured through the recognition and respect of the uniqueness of the individual. As a form of egalitarian care, endorsed implicitly by the UKCC Code, and more directly by the ENB, this notion of professional care is compatible and consistent with the key features of a liberal equality discourse. As stated, within a liberal discourse health care is positioned as equitable when fair rules and procedures and impartial decision-making are used to promote and ensure equality of access. It is equity and equality premised on notions of equality of condition and individual worth. These features are evident in the UKCC's insistence on the nurses' recognition of the key principles of the code, and in particular, the demand to treat everyone the same, by responding to all needs in an non-judgemental manner, and more significantly, irrespective of important differences. Within a liberal discourse, there is the assumption of an equality of condition amongst individuals; people are free to express their rights and make choices. This assumption is

inherent to and endorsed through the UKCC Code of Conduct, with its insistence on client autonomy and independence and the promotion of choice. These principles of equitable, egalitarian and non-judgemental care reinforce a liberal approach to equality and the Code is therefore consistent and compatible with a procedural form of liberal equality. These descriptions of professional practice reinforce notions of individualised, client-centred care that seeks to treat clients the same or fairly. The professional rhetoric is one of respecting diversity within a strategy of inclusion, whereby practitioners seek to ensure the same access to services and treatment. Interestingly, this notion of an egalitarian professional practice differs somewhat from competing discourses that construct nursing practice as a form of surveillance and control that has been widely identified within health care professions (Bloor & McIntosh 1990, Armstrong 1983, 1994). This notion of care suggests inherent constraints to the development of any emancipatory politics in community nursing.

Historically, a discourse of surveillance and control was an explicit feature of the evolving role of health visitors and district nurses. As Dingwall et al (1988:175) argue, in the development of community nursing, one key principle of mid- Victorian philanthropy was the co-option of working class women to maintain order and social discipline. This 'management of the poor' involved instruction on hygiene and parenting and was a nursing role constituted by broader economic and political concerns for population control. For example, the duties of a district nurse were described as nursing the patient and the room. Accordingly, to tend to the sick meant tending those who 'lose the feeling of what it is to be clean' (Nightingale1881:4). The district nurse was to,

'Sweep away and dust away, to empty and wash out all the appalling dirt and foulness; to air and disinfect, rub the windows, sweep the fireplace, carry out and shake the bits of old sacking and carpet, and lay them down again, fetch fresh water and fill the kettle; wash the patient and the children and make the bed'.

These were crusades against dirt and fever which were to "let light and air and cleanliness into the worst rooms of the worst places of sick London" (1881:6). A sound, clean house was seen as commensurate with a sound body and mind. This 'gaze' or surveillance of the poor has also been documented in the emergent role of the health visitor (Dingwell et al 1988, Davies 1988, Bloor & McIntosh 1990).

It is entirely possible that this role remains undiminished; as surveillance and control still remain an integral part of the community nurse's remit and role. The surveillance of clients, families and communities means that community nurses become part and parcel of the disciplinary techniques identified by Foucault (1976, 1979a, 1979b). The nursing 'gaze' is known to classify and categorise client groups, so that nursing produces the objects of its own interests and interventions (Armstrong 1983, Bloor & McIntosh 1990, May 1992, Crowe 1998). These aspects of care are not completely subverted or over-turned, as even in current endorsements of an egalitarian discourse, practice is still potentially controlling. These elements of control are evident in the guidance to the Code of Conduct, where the rhetoric of egalitarian care endorses both a suppression and indifference to significant differences.

The ENB and educational discourses were particularly interesting, as these demonstrated both dominant and competing discourses. The specialist programmes were found to make no overt statements about equality. There were no obvious outcomes concerning the need to respond to inequalities, discrimination or disadvantage, nor any requirements to ensure an equitable delivery of service. The ENB, however, did respond to NHS priorities by insisting that curricula demonstrated learning outcomes that were to meet the needs of a 'multi- cultural' society. In examining the various curricula and course handbooks, it seems reasonable to conclude that equality is a declared goal in both the Universities. In the Small Town University, this was more equality in relation to educational provision than equality as a principle or philosophy for community nursing practice. The Inner City University, on the other hand, revealed a major difference in its development of an anti-discriminatory practice module and assessment of practice. Anti -discriminatory practice, as previously discussed in Chapter One, is a form of practice that draws upon a radical equality discourse. This is a discourse that competes with liberal equality but is relatively marginalized in the NHS generally. However, its appearance as a competing educational discourse in this context remains deceptive. This use of radical equality in the inner city university curriculum revealed the rhetoric of radical equality but upon further examination was found to be liberal in content and form. This was evident in the somewhat liberal definition that was used and the mismatch between module intent and

outcome. For example, in this module, the intent was to challenge and bring about structural change. Yet, the required assessment of those challenges and changes was at the individual level only. Thus, discourses of equality as talk of equal opportunities or anti-discrimination, seemed to be at best central to the overall course or curriculum content and in practice assessments, and at worst, mostly rhetorical and/or marginal and vague.

Therefore, despite the rhetoric of a more radical equality discourses, both institutions' curricula and commitments to equal opportunities and anti-discrimination were rooted in a liberal framework. This meant the curricula acknowledged inequality more broadly but tended to locate and focus change at an individual level. Moreover, even when institutional or structural features of inequality were recognised, the main response was for widened access, rather than to reflect on how institutions and the structures of the NHS are themselves implicated in perpetuating inequalities and require change. However, this review of documents suggests that educational policies and curricula do address some form of equality. Nevertheless, when examining higher education institutions, O'Neal (1996) found, that despite statements and policies, institutions perpetuated a great deal of discrimination through a general indifference to issues of equality in their day to day work (O'Neal 1996). Obviously, the presence of policies and statements and even explicit content in the curriculum are no guarantee of equality in practice. Indeed, further studies show that a general indifference or apathy towards equality or discrimination in nurse education curricula exists (Gerrish et al 1996). However, education is but one aspect of a broader discursive field in which community nurse students and teachers encounter the discursive constitution of equality.

An examination of the equal opportunities policies from all eight trusts and the wider agenda of the NHS revealed that in these arenas, liberal equality discourses were indeed predominant. However, specific to this use in both trusts and the NHS more generally, was the combination of a liberal equality discourse with organisational discourses of economic rationalism. This use endorsed the government's definitions of equality as a measurable outcome or indicator of quality. In this agenda, equal opportunities means equality for all, there is an explicit demand for and promise of inclusion, as fairness and inclusion are argued to be a measure of a just and civilised society. This definition of

equality reflects the government's political philosophy of the 'Third Way', which endorses economic liberalism with principles of social democracy and has created a new political language (Giddens 1998, Fairclough 2000). However, this is of course not only the language of the Third Way and a Labour government but also that of liberal equality. Thus, equality becomes rationalised by making appeals to economic arguments for utilising all available talent. This is seen to make good business sense and is not dissimilar from arguments found in other public sector organisations. Here the language of 'managing diversity' has replaced that of equal opportunities (Thomas 1996). The focus is on the efficient management of finite resources and requires decision-making based upon rational arguments. The government and the trusts' emphasis on employment rather than service delivery in their policies further reinforced this economic view of equality. The Government's Equalities Framework also overwhelmingly addresses employment rather than service delivery. Hence, recruitment, retention and fairer employment practices, dealing with harassment and the introduction of flexible, family friendly workplace practices are to be the main indicators of equality. Service delivery and the experience of users and carers are referred to, although only in terms of the responsibilities of the trusts. These organisations have to ensure staff have the appropriate knowledge and skills to respond to diverse populations.

In contrast to the dominant agenda of liberal equality, professional and trade union organisations talked of a radical agenda for equality and a more political role for community nurses. These bodies discursively constituted a form of equality drawn from a radical discourse of equality. Unfortunately, though this was a competing discourse, it was marginal and its direct impact appeared negligible. This was evident in the community nurses' narratives when no one could recall the work of these organisations in relation to equality and discrimination.

Together, these policies and documents predominantly endorse a liberal discourse of equality. The professional, educational and organisational discourses of economic rationalism discursively constitute equality in ways particular to health care. However, the overall impact is to reinforce, rather than challenge or displace, a liberal equality discourse. This implies liberal equality is indeed a dominant force defining equality in

community nursing. I now explore how inevitable this dominance might be, by examining the community nurses' narratives for their own descriptions and talk of equal opportunities and anti-discriminatory practice. I assess whether the nurses endorse, reject or rework these dominant discourses in order to construct their accounts of equal opportunities and anti-discriminatory practice. I also examine whether liberal equality is an inevitable feature within the community nurses' narratives of equality.

3.3 Community Nurses' Talk of Equal Opportunities and Anti-Discriminatory Practice

I have shown how the discursive context of community nursing actively reinforced a liberal equality discourse through the use of various professional, educational and organisational discourses. In this section I examine how a liberal discourse of equality also appears to be a principal discourse within the nurse' narratives. That is, over two thirds of these narratives did indeed appear to be *consistent and coherent with* liberal equality. I have defined narratives as liberal when the nurses draw upon the key features of liberal equality discourse outlined above (see the beginning of section 3.2.6). In this section of this chapter I intend to demonstrate how this consistency with a liberal discourse is achieved discursively, through an examination of the community nurses' talk of equal opportunities and anti-discriminatory practice. As I have discussed, this is liberal discourse that is inherently flawed, claiming to treat people the same and promoting the suppression and indifference to essentialised differences. I have divided this section of the chapter into three areas of talk; that is talk of professional practice, difference and discrimination, and access and rights to health care. I use these discussions to demonstrate talk of equality more generally and to illustrate key features of a liberal discourse within the nurses' narratives of equality.

3.3.1 Equal Opportunities and Anti-Discriminatory Practice

The community nurses' talk of equal opportunities and professional practice mirrored an understanding of liberal equality and its focus on individual difference. Indeed, all of the community nurses drew upon this liberal discourse at some point in their stories of professional practice. They used this and other related discourses to construct equality

as equivalence, fairness and a just practice. These were often literal reiterations of a professional practice, education and liberal equality discourses. This included definitions of equal opportunities as 'treating everyone the same.' Claire, a district nurse student, reinforced this notion of equal worth, or equality of condition when she said,

'Well, I just think everybody is the same, you know, I mean I don't treat anybody any differently. If they want an assessment or visit they get one." She added an example of her work to explain further "Like care plans, you follow criteria, patient a gets the same as patient b, so everybody gets treated equally.'

For Frances and Helen, a health visitor practice teacher and student health visitor, this was equality of care or treatment. As Frances argued,

'Equal opportunities for everyone, so everyone has the same chance [.]Equal opportunities in health service provisions [.] Everyone should be treated the same [.] I mean it's the same principle that you should be treating everyone with respect.'

This construction of equality with a professional practice meant that for some nurses the Code was influential in defining equality. As I stated earlier in this chapter, the Code endorses a universalised or 'same approach' that clearly needs to suppress significant differences between clients. Helen, a student health visitor, identified equal opportunities as closely linked to the Code of Professional Conduct. As she stated,

'Everyone's got equal access to the services available or resources, and those resources could be financial, knowledge [.] and that each individual, irrespective of race, gender, sex or whatever, has got a full access to them, that's what equal opportunities mean to me.'

Whilst the Code was seen to 'respect' difference, this never seemed to overturn a dominant discourse of equal opportunities as the same treatment, whereby difference was suppressed in an attempt to care regardless. Beatrice, a health visitor practice teacher stated,

'Our Code of Conduct as nurses covers respecting other people's cultures and identities, so I mean equal opportunities isn't mentioned as equal opportunities, but it's part of the code of conduct.'

Or as Claire, a district nurse student emphatically stated,

'But I would see that I wouldn't discriminate because I have an obligation, the UKCC tells me I should be, I have a responsibility for patients. So whether they are gay, black, whatever they are, it's my job to go and care for those people.'

These particular constructions of equal opportunities drew heavily upon the discourses of professional practice discussed earlier. Indeed, the two areas are so intertwined that equality as a practice or work becomes indistinguishable from everyday practice. Frances, an experienced practice teacher, exemplified this approach by stating,

'It's something you do, but it's not something that is, that you get a lot of information on it, or that it's, you know, up in lights, it's just, I suppose it's as though it's implicit you know, you're a health visitor that's what it is [.]I think it's just developed, you learn to develop it as a health visitor." She added, "It is something I do, you know, it's part of my practice but I'm not aware that I'm doing it [.] You get to a stage and you do it more.'

Therefore, equal opportunities as a practice *was* professional practice and developed out in the field. This implies that equal opportunities as a practice develops through experience rather than through education. These discursive constructions also ensure professional practice is re- presented as an equitable and just practice. As Chris, a health visitor practice teacher, said,

'I think you do it automatically as part and parcel of your job, it's not something that's prescriptive, it shouldn't be [.] I think it's the same as our job, the only thing we've put labels on it and we're more aware of it.'

Jan, a practice teacher stated that it was so much part of her job that it was routine:

'I hope it's something I do without thinking [.] I do hope I do it as a matter of course, I treat them as equals, as equal to myself and then on priority of need [.] But it's something I do very much on an individual basis.'

Equal opportunities work was therefore defined as being the same as professional practice. Talk of anti-discriminatory practice was far less evident. Indeed, most of the community nurses were extremely uncertain as to what this term meant. In the context of that uncertainty, some chose to define this form of practice as similar to equal opportunities. As Sheena, a student health visitor, said,

'It makes me think of treating everybody the same way as you would treat anyone else and not to have my own, my own values. Respect for each one's character, each one's way of believing in things.'

Or as Mary, another student health visitor stated, 'No it [anti-discriminatory practice] doesn't mean anything.' Although, she then attempted to define it by emphasising that there was a recognition of people's uneven starting places:

'Anti-discrimination practice means it is more with the colour ethnicity kind of aspect [.] It means starting at the bottom and evening it out rather than equal opportunities, you start from the top and just cream off the top.'

One student, Victoria, even felt the two terms were the same although she was not sure:

'They appear to be, but I think, I get the feeling from the short session we had they were trying to make it stand out as different, but I don't know if it was me that just missed the point or whether there is something, I still feel ignorant, but yeah to me at the minute they appear the same.'

However, Jenny, a district nurse student, attempted to compare the two approaches as distinct from each other. She argued that,

'Equal opportunities I think is reacting to situations and making sure everyone's got equal rights and all the rest of it. Whereas anti-discriminatory to me is being more proactive about it and thinking about it before it happens and putting policies, I know equal opportunities has policies as well, but it's a bit more active. That's my interpretation, and that's not anything I've read so it's probably completely wrong.'

On the other hand, most of the practice teachers had problems trying to define this form of practice. As health visitor practice teacher, Beatrice said,

'I've heard it, yes. Equal opportunities is a positive statement isn't it? And anti-discriminatory is a negative thing, maybe. I'm sure there must be a difference, I'm struggling to think of it.'

This vagueness was further reinforced when students and practice teachers' talked of education for practice. This suggested that issues of equal opportunities and anti-discriminatory practice were dealt with at a very minimal level. For example, the majority of students felt they had little formal knowledge on either issues of equal opportunities or anti-discriminatory practice, regardless of university. Victoria, a student from the inner city university illustrated this when she explained;

'Well to be honest [laughter] we, it still feels very new to me and I don't really understand it, which I feel quite, very ignorant about it and I don't know if that had adequately prepared us [.] just a two hour session, it was more a case of group discussion of your experiences of anti -discriminatory practice or equal opportunities that you came across while working on the course, or that you might have come across, so we didn't really go in serious [.] I don't think any kind of academic education can prepare you, it's more down to you getting out there and getting the experience, I trained in a predominately white, middle class area so I didn't get any experience.'

The practice teachers had an equally difficult time recalling any equal opportunities or anti -discriminatory practice in any health visiting or district nurse or learning disability course. For some, this meant recalling courses of ten years or more, although one or two

could recall good content but there was little discussion of these issues in practice. Furthermore, when asked whether they felt their courses prepared them for working in a multi-cultural society, as ENB guidelines require, the practice teachers and students were unanimous. They cited experience as being far more relevant than education. This was indicative of both a general attitude to education and its role in the development of practice, and to notions of equal opportunities or anti-discriminatory practice. As Sharon, a health visitor student from the Inner City University stated, as had Victoria, the course could only prepare her so far:

'I mean they can't possibly prepare you for the actuality or, or you know, for each particular client group and you've got to generalise it to some degree, all the rest is down to experience.'

Moreover, despite formal policy statements from the trusts, most community nurse students and practice teachers were unable to recall any demands from their employers to practise either an equal opportunities or anti-discriminatory approach to practice. They had not seen nor read their Trust's equal opportunities policy. Yet, most were convinced that their Trust had a policy and were adamant that they would be able to find out more if and when necessary. Jenny and Frances summed up this common position. Jenny a district nurse student said,

'I'm sure it [the Trust] does, I haven't seen it, I'm sure it's there somewhere, I couldn't tell you what it says, but I mean they're all much of a muchness aren't they?'

Whereas Frances, a health visitor practice teacher stated,

'Yes they do have an equal opportunities policy, in our handbook. I can't remember off hand, [what it says] I've probably read it but I can't remember [.] I do know there is a Trust policy on this so I'm sure there is somewhere you can go if you need help.'

However, even the presence of an explicit policy, advocating ethnic monitoring, was not without some difficulty. The practice teacher that had been involved argued that hostility from both the community and staff, together with a lack of managerial or institutional commitment, meant these initiatives faltered and failed. As Laura explained,

'To me it kind of begs the question well once you've got the information, you know the inequalities, what are you going to do about it? Have you got the resources to do something? And that's as far as we've got, and it's quite sad really. There was a working group and there were five of us trained, we didn't get much support really and we're upset about that. It seems it was a big paper exercise, so whether or not they find

anything that makes me feel better about it later, I don't know. [.] I didn't feel that good about taking part, although I did enjoy the training, I could see the positive sides of it. When we looked at the backup and resources and extra bits and pieces and asked what's the next step, nobody could answer the question.'

It would seem, therefore, that the nurses do not appear to draw on the discursive resources of a workplace or educational discourse to construct equal opportunities or anti-discriminatory practice. Furthermore, talk of anti-discriminatory practice was especially vague in relation to the recognised use of equal opportunities. It was talk of equal opportunities that was being constructed as the same as professional practice and this had striking similarities with other nurses' understandings of good practice. In her research with health visitors and midwives, Marshall (1994) found that central to a concept of 'good practice' were notions of client-centred care and a recognition of cultural diversity. She labelled these as repertoires that involved notions of altruism and professionalism in meeting and responding to individual needs. Good practice meant being knowledgeable, reciprocal and sensitive in dealings with clients. Therefore, in these community nurses' narratives, good practice or professional practice was constructed through the notion of 'equal opportunities' rather than through use of the term 'anti-discriminatory practice.'

Equal Opportunities, as a professional egalitarian practice, was being discursively constructed from two dominant discourses. There was the liberal equality discourse of re-distributive justice and the professional discourse of individualised care. The ideology of individualism as individualised care forms part of a professional discourse. Gerrish (1998) locates the rise of this ideology during the 1970s and cites the introduction of the nursing process as key to its development. This is indicative of the move towards 'New Nursing' as Salvage (1992) noted. Gerrish (1998) argues that this conceptualisation, interpretation and practice of individualised care ensures a professional practice that recognises and respects individuality, seeks to provide holistic care and focuses on nursing needs, This is care that seeks to promote independence, fairness and equity. These are principles of practice central to not only a professional practice discourse, but also to a dominant educational discourse. The principle of a fair and just service meant that the community nurses spoke of being equitable in their dealings with clients. It meant talk of offering the same practice in terms of treatment, advice, manner or overall approach. This clearly draws upon liberal notions of re-

distributive justice and Sevenhuijsen's (1998) argument that equality in health care is constructed in two particular ways. First, as a constitutive right and secondly, as equivalence, whereby every citizen is regarded as equal. These norms are invoked with those of solidarity, the aim being to protect weaker parties who would suffer if goods and services were equally claimed and distributed to all. Moreover, when equality is invoked within a re-distributive justice paradigm it relies upon assumptions of abstract rationality and impartiality. To treat the same is to treat according to a prejudged norm and is a specificity that is denied or disguised through claims of neutrality and impartiality.

However, recent studies of the care received by minority ethnic patients and clients found that declarations of impartial and fair treatment were in fact oppressive. Claims to 'treat every one the same,' regardless of significant differences, results in oppressive care and is condemned for condoning a privileged, usually white, set of norms and for preserving the status quo (Bowler 1993, Bowes & Domokos 1993, Vydelingum 1998). Therefore, within this liberal discourse, differences are of an individual nature and there is a subsequent blindness to social differences and relations. In community nursing, this suppression of difference is seen in the use of the Code of Conduct and differences are rendered unproblematic by being de-politicised and individualised. This means that clients needs become health rather than social needs. The suppression and indifference to difference is also evident in talk of discrimination.

3.3.2. Equal Opportunities and Discrimination and Difference

To 'treat the same' relies upon the suppression of or indifference to difference and this is an inherent part of a liberal equality discourse. This 'liberal' tactic for dealing with difference produces strategies of assimilation and integration. This incorporation is so complete that differences and the individual disappear for some. Consequently, these social differences becomes invisible and de-politicised, as Laura, a health visitor practice teacher, exemplified when she said,

'You respect them as an individual, you don't patronise them. Everybody deserves respect whatever part of the ladder they're on and you take them as an individual and work with them like that. I tend not to look at people for whatever class they're in, or

ethnicity, I don't see that anymore, it's really, really strange. I go in, I have my objectives and I see what the clients' needs are, and I try and address those needs.'

Claire, a district nurse student, discussed how 'other' clients' lifestyles were indeed positioned as different. This exemplified a key aspect of a liberal equality discourse, which is that of essentialising difference. This allows individuals or families to be defined as other than 'normal' and therefore, problematic in some way. Claire illustrates this in her explanation of the difference lifestyles and the poverty one of her clients experienced. She spoke of how this affected her and her practice. She stated,

'It was only when I went to work in this area that I was aware of their different needs, you know just the, you have to take your shoes off in some of their houses, those types of things, and how you might offer them something and they wont accept it, either or they want lots more, or they want more than you've got to give them [.] Even different English people you know, it's not just foreign people. Like I think the norm is having hot and cold water, central heating and having a nice home you know, when I went into some of these homes, I asked to use someone's toilet you know, I was working at night and after the third cup of tea and I asked this lady could I use your loo, 'oh yes' she said,' out the back there', and I couldn't see anything so I then looked out the back door, 'it's just in the corner that bucket there', and I thought, I mean to me having an inside toilet is something everybody has got, haven't they ? I was very surprised. So it is just trying to almost bite your tongue.'

This construction of 'other' clients demonstrates both a racialised narrative and the disguised normative base to liberal equality discourses. Furthermore, Claire's account of differences in culture and lifestyle imply biological or essential differences which are innate and, therefore, fixed. In health and social care, discrimination is found to be perpetuated through this process of naturalising or defining difference as problematic (Dominelli 1988, Young 1990, Essed 1991, Cockburn 1991, Thompson 1998). When discrimination is seen as the outcome of difference and is essentialised as intrinsic to human nature, Thompson argues, this is the process by which,

'People are allocated to particular social categories with an unequal distribution of rights, resources and opportunities. It is the process through which individuals and groups are disadvantaged and oppressed.'(1998:78)

In making sense of discrimination and inequality, the community nurses' talk did indeed construct inequality and discrimination as a natural rather than a social phenomena. This view of inequality and discrimination, and its inevitability, were considered compatible and coherent with a liberal equality or equal opportunities in practice. Laura, a practice

teacher working in an inner city health centre, exemplified this approach. She described discrimination as intrinsic to the human subject:

'It's part of the human animal, we like what we know and what we don't know, or isn't the same as us, and therefore different, and to a degree wrong.'

Shirley, another health visitor practice teacher, argued in a similar manner, 'They need to blame someone else, it's only human nature and it tends to be the people you feel don't belong.' Chris, a district nurse added, 'The strong always feed on the weak and that's human nature I don't think you're going to change it.'

The causes of these differences were located firmly in the individual and biology and were indicative of the ways in which discrimination and exclusion were beyond the nurses' control. Beatrice, a health visitor practice teacher echoed these views by drawing on her own experiences,

'It comes from lots of places really, I mean, the bottom line has always got to be an individual, I mean it has got to be an individual that's discriminating at one level but that can go backwards through generations, I mean culturally, I mean I know my grandmother was terrible, [.] so I mean it goes back over generations.'

Thus, community nurses tended to rely upon continuity with the past to explain the presence of discrimination. Historical explanations tend to provide a sense of security, as difference becomes a familiar fixture and fact of life. Even when the community nursing students cited social origins of discrimination, these too were naturalised. Here discrimination was due to a faulty childhood, or parents. Peers were blamed as were the media with its portrayals of stereotypes. Jenny, a student district nurse talked of, 'the way someone's been brought up, the schools they've been to, everything.' In addition, Frances suggested it was due to, 'Ignorance and probably parenting [.] Some people enjoy it, maybe it makes them feel superior'. Chris, a district nurse, expressed a common answer, when she said,

'Probably society, it is society [.] But if you think even from your childhood, from the time you go to kindergarten, you tend to probably be attracted to a certain group, you might not be the one that teased the less able child [.] But these people are targeted by the more able in society and I don't think we can ever change that. We can soften the blow but we won't change that.'

With family type or background as the source of discrimination community nurses were then able to problematise individuals or individual families, communities or peers. Cockburn (1991) has commented upon this process of essentialising difference and the

tendency to relate discrimination to nature, or fate and common sense explanations. She argues that such explanations act to guarantee a version of reality. For the community nurse this is a reality where liberal discourses of equality expect them to suppress or remain indifferent to these differences and there is, in other words, a limit to what they can do. As Chris says, they can only 'soften the blow.'

This use of an essentialist discourse is interesting, as it seems antithetical to the pursuit of equality. As Fuss (1989) claims, those seeking greater equality often reject essentialism as it suggests, 'a belief in the real true essence of things, the invariable and fixed properties which define the "whatness" of a given entity' (Fuss 1989:xi). This is an irreducible, unchanging essence or nature and is in opposition to accounts that emphasise the role of the social and the discursive in the organisation and production of differences (Fuss 1989:2). One form of essentialism deployed in these narratives is that which roots explanations for discrimination in biology, personality or fatalism. Thompson (1998) calls a tendency to revert to so called natural causes as "bad faith" because of the denial of responsibility. Actions are described as beyond people's control and reassurance is sought in some form of determinism, be it biological, psychological, environmental or religious (1998:28). As Potter and Wetherell (1987) argue, this amounts to the community nurses admitting the offence and offering excuses. This is an approach confirmed in other studies, demonstrating that nursing care is discriminatory and oppressive. When nurses deny, minimise and naturalise discrimination they contribute to the perpetuation of inequality (Ahmad 1993, Bowler 1993, Smaje 1995, Gerrish 1998, Thompson 1998, Vydelinghum 1998). It was, therefore, important to assess whether use of liberal equality and talk of the same treatment did indeed suppress or ignore difference and mean talk of oppressive care.

In these narratives that were coherent with liberal equality, talk of discrimination was indeed contingent upon the suppression of and indifference to difference. This process was further reinforced in the talk of essentialised difference. This construction of discrimination as 'normal', depoliticisation and individualisation of important social difference was both generated and reinforced through the influence of the discursive field. Liberal equality discourses are reinforced in nursing through a discourse of individualised care. However, in examining the implications of this, Gerrish (1998)

found that individualised care was especially modified when, in her study, district nurses were dealing with clients from minority ethnic communities. Due to the influence of stereotypes, nurses responded to ethnic diversity by arguing that they too treated everyone the same. They defended this position by arguing that they needed to learn more about these diverse groups. In attempting to move beyond this impasse, Gerrish (1998) has argued that individual nurses do need to develop culturally sensitive care; this is, she argues, the obligation of a caring profession. However, it will not suffice as the only approach, as it individualises ill health and serves to isolate minority ethnic patients and condones structural inequalities. This in turn perpetuates and maintains a status quo. This conclusion reflects the ongoing debates concerning the respective merits of liberal and radical equality and highlights the particular limits to liberal equality discussed in Chapter One. However, this conclusion is in danger of advocating an uncritical endorsement of more radical approaches, implying that 'rescuing' liberal equality from its limitations, by seeking to reverse the liberal/radical or same/difference binary, will suffice . This does not address the inherent limits to modern forms of equality, as it does not deconstruct this binary, nor does it engage with postmodern critiques that suggest alternative strategies are now needed.

Therefore, it would appear that in talk of equal opportunities and discrimination a liberal discourse of equality is indeed being invoked. Naturalising and making difference problematic perpetuates an indifference to significant differences. However, these narratives do not draw upon professional practice and liberal equality discourses alone, they also use and reuse dominant organisational discourses of economic rationalism in discursively constituting equal opportunities, which I discuss next.

3.3.5 Equal Opportunities and Access and Rights

A liberal equality discourse assumes free and equal individuals, exercising their rights as and when needed. Community nurses are, therefore, responsible for responding to these rights by promoting equal access and treatment. In the nurses' narratives, these rights and access were areas of talk that drew directly upon a liberal discourse of re-distributive justice, but together with a discourse of economic rationalism. When Mary,

a health visitor student, described how people had rights to services, she explained this in relation to the client's freedom to choose, She said,

'I think it means there is this service, it's for everybody, you've got the same rights as anybody else in the service, you're free to use it. It's there, it's not imposed on you but it is there. If you don't wish to use it that's fine, you know, if you choose not to use it and then change your mind later on and come back and choose it that's fine as well. Just because you don't use it once, doesn't mean you can't use it again [.]It's there and it's open and it's readily available.'

These principles of choice and fairness underpin these constructions of rights and access. Claire argued this quite clearly when she said,

'If you go to your GP and have something wrong he's going to refer you or me and whoever, I think we all have equal access and again it's whether you choose to go, or you choose not to access it.'

Beatrice also reinforced these rights to access when she said,

'We're all individuals and there should be no reason that anyone shouldn't have exactly the same. I mean some people don't need it because some people are more healthy than others, maybe, but that doesn't mean that the right isn't there.'

These notions of rights and access were often cited in relation to the founding principles of the NHS. Several of the nurses cited how the NHS guaranteed access, free at the point of delivery. Yet, whilst these rights and access were in part constituted through the discursive resources of a liberal equality discourse, this was talk also drawn from a discourse of economic rationalism. This placed limits on these universal rights to access. Kathleen exemplified this response when she said,

'You do need a national health service and I think the basis of the NHS is good but you know everybody has the right to health care, but there just comes a point where the money isn't, there's not enough money in it.'

In addition to a professional demand to promote access and ensure people's rights to health care, it was evident that the trusts in which they worked, determined their workload priorities. This meant there were demands to practise efficiently and there was subsequent talk of the prioritisation of workloads. As Janet, a district nurse student argued,

'You are rationing yourself [.] You have to justify your visits, we record visits each day and obviously, if we just did support visits each day, which are like follow up visits, if all our caseload was that, then they would say 'hold on a minute here, what's going on, you've got all these people' So I suppose we ration in a way.'

Woodward (1997) has argued this economic rationalism results in caring work, and by implication, equal opportunities work, being undermined by the drive for efficiency. This is a trend towards economic rationalism which emphasises efficiency and effectiveness within the NHS. This drive and focus mark a shift from an ethical framework concerned with the individual, to one that emphasises utilitarianism and concern for the greatest number (Lawler 1999). This was a discourse used by the community nurses to define equal opportunities as a practice promoting access and ensuring rights. Catherine, a health visitor practice teacher, demonstrated this acceptance of scarce resources and the way this possibly limited access to her, as a provider of a service, in her discussion of her work. She argued,

'I think it's just how you organise your visits and how you prioritise your visits [.]If you've got a certain amount of time and resources available, what is the most efficient way of, of doing that? Or what is the most effective way of doing that? Very often that is about prioritising groups and that's not, I mean I don't think that's a bad thing.'

Therefore, there is an acknowledgment of the limited resources with which community nurses are expected to promote equal opportunities. This talk draws directly upon the broader discursive field and revealed an explicit recognition and acceptance of the limits to equality work in the NHS and health care more generally. This allows the community nurses to invoke equal opportunities as compatible and consistent with a liberal equality discourse and economic rationalism.

3.4 Conclusion

Liberal equality is a dominant discourse within these community nurses' narratives and more broadly within the discursive field in which they work. This was evident in a number of ways. To treat people the same and remain indifferent to social differences, to promote access within resources, to acknowledge discrimination as natural, are all themes embedded within these narratives and in a liberal equality discourse. These narratives draw on a range of discourses specific to community nursing, to construct these narratives or stories of equality in health care. This use reinforced the dominance of professional practice, education and individualised care and economic rationalism, as well as liberal equality. A less successful discourse appeared to be that of radical equality, as indicated by the less familiar talk of an anti-discriminatory practice. In addition, the influence of education, though displaced by the authority of experience, was evident in much of this talk of individualised care. Furthermore, direct citations of

the UKCC guidance for professional practice, together with the wider NHS agenda to tackle inequalities within resources, meant that these were narratives of equal opportunities that invoked certain truths about equality. These were the truths of liberal equality, constructed in particular forms within health care and community nursing. These truths are further evident in the assumptions of the liberal humanist view of individuals as autonomous and independent agents, capable of intentional action. This ensures respect for and the promotion of individual choice. This reinforced a professional nursing discourse where client-centred care and liberal notions of impartiality were endorsed. A re-distributive justice framework was also evident in the acceptance of scarce resources, allocated according to principles of fairness. Moreover, liberal equality was evident in these narratives when it promised the devaluation of difference. As discussed in Chapter One, it is the inability of modern political theory to respond to and deal with difference that has revealed its inherent limits and disguised specificity. Consequently, these limitations are not merely due to the incorrect implementation of liberal equality. These limits are inherent to these discourses. Thus far, it is possible to conclude that the nurses are using these fundamentally flawed strategies and this does indeed imply the demise of equality practices in community nursing.

However, in the next chapter I question this conclusion. I challenge the notion that talk of equal opportunities *is* consistent or coherent with a liberal equality discourse. I argue that upon further examination of these narratives, other accounts are revealed in which their engagements with liberal equality, displace and challenge this discourse. I contend, therefore, that far from being an inevitable presence in these narratives, the coherence with a liberal equality discourse is superficial. There is instead a far greater level of complexity present in these narratives than previously acknowledged. The nature of that complexity needs to be examined and I explore these diverse accounts, showing how these stories of equal opportunities displace and disrupt a discourse of liberal equality. I conclude that the presence of these diverse narratives, far from implying the demise of equality, are instead the indication of different grounds for the possible 're-imagining' of equality in community nursing.

CHAPTER FOUR

CONTRADICTORY AND COMPETING NARRATIVES

4.1 Introduction

In the previous chapter I demonstrated how the community nurses' narratives of equal opportunities appeared consistent with the dominant discourse of liberal equality. However, in this chapter I question both this consistency and dominance. I reveal a number of alternative accounts also present in the community nurses narratives. I do this by returning to the same narratives, drawing again on the interviews conducted with students and their respective practice teachers and re-interrogate their stories of equal opportunities. In doing so, I contend that the apparent consistency with liberal discourses of equality demonstrated in Chapter Three is far from inevitable. Instead, I argue this consistency between the narratives and a liberal discourse of equality is superficial. This leaves the accounts less determined by this discourse, and in re-examining these narratives, I reveal the presence of more complex stories of equal opportunities. I argue that these stories undermine and displace the dominance of a liberal discourse through expressions of an ambivalence and ambiguity towards equal opportunities and liberal discourses of equality. I conclude that these 'other' narratives of equality have important implications for future understandings of equality in community nursing and health care.

I have divided the chapter between those accounts I define as i) *contradictory* and those I define as ii) *competing.* The contradictory accounts are those where liberal discourses of equality are present yet disrupted by alternative narratives of equal opportunities. These narratives involve inconsistent statements that conflict with liberal discourses of equality. Yet, overall these narratives retain a discursive hold on liberal equality, which by default fail to be endorsed completely. These accounts form the majority of stories told by the community nurses and produce extremely *ambiguous* stories of equal opportunities.

I define competing narratives as those that explicitly challenge and remain sceptical of liberal discourses and promises of equality. These accounts critically question the

assumptions of liberal equality, expressing doubt about the supposed truths and opinions inherent in this discourse. These accounts tend to produce more *ambivalent* stories of equal opportunities. Together, these two sets of accounts produce more provisional stories of equal opportunities that destabilise dominant liberal discourses of equality.

In the analysis of these contradictory and competing accounts, I discuss three similar areas of talk to those examined in Chapter Three. Each of these areas of talk illustrate key aspects of a liberal discourse of equality in community nursing, namely talk of equal opportunities and professional practice, difference and discrimination and the principles of equal access and rights to health care. This structure will illustrate the particular contribution each type of account makes in displacing this dominant discourse.

4.2 Contradictory Narratives

A re-examination of the nurses' narratives revealed that over half of those narratives that had first appeared coherent with liberal equality, were on closer examination, contradictory. These contradictory stories served to disrupt and destabilise a liberal equality discourse. Through talk of professional practice, difference and discrimination and equal access and rights, I will highlight these particular stories and the challenges these contradictory accounts pose for liberal equality.

4.2.1 Equal Opportunities and Professional Practice

The contradictions expressed within the community nurses' narratives demonstrated an inconsistent approach to equal opportunities and professional practice. Declared intentions to treat people the same and yet respect people's different needs, as endorsed in the professional codes of practice and by the nurses, were in fact ambiguous and uncertain. This is demonstrated through the following extracts. Here struggles to treat people the same are contradicted by attempts to recognise differences. This struggle to acknowledge difference is revealed as problematic within a liberal discourse, compromising notions of equitable care or fair access and treatment. Janet, a district

nursing student was someone who argued that equal opportunities meant having the same opportunities to health care, within resources. Yet she commented directly on difference when trying to argue that she would treat clients the same, she stated,

'But there are differences [.] You couldn't treat everybody the same and treat this person the same regardless.'

In the previous chapter, Claire, a student district nurse, had insisted that the UKCC code of professional conduct ensured fairness and that giving the same practice was central to her dealings with different clients. This, as I argued, clearly reflected many features of the liberal discourse of equality. Yet on further examination, she expressed contradictory and inconsistent statements when attempting to describe her practice and equal opportunities. Initially professional practice was unproblematic when she stated,

'I just think everybody is the same, you know, I mean I don't treat anybody any differently, if they want an assessment or a visit they get one. I don't, I'm not going to discriminate against them because of their dress or like people get discriminated [.] Because of their postcode or insurance is high because you live in a certain area.'

She continued, however, to contradict these statements of treating 'everyone the same' and 'not discriminating', revealing how the differences she claimed to ignore disrupted any promise of an equitable service:

'I suppose your prejudices might get in the way if you have certain prejudices about a particular client group, I don't know, you might find yourself not spending as much time with the client, you do the care but may be not spend so much time having a conversation. I don't know, I mean, we all have patients that we like and not like as much [.] Some people are prejudice [.] You'll never change someone [.] We have our own culture don't we?'

This inability to suppress difference challenges the liberal equality premise of equal worth meant that she continued to explain how treating everyone the same meant was,

'Offer[ing] the same as you'd offer to everybody else [.] And [if] something is staring you in the face you have to do something about it even though you may not like them, because they 're black, Chinese what ever.'

Jayne, a health visitor practice teacher, also dealt with similar issues. She attempted to explain how she sought to value and not suppress difference in terms of clients' various needs but this involved contradicting her statements of liberal equality and its compatibility with professional practice. She stated,

'I think it's difficult, I think that by treating everybody the same for a start, although they're not the same, and you do have to, you do have to change the way you'd say something. [.] It's probably important to use the differences [.] But hopefully, they should have the same information, the same opportunities, no matter where they are, whatever situation they're in. [.] You don't want to remove their differences, the difference, the difference is actually what make us individual.'

Leanne expressed similar contradictory, less certain views when discussing equal opportunities. In discussing professional practice, the liberal promise of the same treatment or fair care was tentative. This was evident when she stated,

'I would feel that people should be treated that equal, [.] Should be treated as equals, you should respect people, you should offer them the best you can[.]Wherever they come from, whatever they do.'

However, despite these declarations of doing as much as she could, she later argued this promise was in fact inherently limited,

'You can only look after people's health if everything else is fairly okay and I suppose maybe that's the problem with equal opportunities, the other things aren't being looked after, so, you know what I mean, we can only help so much with health, but then I think you only can anyway.'

Chris, a health visitor practice teacher, had previously argued equal opportunities was the same as professional practice when she said,

'I think you do it automatically as part and parcel of your job, it's not something that's prescriptive, it shouldn't be [.] I think it's the same as our job, the only thing we've put labels on it and we're more aware of it, but it's, no it's the same, it's how I feel anyway.'

Yet, this ability to promote equal opportunities meant that nurses were not always positioned as professional and equitable .She continued to contradict this assumption:

'We say things, or we pre-judge or we stereotype [.] It's in us, the strong always feed on the weak and that's human nature.'

These emerging difficulties, in the encounters with a liberal equality discourse, were further complicated by talk of the time and effort it took to 'do' equal opportunities. This meant the community nurses sought to explain why they had to cut corners, or not unearth too much, contradicting their claims to treat everyone the same. Frances, who had talked of treating everyone fairly, now talked of the pressures of time and how this led to not picking up on cues,

'If you're absolutely frantic and really, really busy there are times when you go and do a visit and you just think, I don't want to pick up on anything here because I just haven't got the time to deal with it.'

Beatrice also talked of the ability to tick things off and,

'Not really looking at the whole picture [.] You want to rush in and out do a developmental check and not ask too many questions, you don't want to make more work.'

Jenny, a district nurse student reiterated these concerns,

'I think we can all tend to skim over it a bit sometimes and just do the care and go. [.] You can understand people not making a huge effort but at the same time it would be nice for it all to be in place so it wasn't a huge effort to organise it.'

Kathleen talked again of the limited resources and the work involved in promoting equal opportunities in practice,

'It's hard work, it means hard work to people, it's easier to ignore things [.] It's easier to think someone else will do it and sit back.'

Likewise, Jayne talked of how sometimes 'you just do the basics.' This inability to respond to, or value difference was further reinforced in the way certain forms of difference were continually invoked, contradicting all claims of a universal and fair service.

4.2.2 Equal Opportunities and Difference and Discrimination

In liberal discourses of equality, the dominant strategy for dealing with difference was shown to be to one that suppresses, individualises and depoliticises difference. However, in these accounts there is evidence of contradictory and explicit talk of discriminatory stereotypes and the process of labelling clients, families or lifestyles as natural and endemic to practice. These stories contradict and undermine the liberal discourse of equal opportunities in two ways. First they contradict the liberal promise of equality of inclusion and second, they contradict the assumption that professional practice and care is compatible with equal opportunities. These accounts show the fragility of the discursive constitution of professional care as equitable, reciprocal and sensitive, enabling client autonomy and access to services and the difficulties encountered when engaging with an inherently limited discourse. These limits are seen

in the contradictions evident in the talk of stereotypes and the responses to claims of discrimination.

Laura's narrative represented a good example of these inconsistent and contradictory stories of the liberal promise of inclusion. Laura had argued previously, in Chapter Three, that she tended not to look at her clients for what 'class they're in, or ethnicity.' She had argued,

'I tend not to look at people for whatever class they're in or ethnicity, I don't see that anymore [.] I go in, I have my objectives and I see what the clients' need are.'

Yet, despite this insistence, class and ethnicity were imbued in the stereotypes she reported as potentially affecting both her practice and her client groups. She discussed how stereotypes circulated out in practice and could potentially influence care. She argued that,

'Everybody has certain views about minority populations. I mean whether it's your parents and the way, you're brought up when it's always said black people are lazy or spongers or an underclass [.] With an African population there's lot of whispering and rumour goes around about how they are able to afford, with child benefit, new, you know, things like that. Nigerians and they're seen as fraudsters you know, they try and, because of state benefits, keys are exchanged for flats and people getting flats [.] Black people, Caribbean people are seen as thieves you know, the Kurdish aren't very well looked upon, you have travellers and all the stuff that goes with travellers. You know just generally, they lay about, these are just things we hear and if you were to pay any attention to it you'd never get your work done [.] But you've just got to bypass all that or wade through it.'

She continued, however, to contradict this ability to 'wade through' all this when she talked about how differences mattered so much that inclusion then became an impossible goal. She argued that,

'As soon as you see colour, as soon as someone opens their mouth there's differences [.] If it wasn't colour, people always want to blame somebody [.] So this equal opportunities, [.] It's a word, it's unobtainable in a lot of ways it's a utopia.'

Linda, a learning disabilities practice teacher, disputed the possibility of 'wading through all this'. She had talked previously of equal opportunities as, 'giving everybody, despite their colour or creed, disability or ethnic origin, every individual has the same opportunities.' Yet she also contradicted this with talk about those moments when differences mattered greatly, especially those of her clients. She argued this prevented any equal opportunities:

'I mean the disability is a barrier, they will never accept these people as equals [.] I would like to see this group as part of the community.'

Claire reinforced this when she contradicted the liberal promise of inclusion. She had previously argued that 'I have a responsibility for patients, so whether they are gay, black, whatever they are, it's my job to go care for those people'. However, she was also able to contradict this by saying,

'I may not spend as much time with Mrs A as Mrs B but that's because Mrs A is a misery, I don't really want to chat to a misery today because I feel miserable you know what I mean, but they get the same care, ultimately, I do the same care and attention.'

This statement clearly undermines the assumption that Mrs A does get the same care. These narratives reveal that claims of inclusive care as equitable, reciprocal and sensitive, enabling client access to services are indeed contradicted. Instead, these narratives displace both the dominant hold of liberal equality and make problematic its compatibility with professional care.

Turning to consider talk of discrimination, it is apparent that a liberal equality discourse assumes fair procedures will ensure the minimisation and even the prevention of inappropriate discrimination. However, the following extracts reveal how the minimisation or prevention of discrimination were extremely problematic This talk contradicted the assumption of fair procedures and the many declared intentions to treat everyone the same. For example, Jenny had previously talked of equal opportunities as 'instinct' and entirely compatible with professional care. Thus she talked of the importance of dealing with claims of discrimination by looking ' at it seriously' and asking questions. However, she contradicted this by then placing limits on this, by arguing, 'You can't take on everything.' She claimed she would respond to discrimination if this directly involved the care that she was giving. This placed somewhat arbitrary limits on her dealings or responses to discrimination on behalf of her clients. In other words, there were some unarticulated sources of discrimination she would not deal with or respond to. However, having rationalised her attempts to deal with a claim, she then contradicted this intent. This was evident when she described how she would respond. This implied a large degree of discretion and invalidated any claim to treat 'it seriously'. Furthermore, particular views of patients as 'embellishing or creating' refuted any claim to treat everyone fairly. She said,

'Initially, well first of all you've already got your opinion of the patient and whether or not they're likely to embellish or create or whatever. [...] It could be that the staff nurse or sister or whatever hadn't meant it the way it sounded, or the emphasis had been wrong or it had been misunderstood or whatever, so you've got to try and figure out whether there was any actual malice.'

Questioning the authenticity of a claim and then minimising this by only attending to 'actual malice' shows how discriminatory processes are at work. Claims of discrimination dismissed as a character flaw of an individual client, or as a criticism of an otherwise genuine attempt to care means the 'offence' of discrimination is both acknowledged and denied as Potter and Wetherell (1987) suggest. Professional discourses contributed to this process, being drawn upon to justify both doing something and doing nothing.

Janet, a district nurse student, illustrated similar themes when she defined her response to inequality or discrimination in community nursing care. She had previously argued that equal opportunities meant,

'I would treat everybody the same at a basic level and assess everybody at a level below or above it, that's what we do, we go out and assess and treat, yes treat people the same [.] Everyone should have the opportunity to, the rights to a GP and [.] Access to us [.] It's treating people the same [Nurses] Don't judge people and treat people equally, assess what they need and offer what you feel is applicable.'

However, central to her decision to act or respond to discrimination were again, rather arbitrary notions of acceptable/unacceptable expectations. Initially she argued a position consistent with her view of equal opportunities when she said,

'If a nurse went in and said, "I don't think you're worth me wasting my time on. I don't feel that I should come in and give you this and this, because you're not helping me, you're not helping yourself [...] or maybe they have this instant dislike of this patient, and I hope nobody would say this but, " I don't get on with you, I don't want to come in your house because its dirty, its not very clean, I don't like the area," I hope nobody would say that but that's the sort of thing I would define as discrimination. You're being, you're being critical of their way of life, you're being judgmental of the way they are living, this would cloud your decisions about what you'd be doing.'

However, she also sought to qualify this and continued to underline this position as she described when and where discrimination was legitimate:

'We had an elderly lady who lived on her own for a very long time. Everything was very primitive, outside toilet, no hot water, gas, um a coal fire, she was doubly incontinent, wouldn't wear any pads and she had horrendous leg ulcers. We were called in to, and social services, we wouldn't go in there, and although we were not

discriminating we also have our points of view, we shouldn't be expected to go into that.'

Having said this, she reflected upon how people's experience of discrimination stemmed from difference:

'They are regarded as different from the norm; we're very traditional as a race aren't we? Everybody has to conform [.] Each era has it's own stereotypes.'

She argued discrimination was a 'human trait' and yet equal opportunities was a worthwhile activity because otherwise, 'you're not going forwards are you? You're not progressing.' However, equal opportunities was difficult because,

'In some cases people can be quite demanding, this is my right [.] and then become quite violent and nasty about it[.]The balance is altered but we're going the other way.'

Despite a belief in her own fairness and the promise of equal opportunities in health care, Claire expressed serious doubts about the possibility of change through the use of equal opportunities. Equal opportunities were,

'A waste of time because you're not going to change your views about a particular group of people, no matter how much you go in there [.] Having all this equal opportunities is fine but it doesn't always work all the time, it just protects some people some of the time.'

These narratives reveal contradictions in relation to the liberal claims of inclusion and intentions to suppress difference. Instead, these stories reveal the limitations of this promise and talk up rather than suppress difference. This results in practical strategies which talk of overcoming and dismissing the effects of these stereotypes whilst, at the same time, recognising their damaging impact. These stories acknowledged discrimination as a core feature of practice. As a result, both liberal and professional discourses and the promise of inclusion are revealed as problematic. These narratives reveal the contradictory talk that results from an engagement with liberal equality and how this constitutes equal opportunities as a more ambiguous practice. A further area in which this discursive displacement occurs concerns the liberal promise of equality in health care in terms of access and rights.

4.2.3 Equal Opportunities and Access & Rights

Equal access and rights are central concepts to liberal equality discourses in health care. As I argued in Chapter Three, liberal forms of equality are premised upon assumptions

of sovereign individuals of equal worth, endowed with equal rights. This subject is assumed to be free to exercise these rights to health care when needed. Nurses then become the bureaucratic response to ensuring those rights. This they do through the provision of equal access to health care. However, in these narratives those apparently free individuals are positioned in different ways, contradicting and undermining these liberal assumptions. Furthermore, the relationship between the client and the community nurse was also contradictory, as the nurse was both positioned to promote and not promote access to health care. Chris, a practice teacher, related a very common view on these issues:

'Yes there should be equal rights to health care but you know it doesn't happen. It tends to be again how well you can articulate, through the hierarchy, and then how you are on your illness or whatever it is in health care, you know, what's available, how much you know that's available. Yes, you must have that knowledge, if you haven't got it, doesn't necessarily happen, it should happen but it's, all I can say it's very subjective, it depends on who you're dealing with really and where you live.'

She added, 'obviously if you have the money then you don't need all this equal opportunities in health care, you just go ahead.'

Frances agreed, 'It's much easier for maybe a white middle class articulate professional to get what they want from the service [.] It might differ for someone who isn't articulate, maybe from a lower social class, maybe a different race.'

She thought this depended on education, the two- tier system in health care, and money, people's ability to pay. Claire also quite clearly positioned clients differently in respect of access and rights. Here she positioned middle class clients with rights who could more readily exercise their rights and gain access to services and this had an enormous impact on her work. This greater access was due to the demands and expectations of these clients. As Claire said,

'Yes, I mean the more educated have very different needs, I think they expect a lot more from us as professionals, their needs probably are more greater, whereas the others aren't, they seem to be quite happy and grateful for what they get, if I didn't go in more than three times a week they'd want to know why, they're just more demanding.'

These 'others' were yet another group of clients positioned in relation to, but differently from middle class clients. These other clients were defined as being in more need of her help and her service, she stated,

'People that are more articulate in social class one, ask and get what they want, people in lower social classes either aren't aware, or aren't able to get access due to, because

they don't know how, or they ask and don't get and don't pursue it, whereas the more educated will ask again and again and till they get it.'

This various positioning of different clients was interesting as it contradicted notions of the sovereign individual with equal rights to equal access. However, it also made problematic the nurses' own bureaucratic response to these rights. Middle class clients were, for example, deemed as the 'worried well' that tended to be able to take on board what the community nurse said. These were clients who asked more questions and were generally more aware. Linda, who had previously commented favourably upon on the openness of the service, now positioned middle class clients as problematic as they were associated with the increased use of this open service. These clients were seen to,

'Take up an awful lot of time, ring you up with the, sort of the. Worried well really, lots of lots of sorts of concerns and anxieties about the baby, [.] Then there's a part of you that thinks oh hang on a minute, why are you taking all of my time when there's a lot of people that are most in need and I cannot get to because you're blocking my time.'

Working class clients, on the other hand, were often defined as less able to ask questions, not wanting to ask because of the stigma of receiving help, or had difficulty 'making them selves heard'. However, not all working or so-called 'lower' social class clients were viewed as such. These were a group who were variously defined as both problematic and dependent. For example, when these clients were more demanding of community nursing interventions they were also labelled, but not as the worried well. Janet, who had described community nurses as fair and non-discriminatory but as having their own views of clients, went onto describe these clients as complex groups,

'There's one half who know their rights, they're on income support and they have everyone running around after them and they know their rights right down to the last letter, but the other half of clients, who could do with the help, but they don't want to ask because of the stigma, and the word social services just rings alarm bells in their ears and they don't want to ask for anything and sometimes they don't know their rights.'

However, community nurses not only positioned their clients, they also took up their own particular positions in this relationship. Most community nurses talked of how they sought to promote access to ensure equitable and therefore professional care. Yet there was a notion that 'doing too much' in relation to empowerment or advocacy for clients was as great a problem. This was because doing too much constituted 'spoon feeding

them' and this was seen to compromise a client's independence. Laura described this position thus,

'I'll give them information and explain to them what they need to do and how to go about it, but I won't actually get involved in doing it for them [.] But I feel if you're not careful you can do too much and take away their oomph to get on with it [.] I don't believe I can do everything. I know what I can do and what I can't. I'd put the onus back on the client.'

Helen, a student health visitor, who had already talked of how fair the system was, now talked of health visitors' expectations and how provision of a service was dependent upon a number of certain qualities,

'I think it depends on how accepting clients are of a service or an intervention and how amenable they are to you visiting, or how amenable they, and if you get someone who is quite a bit fed up with the service I think you're less likely to go back into that situation than somebody whose perhaps is quite welcoming in respecting your view.'

These accounts reveal complex talk of clients' needs and rights and access. These ideas contradict and displace liberal equality discourses of sovereign individuals able to access services via the nurses when needed. These accounts are indicative of the diverse range of stories of equal opportunities in health care and the limits to liberal equality. These stories do not overtly challenge liberal equality discourses but they do indicate a less than coherent account, revealing its inherently flawed assumptions of guaranteeing equitable care, equal rights or access.

There was one narrative in particular that demonstrated the contradictory stories of equal opportunities extremely well. Helen's narrative provided one of the clearest examples of how contradictions disrupt liberal discourses of equality and produce the ambiguity expressed. I have kept the sequence of Helen's narrative intact to demonstrate the movement between those moments where there is an expressed consistency with liberal discourses and those where there are expressed contradictions and ambiguity.

4.2.4 Contradictory Talk – An Example

With regard to professional practice Helen, a health visiting student, argued this practice was part of the 'fairness of the system', stating the system ' deals with them fairly equally you know [.] A lot of them are fairly similar, quite complex needs or whatever.'

However, as she continued it became apparent that her notions of fairness were contradictory and potentially compromised by the degree of control health visitors were seen to have and by the discretion implied in their 'willingness' to allow clients to access services. She continued,

'I mean in many ways health visitors are the gatekeepers for the service so I think that depends on how, how willing the health visitor is to allow those people access to the services, I mean the services are there; it really just needs the health visitors who either say yeah or nay to that.'

This control and discretion did not appear to impact upon, nor contradict Helen's own definition of equal opportunities:

'I mean I suppose it's just that everyone's got a equal access to the services available or resources and those resources could be financial, knowledge, all of the road things and that each individual, irrespective of race, gender, sex or whatever has got a full access to them that's what equal opportunities mean to me.'

Furthermore, equal access was never acknowledged as incompatible with the everyday practice of labelling or health visitors' dealings with different clients. Whilst Helen's comments indicated the way discrimination was spoken about in health visiting practice, she also revealed ways in which discrimination was separated out from talk of equal opportunities. This allowed Helen to continue to acknowledge discrimination *and* talk of equal access,

'I think we discriminate against people not, not intentionally, but I think we do because we label people, we label people because of where they live and we know the people because of their lifestyle and we label people because I think that, that's discrimination, but I don't see it, I see it slightly different to access to equal opportunities. [.] I think we label a particular estate like there's an estate in Y, oh that they live in that estate, I think that's discrimination. [.] And that the fact that a lot of our clients will have changed partners, you know, three or four times, you know they, each subsequent child will have different father, and that's something and there's judgements made on how many times they move houses and yea, I think discrimination is, is fairly widespread in health visiting.'

Later Helen argued that health visitors dealt with equal opportunities fairly well, partly because of the underlying philosophies or principles of practice. Yet the profession can, she argued, remain inherently discriminatory and oppressive. She stated,

'I think health visitors tackle the equal opportunities quite well, because I think they, I think they believe that everyone should have equal access to the services, but I think discrimination is much more difficult to tackle, because health visitors as a rule tend to be white, middle class and we go with a whole set of assumptions I think into areas that are very different or very dissimilar to the life that we lead, so I'm not sure how you can actually change the whole culture, you know, your whole belief system, which I think is

what you need to do to tackle the discrimination there. [.] So many of the lives, so many of the families' lives are so different to the life I lead and so many of them lead that sort of life. It is quite difficult and I and I could never live the way that some of my families live. I'm not saying that they're choosing to live like that, but their whole attitude and their approach to living is very different.'

Helen continued,

'I don't, [discriminate] not in those sort of very, very *public* things and I don't think many people in health visiting I don't think, health visitors do, I mean I think it's very much based on an assessment, on how a particular parent is with a child and I don't think it's sort of well they're black and that's why they behave like that, I think it's, I don't think that we make judgements on well, my experience of health visitors is that I don't think they particularly make judgements on people because of their colour or race or whatever, anyway. I'm not sure that a particular statement saying treat everybody equally or whatever would make any difference.'

Obviously, if health visitors judge, but do not discriminate on the basis of 'public' indicators, this implies less obvious, more hidden indicators may be at work. This was not seen to compromise equal opportunities work. Helen continued to describe what health visitors appeared to do in relation to equal opportunities, clarifying her thoughts as she talked, she added,

'I mean in many ways I think health visitors do sort of don't do equal opportunities they sort of, well, I envisage that I would promote a service more to the people who have great needs. [.] I think it's just how you organise your visits and how you prioritise your visits. Yea, I, I think we do equal opportunities by giving greater service to those who are least likely to have it, so in many ways you give them more of services to those than you are to other groups. Yea, I mean, I feel I've said and I think health visitors, as you know, on the whole are pretty good to be honest.'

This was followed by a discussion of the tensions involved in practice,

'I think that's the way, certainly, the whole principle of health visiting is about working with those least likely to use the service and I think, I think the whole culture of health visitors is that we do make judgements on people, yea but we are asked to make judgements as well on people, we're asked to make assessments on people on their ability to, that's difficult as well, not being judgmental, but then being asked to make judgements.'

This ambivalence was, however, resolved partly at an individual level, as Helen remained convinced she did not discriminate,

'I don't discriminate against people because they're black, or because they're male, or because [.] We're all bound by our Code of Professional Conduct so it's written there quite clearly isn't it?'

However, the denial of discrimination was often contradicted by talk that didn't just suppress discrimination or assimilate differences, as was evident in liberal discourses of equality, but instead invoked these as key features of practice. Helen's narrative is a good example of the movement between an official professional discourse endorsing liberal equality and an engagement with racialised or discriminatory discourses. These moves are contradictory and while not replacing liberal equality or subverting of its compatibility with a professional practice discourse.

To summarise, these accounts reveal contradictions that disrupt any apparent coherence with a liberal equality discourse. This challenges this discourse's dominance. On further examination these accounts do not simply advocate fairness, or a same service or individualise differences as first appeared. Instead of seeming consistent with liberal equality discourses, further interrogation reveals less certain and more unpredictable discursive accounts of equal opportunities and practice. However, contradictory accounts were not the only stories. There were also more challenging and sceptical accounts that added to this diversity and complexity. These I defined as competing narratives.

4.3 Competing Narratives.

In addition to the contradictory narratives, a further third of the community nurses expressed consistently sceptical views of equal opportunities. Although these accounts were less usual than the contradictory accounts described above, they were extremely important. For these competing narratives explicitly challenged the assumptions of equal opportunities as a form of liberal equality and more directly as a professional practice. These accounts used similar talk but in different ways. These were narratives that queried the claims that practice sought to promote the same access and deliver the same treatment to clients. These accounts also challenged liberal equality principles through explicit and direct talk of how discrimination was perpetuated in practice and how clients with various needs were positioned differently. Furthermore, the promises of equal rights and access to care were compromised not only by the system, but also by the culture of community nursing. These features of practice were argued to be complicit in reinforcing an inertia that perpetuated and reinforced disadvantage.

4.3.1 Equal Opportunities and Professional Practice

In these narratives, the liberal assumption of the same or equal treatment and inclusion as unproblematic was doubted and directly challenged. Chris was adamant that equal opportunities were never about treating people the same. She said, 'I think it's about treating everybody differently, I can't treat any of my clients the same'. Jayne was unequivocal, 'all of us practise differently, we are different individuals.' Georgina argued more directly that equal opportunities in health care was not equality in terms of the same service, she stated,

'Equality isn't about everybody being the same; the service would be quite, quite different. We're not trying to make people the same we need to respect differences...but we don't really want them to be treated in any different way.'

For Victoria, scepticism also stemmed from both the ambiguity surrounding the term and, in her view, the overall inertia of the system. She summed up equal opportunities as rights to health care. However, she remained critical of a term she felt was tokenistic, which once articulated was often dismissed,

'You can see it when people mention it, people cringe, it's like at interviews, you think oh don't ask me this because it's so waffley, and you're not given clear guidelines on it. It's the same with the new NHS you know there is more focus on health inequalities, and we are fighting for that, but it's as if we've set it up now, so it is going to be an uphill struggle to talk about it really, because people are turned off from it really.'

Kathleen, a student health visitor, was doubtful of the ability to treat people fairly. This treatment potentially slipped into different and then oppressive care, she indicated this when said,

'Health visitors are no different, you know, and the type of service and the type of care they give is entirely, it's a very individual thing, but you know you might think well you know I don't actually like that person so I'll only spend two minutes with them and I'll do the basics and them I'm out, do you know what I mean. But you know is that right? Is that fair? You know, or how long I spent with one person and I only spent x amount of time with another person, so yea I think we could be.'

Jackie, a health-visiting student, was particularly sceptical of the reality of equal opportunities in practice. Whilst reviewing her Trust's equal opportunities policy she stated,

'When I was reading it [the Trust's policy] I thought yes, we try to work towards it, yes absolutely. It means everybody should get an equal service."

I asked if this was possible and she replied,

"If you had the resources to treat everybody as individuals then yes, but in reality not, you lift up the edge and think I'm not looking in there it's too big .'

Conversely, whilst these sceptical accounts challenged the coherence of liberal equality, they still constituted equal opportunities as work mainly at an individual level, thus reinforcing and endorsing the appearance of liberal equality. However, a few community nurses were extremely sceptical of this approach and talked of equal opportunities as something more, as an approach that needed to encompass work at a structural level in order to deal with inequality. When asked how they would define equal opportunities, Georgina, a health visitor practice teacher said,

'I would see it basically; equal opportunities technically would be the removal of disadvantage in competition with others. But that can be quite limiting can't it? When asked in what sense? She replied, "Well it's not necessarily talking about equality in terms of treatment or necessarily outcome.'

For this practice teacher, equal opportunities, as an individual practice, was clearly problematic. For whilst it allowed clients an opportunity to participate or compete for access, it failed to deal with treatment and outcome. This draws upon a more radical discourse of equality as I discussed in Chapter One. However, as Georgina constructed equal opportunities as a struggle to remove barriers to services, there was no talk of how those services may be problematic. Nor was there any acknowledgement that choice is never neutral or value free. For Jayne, a health visitor practice teacher, this desire to work at more than an individual level was also present but constrained by the everyday demands of the service. She found it,

'Harder to work at the policy level because, it's harder to do as an individual so you tend to have to get together to do something and I don't think it's something we're particularly good at doing because you tend to think, oh I've got these hundreds of people to see and you tend to focus on what you're doing rather than wider issues.'

Equal opportunities as a practice had previously been defined by many of the community nurses as being the same as professional practice. I showed in Chapter Three how this was further endorsed by the vagueness of professional codes of practice, defining equal opportunities as a set of guiding principles or philosophy of practice. Yet in these accounts there was an ambivalence towards these discourse as the community nurses talked of further constraints in practice. This was talk of being rendered less

effective in practice by what they defined as either a health visiting or general nursing culture. This culture constructed the normative base to community nursing care with particular values, customs and beliefs being privileged. These privileged understandings defined the 'normal' or expected responses to equality and discrimination. In these competing accounts, cultural effects and the norms of practice were presented as either inconsistent with declared commitments to equal opportunities, or as a more critical comment on everyday practice.

When discussing the perceived effects of culture, discussions were often in relation to the effects upon practice and the community nurses' own position in health visiting or district nursing. Helen, who had stated earlier that the system was fair, argued however,

'Health visitors as a rule tend to be white, middle class and we go in with a whole set of assumptions, I think into areas that are very different or very dissimilar to the life we lead. So I'm not sure how you can actually change that whole culture, you know, your whole belief system, which I think is what you need to do to tackle the discrimination there.'

And Claire argued that any challenge to the system threatened her position with her peers,

'You know, maybe if you challenge them it makes them think [.] But if you work with them, I don't know, they might think you're a bit of a goody goody.'

Similarly, community nurse students were critical of a community nursing culture and the service generally. This meant health visitor students, such as Mary, were able to argue culture was a major constraint on developing an equalities agenda. She spoke of the entrenched nature of this health visiting culture,

'I think what we are going to get rid of is the middle class right, the twin set and pearls, I think sometimes its viewed that our profession as well and its not that way [.] But there are a few who lecture on how to do it and I still feel its kind of 1950's woman, but I think it's the professional health visitor and when I came in to it I didn't realise what I was letting myself in for really.'

Jackie also talked of this culture as constraining professional practice generally and, by implication, equal opportunities work. Having just finished the course, she was aware that her enthusiasm and efforts could potentially be curtailed by the sheer pressures of 'normal' practice in which she saw a community nursing culture resistant to change. The culture of health visiting was described as controlling, especially of those who potentially sought to challenge the system by ensuring that all health visitors,

' Keep their heads down, they toe the line, they [.] The ones that don't agree with they change, we just revamp, they move on, or they resign or they get sidelined into a corner [.] I wanted to do the health visitors' training to make a difference, even as I was thinking that, I was thinking yeah that's not going to happen.'

She argued that equal opportunities was,

'Largely irrelevant to their practice that's the problem, what they do day by day, it's part of this culture of we're not going to look at our reactions to people, and the way we are.'

Even when directly discussing her trust's equal opportunities policy, Jackie remained doubtful of anyone's ability to change the profession, as she said,

'I'm sure these groups that put it together are committed to it, but I'm sure if you ask fifty people, they wouldn't, I mean I haven't till now. [As we sat looking at the policy] It's like Blair's tanker [laughter] it would take years to turn around because of the culture. They say large numbers of health visitors will retire in the next few years and so if new staff, I don't know?'

Kathleen agreed, she felt health visitors were not,

'A very proactive group health visitors, I've found, very much, oh laissez faire and you know just trying to make us agents of change in an area that they're not going to change, it's difficult.'

Interestingly, these students positioned themselves outside of this culture, as yet to be inculcated with such norms. Yet community nursing gives rise to a particular set of dominant norms of practice, which govern nurse- client relationships. This dominant culture is constituted in a community setting in which wider social relations are reflected and reinforced. This results in forms of regulation and control, constituted in and by everyday routine practices and reinforced by dominant professional ideologies. Furthermore, nursing is argued to achieve an authoritative position through the ordering of bodies (Crowe 1999, 2000). As Foucault (1979a) suggests, discourses constitute, order and inscribe bodies through mechanisms of disciplinary power. For example, in community nursing, and incidentally in equal opportunities too, the ordering of bodies are those perceived to be in need or disadvantaged. This ordering is achieved through the generation of persuasive and pervasive discourses, which in this case, appear to be the dominant discourses of professionalism and liberal equality. One effect of this culture is to reinforce the presence of discriminatory stereotypes as a norm of practice. However, in these competing accounts the liberal equality promise of suppressing

difference, or a more ambiguous position of 'overcoming' or 'wading through' these stereotypes, is made far more doubtful.

4.3.2 Equal Opportunities and Difference and Discrimination

The struggles to deal with or reject labelling and stereotypes were especially evident in the competing or sceptical accounts. Here there was talk of the way discriminatory stereotypes were said to structure community nursing work. Jackie, a health-visiting student, was generally very critical of equal opportunities. Her narrative clearly demonstrated the doubts, questions and critical stance that defined these accounts. She began by recalling the difficulties she had encountered in practice when dealing with difference:

'Well the service delivered, everybody has the right to the same service but it doesn't happen because of all this categorising and stereotyping, you get the service that goes with your stereotype, you know you're a middle class mum and you cope, you have your network and you'll ask for help when you need it, you're unemployed living on the estate and struggling on income support and we keep an eye on you. Where I am at the moment with the middle class 'okay people' after the baby's born they don't really get a service. I suppose it's prioritising, saying they're okay, they'll managing and if they're not managing in a way that's less dangerous, you know, they'll come to the GP or their partner will help [.] so the service is not equal, all sorts of judgements are made and half the time you're not even thinking about it, that's the danger really.'

These stereotypes were argued to circulate, out in practice, originating from other community nurses. She stated,

'It's what you get to hear, the weird one is they know how to work the system, they get everything they can, their class is a problem, oh you, they live up on the estate and that has meaning of its own, not only in life outside, talking to friends you know, you said Mrs X lives on estate and all that goes with it!'

When asked what "all that goes with it" meant, she replied, "Oh unemployed, scrounging, wild children, *they* don't listen, you can go over and over again and they do what they want, they never do it."

Her explanation for such labelling was the stress of the job, producing a reliance on stereotypes and she was, therefore, sceptical of their disappearance or removal. Jenny, a district nurse student, had similar stories of particular clients being represented to her in practice,

'Yea, people who say that particular patients will have particular temperaments this patient is one that you hear a lot [.] That person is never quite satisfied or is grumpy or

whatever, you know, and I think they should put themselves in their shoes, if that's the way they're going to describe them, I think it's lack of empathy.'

Jayne, a practice teacher, agreed. Health visitors, she argued,

'Judge the way they spend their money, I probably wouldn't have gone on the holiday of my dreams I would have tried to put that money into housing or furnishings you just don't know, so I think its, we shouldn't discriminate against people we shouldn't be judging people really, actually putting those things aside when you're working. Its hard, I mean it is hard I'd admit and I've listened to colleagues you know talking about you know, I used to think if they can afford a big television and videos and they can't afford you know milk for the children, so you're up against things like that, well at least that television and video will keep the children occupied.'

A more obvious example of just how these stereotypes perpetuated discriminatory services was evident when Kathleen spoke of the overt and indirect discrimination experienced by her clients. This tended to refute any claim of an equal or accessible service. She stated,

'The two male doctors do not like single parents and we've actually had women coming back to us saying, 'I know I'm a single parent but I'm not a bad parent' [.] It's very subtle, it's not what he said, what he has, it's what he has said by not saying, his actions have spoken louder than words, saying you know, well if you can't cope on your own you should do something else, or, why is your child always sick? [.] He did not like the fact that she was a single mum, it was obvious to us but I don't think he even realises.'

Mary had similar examples of GPs,

'The GPs definitely discriminate over who they take on their books [.] I was very shocked when the GP herself told me that they actively select out.'

These students distanced themselves from this talk of discrimination as the sources were seen as lying somewhere else with other colleagues. These were community nurses authorised to talk of discriminatory stereotypes and practices, which they implied they were expected to collude with. Yet they were also enabled to talk of their struggles to deny and attempt to subvert these crude stereotypes. These challenges and scepticism confirm similar findings by Bowes and Domokos (1998). Their research looked at health visitors' work with Pakistani women. They found health visitors spoke explicitly of the need not to stereotype and could find no evidence of them operating with the crude accounts that had been suggested by earlier commentators. However, having acknowledged the community nurses' critical stance, it is worth noting that these competing narratives, like the contradictory accounts, also constructed stereotypes as a priori features of practice. Yet, these competing accounts argued community nurses

were also potentially very much part of the problem of discrimination, as everyday practices tend to support a system that actively surveys, labels and categorises clients. Overall, the community nurses' comments on these processes are both critical and ambivalent regarding their ability to collude with and be actively involved in discrimination. Yet central to liberal equality discourses are assumptions that discrimination will be minimised, if not prevented, by the promotion of fair rules and procedures. These are rules and procedures that clearly fail, as the presence and effects of stereotypes indicate.

Cynicism was also expressed over the degree to which community nurses could change or ameliorate the effects of discrimination. Responses to claims or incidents of discrimination and inequality had again to fall 'within my [i.e.nurse] remit' as they had within the contradictory accounts. Only this time there was an explicit acknowledgement of the power that was involved. When asked how she would respond to claims of discrimination from a client, Victoria doubted she could achieve any change, she said,

'As a health visitor you can say this is bad practice going on here, it's not safe here and they're being harassed, on those grounds you can try and assess, but at the end of the day I'm not sure how much power we have?'

Georgina, a health visitor, took a more critical and proactive role, using the complaints procedure within the Trust to tackle discrimination, encouraging the individual or the family to put it in writing, she said,

'If they feel they're being discriminated against then they're being discriminated against [.] I would want to discuss it with them and maybe look at ways of actually dealing with it. It may be on an individual level, it may need to be taken further, support from union reps, the manager, policies.'

However, she was also sceptical of this response because,

'Nurses could be part of the problem because they could be seen to be in a power relationship with the client, we talk about working in partnership and of course that's what we should be doing, but we could be paying just lip service to that.'

If responding to discrimination to ensure the continuation of fair rules and procedures is a measure of liberal equality, then such responsiveness should form part of the overall professional practice approach to ensuring equal opportunities. These accounts suggest

responses are, however, haphazard and uncertain as these accounts doubt the core principles upon which equality in health care supposedly rests and is guaranteed.

4.3.3 Equal Opportunities and Access and Rights

In these competing narratives, there is then an explicit challenge to the dominant discourse of liberal equality. This discourse proposes reliance upon fair rules and opportunities and implies these will ensure equal access and treatment. These competing accounts challenge this directly. This is perhaps unsurprising, as these narratives have already indicated there are other mechanisms at work for allocating resources, as in the use of labels and stereotypes. These unfair mechanisms were evident in discussions of client's needs and choices. These discussions reinforced those previously examined in section 4.3.2 on discrimination, where examples of limited access were both implicit and apparent. These competing accounts challenged and questioned the liberal assumptions of equal rights and access more so. Sharon, a student health visitor, argued that equal access was an illusion,

'The inverse care rule does exist' which she argued was reliant on available resources and 'an attitude of the deserving [.] If it's a respectable household and they're respectful and they do as they're told, and you're more likely to be offered that access.'

Jackie, a health visitor student, had already spoken about how 'everyone had the right to the same service but it doesn't happen because of all this categorising and stereotyping.' She continued to describe how this form of surveillance impacted on access to services, as she said,

'They may be struggling and they may well be harming their children and not asking for help because they don't know how to, or not asking because their child may get taken away, and of course the reality is they're almost right, they are more likely to come in, the social workers, so they keep it secret. So the needs are there but we're not able to address them, so the service is not equal.'

Georgina, a practice educator, talked of how equal access was an illustration of how equal opportunities was intertwined with another dominant theme, that of respecting an individual's choice to use services.

'This is why equal opportunities on their own aren't enough, you need equal access, equal treatment, but at the same time, obviously people do have a right to chose and we've got to respect that. But equally, there could be barriers and blocking them taking

up their rights and we'd want to make sure to remove those as best we could. [.] We haven't got equal opportunities and I don't think equal opportunities are enough, we need equal treatment, equal outcomes, I mean that may be very idealistic but that's what we should be working towards.'

Penny, a community psychiatric nurse, was equally sceptical about access and rights to health care when she said,

'The reality is that some people don't fit in and there is always a norm but then I don't know how you would set a service up to be that sensitive? I think it is an attitude thing, people who work in the service and those who access it [.]that needs a huge conceptual shift and will take ages.'

Kathleen's narrative offered a particularly good example of how access, rights and needs came together. She drew upon a description of the area in which she had previously worked to demonstrate how different clients had different access to her, as part of the health visiting service. This underlined her general discussion on the limited access some clients had to a health visiting service. She said,

'Yea, this place is a very, suburban area and its a very, I don't like to use the words, but it is rather affluent, I haven't seen any deprivation here whatsoever and I've come from working as a midwife in another place where we get a very high mix, ethnic mix, social class mix. Whereas I find here, it's mainly middle class families that we're looking after. I mean, in the city, it was survival and literally we weren't going in to see the families, we were going in to see that the children were okay, there was no such, I don't remember a health visitor ever giving weaning advice or a mother ringing up about sleeping, it was about the benefits that they needed, the crises that they were having with their partners, their family, eviction orders or whatever, it was never bread and butter health visiting as I see here [.] what I've heard called bread and butter health visiting, sleeping problems, teething problems, coping with motherhood problems but rarely social problems.'

The construction of 'bread and butter health visiting' as opposed to a 'real' practice relied on the presence of certain indicators of difference and need, including poor housing, low income and unstable relationships. This extract demonstrates how competing accounts are sometimes tightly intertwined with a liberal discourse. Kathleen still drew upon liberal discourses of equality, with her concern to promote access and ensure equal treatment for the most needy. Yet, at the same time, she remained sceptical of the promise of liberal equality with its reliance upon the suppression of, or indifference to these inequalities or social problems. This ambivalence towards liberal equality is further compounded when she added,

'[We] Give them advice and support, but are we really helping? Yes we're helping their problems but we're not changing society that they live in [.] if you look at who's in power, it is a very white middle class well educated group [.and] there lies part of the problem, the majority of the problem, how do we change that?'

These accounts reveal levels of scepticism and challenge towards claims of equal rights and access which contest and displace a liberal equality discourse. Together, these competing narratives, and those accounts I defined as contradictory, question the continued salience of liberal equality.

A re-interrogation of the community nurses' narratives has revealed an enormous degree of complexity and diversity, expressed through contradictory and competing stories. Together, both sets of accounts construct both an ambiguity and ambivalence towards liberal equality. The contradictory stories were more vague in their use and rejection of a liberal equality discourse, whilst the competing accounts were both more decisive in refusing to endorse this discourse. Together, this produced more provisional stories of equal opportunities. These were stories that undermined and disrupted and displaced dominant liberal discourses of equality. These narratives, therefore, appear to leave equality on very uncertain grounds.

These stories seem to imply that the discursive construction of liberal equality is being displaced through confused and indecisive talk of equal opportunities. This confusion could be argued to constitute a cultural inertia and a status quo that protects the nurses' interests. This would suggest serious limits to equality in community nursing. However, confusion and bewilderment appear to be rather insecure grounds for maintaining a status quo as maintenance implies a degree of effort. As Cockburn (1991) argues, cultural hegemony has to be worked at, and there is no evidence of this effort in this chapter, or of the nurses' sustaining professional interests or pursuing similar ends. I would argue that if that work is present in these narratives, it is both far more haphazard and uncertain and, therefore, potentially more provisional than previously considered.

A further interpretation would be to argue that this talk amounts merely to confusion that is incapable of generating any meaningful political action or change. These reasons would also suggest that there are serious *limits* to equality in health care. However, I argue to the contrary, as I propose that these expressions of contradiction and competing

versions of events are not incapable of producing change, nor are they the result of vested interests protecting the status quo by choosing to ignore or failing to engage more fully with liberal equality. Rather, these stories are generated through that engagement. It is the inherent limits of liberal equality and its associated promises that are fully evident in these narratives.

I recommend an alternative interpretation of this diversity. I argue that these diverse and complex narratives displace and disrupt liberal equality discourses, and in so doing, reveal the *possibilities* for equality in health care. I argue that the ambiguity and ambivalence found in the contradictory and competing accounts expose possibilities for equality and a way forward beyond the impasse of liberal equality. The evidence for this is to be found in this chapter. This has shown that the discursive constitution of equal opportunities is contradictory and uncertain, not always suppressing, but sometimes embracing and invoking difference. Furthermore, competing accounts reveal scepticism and challenges that contest both liberal equality and the perceived hegemonic hold of nursing interests. Together, these accounts revealed how nurses actively struggled with recognising difference and attempted to resist or subvert the assertion of certain forms of difference, especially those represented as static stereotypes. These struggles are indicative of the inherent limits to liberal equality, as it is discursively constituted within community nursing.

4.4 Conclusion

By deconstructing and re-interrogating equal opportunities in these narratives, I have revealed the nature of these diverse accounts. I have shown that equal opportunities are discursively constituted by, and discursively rework liberal equality discourses into more sceptical, contradictory and inconsistent accounts than conventional modern accounts would have. Therefore, in its use, the discursive effects of a liberal equality discourse are far more complex and diverse. This produces a local and specific use that contests not only the assumptions of liberal equality and those of an equitable professional practice or health service, but also questions the unity or hegemony of vested interests sustaining a status quo. However, the processes through which these particular narratives develop remain less evident. It is these processes, which account

for the *presence* of these complex and diverse stories of equality that will be examined next.

In Chapter Five, I undertake this work, by demonstrating how these diverse accounts are contingent upon a number of various and competing selves. These selves are invoked during discussions of equal opportunities and practice. I argue that how the community nurses position themselves within these narratives is critical to an understanding of equal opportunities in health care. Together, these stories of equal opportunities, and the discursive constitution of selves, provide possibilities for practitioners to begin to conceive of equality in health care in different ways. In conclusion, I argue that as a result of these findings equality is left on very different grounds from those inherent to modern liberal discourses. These grounds are compatible with a postmodern emancipatory political project in community nursing and the possibilities for its inception are discussed in Chapter Six.

CHAPTER FIVE

CONTINGENT SELVES

5.1 Introduction

Thus far, I have shown that accounts of equal opportunities co-exist and simultaneously endorse and challenge liberal equality. My aim in this chapter is to develop this analysis by considering how these diverse accounts arise and how talk of equal opportunities implicates the nurses' own personal and professional sense of self. In so doing, I utilise the postmodern and poststructural concept of the decentred and destabilised self, as this allows for an examination of diverse subjectivities and identities. I propose that these narratives or stories of equal opportunities are not reflections of the intentionality of unified subjects. Rather, these stories are contingent upon sets of discursively constituted selves. In telling these stories of equality, and engaging with a liberal discourse, the community nurses are positioned and position themselves in various and particular ways. They draw upon and construct complex professional *and* personal selves and these are selves that are embodied. These identities are continuously invoked and more importantly, *interact,* as these stories of equal opportunities are told. The community nurses actively choose and/or reject and creatively rework these subject positions, constituting their own identities and subjectivities, as well as these being constituted by the range of discourses found in community nursing. Therefore, the nurses are both the site and subject of these discursive struggles (Weedon 1997). It is in these struggles and interactions that these selves emerge. This produces the coherent, ambivalent and ambiguous accounts of equal opportunities seen in Chapters Three and Four. I conclude that these selves are highly significant as they reveal the different grounds from which to understand talk of equal opportunities.

The chapter is divided into three sections. I first outline the postmodern concept of subjectivity and identity and the relationship of this fragmented self to discourse. I then demonstrate how particular selves reinforce the coherence with liberal equality found in Chapter Three, *and* the ambivalence and ambiguity I discussed in Chapter Four. The range of selves depicted in this chapter is defined from the community nurses' implicit and explicit references to variously positioned selves. I explore two principal categories

of these selves, namely *professional and personal* and show how these are contingent upon each other. This contingency reveals an interaction that produces a range of complex subject positions taken up or rejected by the nurses. Finally, I argue these selves are *embodied selves*. This reveals the significance of gendered, classed and racialised bodies and how talk of these selves embodies talk of equal opportunities.

5.2 A Postmodern Self

As I discussed in Chapter Two, the modern liberal humanist conception of the self and subjectivity is conceived of as an individual subject who is the source or origin of meaning. Inherent to modern conceptions of the subject and subjectivity are qualities of a universally fixed, coherent and unique 'essence' or human nature. This essential self is transcendent and ahistorical, abstracted from bodily or emotional concerns and, therefore, capable of rational thought and action (Flax 1990, Weedon 1997). However, poststructural theory proposes the displacement of this modern subject. In place of fixed and unified essences are socially and culturally produced subjects, identities and subjectivities. These subjectivities and corresponding subject positions and identities are discursively constituted in broader discursive fields through contradictory and competing discourses. Thus, the self is socially and historically variable; this is the fragmented self, made up of diverse and plural identities and modes of subjectivities. Weedon's definition of subjectivity is useful here:

'Subjectivity' is used to refer to the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world.' (1997:32).

This view of the subject's sense of self is experienced in a social context where language and culture give meaning to experiences and identities. This fragmented self is both the subject of and subjected to discourse. In order for a discourse to achieve control or dominance, it must make appeals and recruit subjects to particular subject positions where individuals adopt identities. This post modern or, more accurately, post structural view of the subject is epitomised in Foucault's work. His genealogy of the modern subject aimed to show how the subject came to be constituted and inscribed through discourses and subjected to disciplinary technologies of surveillance. For example, these technologies of surveillance governed sexuality, madness, criminality and the

docile subject, who became the object of the clinical gaze (Foucault 1976, 1979a, 1979b). However, a view of the subject as defined by discourse implies a lack of agency. Indeed, many feminist critics have either rejected or remain sceptical of Foucault's critique, seeing this to be a complete rejection of subjectivity and agency (Hartsock 1990, 1996, Benhabib 1995). I do not subscribe to the early Foucauldian notion of agency. I concur with those feminists, and in particular, Sawicki (1991) and Weedon (1997), whose use of Foucault's later writings allows for a particular conception of agency (Foucault 1986, 1988). Foucault later argued for these 'technologies of the self,' when he spoke of the,

'Intentional and voluntary actions by which men not only set themselves rules of conduct, but also seek to transform themselves, to change themselves.'(1986:10).

As Weedon argues, agency is to be found 'in the social interactions between culturally produced, contradictory subjects' (1997:176). This is a poststructural subject who is neither fully autonomous nor fully determined, neither the originator of discourses and practices which constitute its experiences, nor fully subjected to them. As Sawicki (1991) states, this is a subject who is,

'A critical subject, one capable of critical historical reflection, refusal and invention. This subject does not control the overall direction of history, but it is able to choose among the discourses and practices available to it and to use them creatively. It is also able to reflect upon the implications of its choices as they are take up and transformed in a hierarchical network of power relations. Finally, this subject can suspend adherence to certain principles and assumptions, or to specific interpretations of them, in efforts to invent new ones.' (1991:103).

These accounts of subjectivity and agency are compatible with feminist concerns, indeed they contain many similarities with a feminist politics of consciousness–raising (Sawicki 1991:104, Weedon 1997: 33). Feminism therefore concurs with the post structural view of the individual as the site of competing and conflicting forms of subjectivity. Individual subjects are seen to give meaning to experiences according to pre-existing systems of language and meaning found in discourses. These systems of statements or discourses shape their ways of thinking and the subsequent positions with which they identify structure their sense of themselves and their subjectivity (Weedon 1997:32). As Burr (1995) argues,

'Who we are is constantly in flux, always dependent upon the changing flow of positions we negotiate within social interaction [.]Our subjective experiences of ourselves, of being the person we take ourselves to be, is given by the totality of subject

positions, some permanent, some temporary, and some fleeting, that we take up in discourse.'(1995:146)

There are many forms of subjectivity available, variously privileging rationality, science, common sense, superstition, religious beliefs, intuition and emotionality (Weedon 1997). However, not all forms of subjectivity are equally accessible as relations of power and historical social factors govern approved subject positions. Moreover, dominant positions include those historically approved positions prescribed as the exclusive domain of certain social groups. This is evident, for example, in the subject positions governing notions of citizenship and equality of opportunity in education or employment, or in the way the community nurses took up the position of a professional self. (Weedon 1997:92). Thus, certain groups benefit from powerful institutionally located discourses. This implies that other competing or oppositional discourses are less powerful.

Exactly how the community nurses come to take up subject positions and associated modes of subjectivity, prescribed within certain discourses, is especially significant. Feminists, like Weedon, argue it depends upon the success of a discourse in appealing to an individual's interests and securing their allegiance. Furthermore, these appeals are never final but always open to challenge and change. As she states,

'The political interests and social implications of any discourse will not be realised without the agency of individuals who are subjectively motivated to reproduce or transform social practices and the social power which underpins them. Individuals can only identify their 'own' interests in discourse by becoming the subject of particular discourses. Individuals are both the *site* and *subjects* of discursive struggle for their identity.'(Weedon 1997:93)

As I briefly discussed in Chapter Two, discourses operate as historical, social and institutional structures or frameworks of meanings and are always in process. They are continuously contested and need to be defended and legitimised by recourse to particular bodies of knowledge. This local contestation occurs within discursive fields and the power to control these fields relies on claims to knowledge. This is knowledge embodied not only in writing but also in disciplinary and professional organisations, in institutions and in social relationships (Scott 1988). Discourses work as systems of meaning that constitute conflicting versions of reality and interests, often making appeals to essentialist or common sense explanations. This can be seen in the way some

community nurses defined the presence of discrimination through recourse to common sense accounts of the 'naturalness' of prejudice as being 'in all of us'. The most dominant discourses, like those of liberal equality, for example, have firm institutional and material bases in law and in welfare. These positions help maintain, defend and reinforce particular forms of knowledge and powerful interests. Competing or 'reverse' discourses are therefore engaged in a constant struggle to win an individual's allegiance as these accounts are often marginalized, rendered less effective by being defined as deviant or problematic in some way (Weedon 1997). For example, liberal discourses of equality remain prevalent by appealing to dominant, common sense notions of individual fairness or the naturalness of inequality, more than, say, radical accounts of equality. These latter discourses are marginalized, defined as problematic and in the process rendered less viable in their attempts to challenge oppressive relations and structures.

The positioning of various discourses as dominant and marginal involves power. This is evident in the way certain social institutions, modes of thought and forms of subjectivity are more available and are readily linked to social structures and practices in society. For example, in health care, Foucault (1976) argued medical discourses achieved their dominance through particular forms of knowledge concerning disease and pathology. The dominance of medicine meant other competing discourses, like nursing for example, become engaged in discursive struggles to legitimise their versions of the truth (Fox 1993, Lupton 1994, Nettleton 1995, Scambler & Higgs 1998, Crowe 1998, 2000).

Similar processes can be found in politics and welfare state activities. I have shown how liberal democracies presuppose an autonomous, individual or self. Like medicine, the activities and practices of governments and welfare agencies are seen to constitute subjects through techniques and practices of experts. Governments and welfare practitioners collect, collate, classify and calculate data, producing institutional practices that reinforce surveillance techniques. These activities are complemented by individuals engaging in practices of the self, shaping their own lives as well as reacting to the influences and actions of others. This 'cultivation of the self' is a social practice that gives rise to relations and institutions and modes of knowledge (Foucault 1988). This is evident in expert techniques of individualisation and is seen in the expert's need, and an

individual's need, to know one's self (Bloor and McIntosh 1990, May 1992, Armstrong 1983, 1994). The later Foucauldian self is a self both constrained and enabled by discursive practices. This produces an account of the individual far removed from the assumptions of the unified subject at the centre of liberal humanism. This is the same self at the centre of modern political theory, a political subject as an autonomous, rational and independent self, endowed with sovereignty and rights and freedoms. This is not the self I examine in these narratives.

Indeed, in this chapter, I displace any notion of a unified modern liberal self at the centre of these community nurse narratives. Instead, I develop an analysis that reveals a range of diverse selves. I argue that two principal categories of *professional and personal selves* are continuously invoked. Moreover, these selves, far from being separate, are highly contingent upon each other and *interact* in ways that are extremely significant. It is through these interactions that both the complex mix of identities with corresponding modes of subjectivity is revealed, and the range of narratives is understood. Within *professional selves,* there are a number of distinct positions; these include, a more formal *practitioner self* and an *impartial ethical/ moral self* and a reflective *or intuitive self.* These positions do not merely reflect but actively constitute various aspects of 'being a professional community nurse', which, as I have argued previously, also assumes 'being egalitarian'. Therefore, an examination of these professional selves reveals how 'being professional/being egalitarian' constitutes and is constituted by talk of equal opportunities. However, these selves cannot be understood without an examination of the personal selves they both generate and attempt to suppress.

Within *personal selves,* I reveal a similar range of distinct positions adopted by the community nurses. These include talk of *concealed and dangerous selves* and a *partial ethical/moral self.* These selves constitute 'being personal' as a set of positions that are more subversive than the intuitive professional self for example. Even though similar qualities of experiential, tacit knowledge and emotions are invoked, these are defined as disturbing and challenging in relation to the development of egalitarian care. These difficulties are derived from, and are to be found in, the interactions with professional selves. The attempts to suppress, negate or legitimise and authorise these selves produce

struggles from which these complex personal and professional selves emerge. Furthermore, extremely important to this mix is the way both sets of professional and personal selves are *embodied.* These diverse, embodied selves reveal the significance of classed, gendered and racialised bodies that overlap and intersect with these professional and personal selves. It is these selves, with the resultant narratives of equal opportunities and anti-discriminatory practice that constitute the different grounds from which a postmodern emancipatory project can develop.

5.3. Professional Selves

Professional selves were drawn from a dominant professional discourse. The presence of a professional community nursing discourse was noted in Chapter Three, where I argued a professional community nurse role, with associated core qualities and skills, was constructed. As a brief reminder these included the following attributes; being fair and equitable, able to provide holistic, sensitive and reciprocal care and able to promote choice, autonomy and the empowerment of clients. Furthermore, I argued when community nurses drew upon these dominant discourses in constructing their accounts of equal opportunities these tended to be coherent with liberal equality. Within these narratives, a professional, egalitarian self was invoked as an individual concerned with 'being professional' over matters of egalitarian care.

5.3.1 A Practitioner Self

As I established in Chapter Three, professional care is compatible with the pursuit of equality in health care. However, Frances, talked of how equal opportunities was part of not just *a* professional practice, but *her* professional practice, and she demonstrated how a professional practitioner self, as the 'we' in her narrative, was intrinsic to this work,

'It's part of your work, you know, because we're targeting needs [.] We're not showing any prejudice to anyone, we're not discriminating on colour, sex, class, anything like that [.]You know that's the main crux of health visiting [.] You're visiting everyone and giving everyone the same service.'

Chris defined equal opportunities as a process that was her responsibility, as a professional. As she spoke of how she would instruct her student to undertake this

responsibility, she reinforced some of the core values and principles of practice outlined earlier,

'I think it's up to us as professionals to make it easier for them [.] These are the ones we have to advocate on their behalf, [.] By treating all clients, not only equally but also being aware that they're individuals and using all her professional knowledge and treatment, when I say treating all clients the same, it's using her professional knowledge to assess the situation, so she's giving them all the same information.'

These professional selves also appeared throughout the more contradictory narratives and Laura's story is a good example of this. Her professional practitioner self was evident when she offered an example of her work with a particular client. Here, she voiced fundamental principles of a professional practice,

'One of my clients is Somalian [.]There's a multitude of problems, she's a lone parent, she's a victim of domestic violence, she's got four or five children. The flat where she lives is on the top floor, very sparse, but she just gets on with it, because she feels that's her lot. So the issues around that are trying to give her some sense of self worth, going in with the advocate, finding out where she's at, if she's happy with her life, making sure the children are as healthy as possible and see what other resources I can tap into and see what else she needs [.]You need to make sure people are aware of what services are available.'

She continued, using these principles of professional practice to position her self in this work.

'From my point of view, as a community practitioner, you can't screen people all the time, you can only lead them so far but then you have to expect them to take the lead themselves, so where it might be necessary I'll give them information [.] But I wont actually get involved in doing it for them [.]You can't do everything; otherwise, you spoon-feed them and then you're taking away their autonomy by doing that.'

Together these extracts highlight key features of a professional practitioner as a subject position available within a professional community nursing discourse. This is evident in the references to holistic, sensitive and reciprocal care and the expressed concerns for client autonomy and empowerment. This is a professional practitioner self both directly referred to and more indirectly implied when discussing equal opportunities and practice. This self was invoked more often than not with illustrations of direct examples from their own practice. This served to demonstrate their own affiliation with equal opportunities as professionals. Thus, talk of *liberal equality* becomes the means by which professional practitioner selves are invoked and reinforced. This is a subject position also evident in both professional and educational discourses, with talk of reciprocal or more egalitarian client-nurse relationships. However, alongside this

position was a more intuitive professional that could draw upon her own subjective feelings and experiences and incorporate these into the role of the professional community nurse.

5.3.2 An Intuitive Self

Community nurses spoke of equal opportunities as activities involving the use of a professional self but alongside, and complemented by, their personal intuition, values and beliefs. This is a nurse who draws on education and professional practice discourses but together with their own experiences. Leanne argued equal opportunities was a professional practice that involved her own views,

'I really believe that you should treat everybody as equal and that it is not to do with work, that it's to do with my own thinking, my own personal value if you like. Even if I wasn't a health visitor [.] I would feel that people should be treated [.] As equals, you should respect people, you should offer them the best you can give, and which ever way they are, wherever they come from, whatever they do.'

Shirley, a health visitor practice teacher, commented on how different personal life experiences contributed to a professional self:

'Health visitors who've had the same training will be different because of life experiences, the way they've been brought up.'

The affirmation of the personal was to be made from combining professional qualities or selves with these more personal attributes or previous life experiences. This was further alluded to when Marion talked of how district nurses could develop sensitive care. This involved a mixture of insight and experience, together with natural instinct. This was argued to complement a professional practice and Marion referred to these qualities when she stated,

'I suppose you've got to have some idea yourself and you've got to be that way, or have some knowledge, or at least recognise within you [.] I think some people need to be jogged and say, 'have you thought of,' and other people, it's sort of like natural instincts or abilities.'

This professional intuitive self was also constituted in relation to a moral identity, as seen in the invoking of an impartial moral and ethical self. This was a self that talked of equal opportunities as involving impartial, moral judgements and ethical decisions. This

entailed the delivery of care in the context of scarce resources, with one of those scarce resources being the nurse herself.

5.3.3 An Impartial Ethical and Moral Self

The accounts of promoting equal opportunities in practice, and more broadly within the NHS, was illustrated through talk of access, rights, equity and fairness. This was evident in both Chapter Three and Four. This talk emphasised ideals of impartiality, neutrality and apparent objectivity, together with critical talk of liberal equality's failures to guarantee equal access, fairness or responsiveness to different needs. However, in using these stories, the community nurses conveyed not only an understanding of equal opportunities but also constructed accounts of their selves as both being ethically and morally fair and just, despite constraints in their day to day work. This involved the constitution of a moral identity; this was a self that made judgements and decisions about care, based upon ethical and moral principles. In the context of these professional selves, this encompassed an objective, rational stance regarding the distribution of finite resources and the delivery of health services.

Sevenhuijsen (1998) argues the task of *modern* universalist ethics, or an ethic of justice, has been to argue for the formulation of higher principles with which to judge or decide in cases of conflicting interests, rights, and opinions. These principles or rules are then applied to specific cases. Key concepts of a universal ethics include equality, autonomy and justice and are guided by the application of rules and principles of neutrality, impartiality, abstraction and objectivity. Sevenhuijsen argues, re-distributive justice is underpinned by a notion of universal ethics which, as we have seen in Chapters Three and Four, the community nurses' narratives made reference to. This was evident in their need to develop and use criteria with which to distribute scarce resources, even though this compromised care or provoked conflicts between rights and obligations.

Janet's narrative was a good example of these dominant arguments for the efficient and effective use and distribution of resources. She had previously expressed contradictory views when she had spoken of equal opportunities, now when talking of how the NHS generally should respond to need, she argued 'In theory yes, but not in practice[.] We

have limited resources.' She went on to give a fuller example, implicating her 'self' in this position,

'Where do you draw [the] line to health care? [...]Somebody could perceive cosmetic surgery as a type of health care, it might be extremely important to them, the way they look, but can you justify the expense of having an operation at the cost of not providing basic services [...]That is what we're here to provide, the care for that particular client's needs and so give the best possible care within the resources.'

Working within resources meant having criteria with which the professional 'we' or she could judged and decided who would receive care, as she argued,

'We don't ration, well when I say we don't, we have to go and assess what their needs are [...] What we do prioritise are the needs of somebody [....] So I suppose you are rationing yourself in that respect.'

Janet later developed this ethical and moral stance by insisting upon an individual's moral obligation to look after themselves and she made rationing legitimate by utilising both professional and economic discourses, as she said,

'Well I feel everyone is entitled to the best possible nursing or medical care that is available, within the resources. I mean it shouldn't be up to us to decide, regardless of whether we feel they ought to be paying for this or not, because after all the government has said in the past, a free health service for all. [.]But I still feel we have a duty to point out that this is costing the health service, the government, the taxpayer, X amount of money because of what you're doing here, you need to do this and this and this to improve it and you really need to take a bit of responsibility for your own health.'

Denise chose a very similar example to Janet, illustrating how she positioned herself with regard to resource issues. This was a positioning she achieved through the avoidance of judgements or decision-making and by legitimising constraints as fair,

'I don't think the NHS is a complete endless pit of money and it's difficult if you're talking about perhaps some form of plastic surgery, if you're talking about fertility [.] then you get these issues in the press about treatments, very, very difficult, sometimes I'm an ostrich [.] I mean do we want to be paying horrendous taxes and have everything?'

Sheena spoke of these issues as constraining her practice, but these constraints also compromised her practice,

'I think the problem is resources all the time, but otherwise we can do it, but you find sometimes, for example, like interpreters, I want to give people equal opportunities and because we haven't got the interpreter, sometimes you find yourself then using a member of the family and really they shouldn't be interpreting for them.'

The narratives demonstrate how the nurses positioned themselves within different discourses. To be professional is to conduct care work within an ethical and moral framework and yet there is a demand to be not only effective but efficient too. These pressures and constraints need to be made compatible and reasonable with 'being ethical and moral'. This was achieved best when they drew upon a professional discourse, which endorsed this form of universal ethics and where there were rules or criteria to follow. Beatrice, for example, made explicit reference to rules and procedures she used to decide the distribution of a scarce resource, like health visiting time. As she spoke, she reinforced a notion of her self as fair by using what were implied to be impartial, objective and neutral criteria to treat like cases alike, as she said,

'Two people who've got the same health problem and health need I think it shouldn't be on what class you are, what culture, what sexuality, what gender you are, it should be on the actual health need it should be based on. There's only so much money in the pot so they have to make decisions [.] We have criteria about whether people are active or monitoring and how active they are, i.e. how much of the service they get really. And then we have different levels of active, about whether a person, what a person is like, or their accommodation or their vulnerability and danger.'

Shirley explained how she delivered an equitable service and how, in turn, she had to make judgements and decide priorities,

'Taking the antenatal, when they're pregnant, they all get a letter saying how they can access me, which puts the responsibility back on them, with equal ops you would make sure everybody got the same time. In reality, some get more time than others. I think the other thing would be if they were new to this country they would get more time than say someone who knows, that's making judgements I know [.] You've got to make your own priorities, because when push comes to shove you've got to know in your own mind that you've made the best choice.'

Shirley made reference to the accountability required of all practitioners and she drew on the Code of Conduct and Scope of Professional Practice, discussed earlier in Chapter Three. This is a reminder that, in practice and in moral and ethical decision-making, the community nurse has a great deal of autonomy. Their day-to-day work is often invisible, as they work alone in practice and there is, therefore, a certain amount of freedom and potential for discretion and difference in service provision. Indeed, in an examination of district nurses' management of their work, Griffiths (1996) found the process of caseload management was ill defined and highly idiosyncratic. Therefore, the use of rules and procedures are seen to remove this ambiguity. For Laura, the use of

rules and criteria for deciding where resources go, reaffirmed rather than provoked moral compromise, as she stated,

'My priorities are the children. First and foremost I'm looking at the welfare of the whole family but I'm looking at the welfare of the children [.] Is there anything affecting, or stopping that child from growing, or anything that's stopping the mother looking after the child properly.'

The full force of an economic discourse can be seen in Jenny's narrative, when she argued that equal access was a desirable ideal in the face of scarce resources,

'It shouldn't be, but you can understand them being realistic. At the end of the day, we're skint most of the time and if you've got, you know, only one person needing that service, how can you justify it?'

These resource pressures meant that judging and deciding upon limited care tended to be defined as acceptable, both ethically and morally, and professionally. As Frances had previously suggested, 'We all tend to skim over a bit sometimes, just do the care and go.' Shirley agreed, 'You've got to cut corners sometimes that's reality.' This moral ethical self was compatible with a professional self and drew on a discourse of economic rationalism that endorsed the partial meeting of needs. Jenny described this as the 'reality' of practice, which allowed her to position herself as moral and just but also realistic,

'Half the time, it's like what you don't see doesn't hurt you, I can only deal with as much as I've got, so I don't want to know that's going on in the corner over there because I haven't got the time.'

Together, these accounts suggest the presence of a moral, ethical self, which is not only compatible with a professional self and liberal equality but is drawing on an ethic of justice discourse. This means there is a concern to deliver care according to impartial and objective criteria according to rational principles of economic efficiency and effectiveness. Even when moral compromises occur or where scepticism is evident, this discourse still forms one of the dominant influences in which a moral ethical self develops. Moreover, these ethical moral selves make appeals to both a political equality, concerned with human rights and equal worth, and economic equality, concerned with equal life chances, resources and welfare. As Phillips (1999) argues, the latter form of equality has recently receded and been separated from debates on political equality. Current equality debates now focus on accommodating difference but no longer

promise, or discuss, the redistribution of resources (Phillips1999:50). This shift in focus is evident in the nurses' narratives. In the broader context of the NHS and community nursing, these debates between political and economic equality have, until recently, been relatively silent. The current government agenda may alter this balance.

5.4 Professional and Personal Selves in Nursing - A Discussion

In these stories of equal opportunities, the community nurses invoke a complex set of professional selves. This revealed a professional, intuitive and moral practitioner, which together offered an account of professional selves as relatively unproblematic. These accounts reinforce, rather than displace liberal equality. These selves also appear to reflect the traditional sociological account of the professions. These were perspectives that positioned professionals as individuals who were skilled, educated, rational and objective. Being altruistic, beyond avarice and greed, these were individuals motivated by higher rewards, working in the best interests of others and ensuring they did no harm. However, as Witz (1992:40) argues, this static, essentialist and ethnocentric view of professional traits or attributes was radically displaced by a new critical theory of the professions. This was a view of professions as occupational groups concerned principally with power. This analysis identified how occupational groups utilised strategies of demarcation and closure to further their professional projects. This in turn revealed the gendered nature of the agents of these projects and the inter-occupational relations of subordination and domination (Witz 1992:68). This recognition of the gendering of professional projects is significant, in that it reveals the political nature of what were previously considered benign and neutral forms of organisation. This has produced an understanding of ' professions' as constructed through and by dominant organisational discourses imbued with masculine concepts of professionalism (Savage & Witz 1992, Halford et al 1997, Pringle 1998). Moreover, the general drive within nursing towards 'professionalisation' has endorsed this understanding (Witz 1992, Walby & Greenwall 1994, Davies 1995).

In nursing, this was a bid to secure a professional status and involved a series of strategies. This was especially evident at the turn of the century in the bid for state registration and training (Witz 1992:144). These nursing professional projects have

meant the adoption of rational, abstract, 'masculine' accounts of professionalism. By definition, these promoted a masculine project that excluded qualities culturally designated as feminine and made problematic any ambition to professionalise. As Davies (1995) argues, the uncritical endorsement of these strategies means a continued subordinate positioning for nursing, serving to perpetuate and reinforce it as an adjunct to the 'real' work of medical men (Davies 1995). This is an endorsement that creates a particular set of binds that nursing needs to address. As she argues,

'First, nursing aspires to be a profession when the concept expresses a gendered vision that is the denial of the feminine values of nurturing that nursing seeks to espouse [and] second, nursing aspires to be a profession when its own work is part of a gendered division of labour that helps sustain 'profession' for medicine.' (1995:62)

One response to this has been to revalue qualities of emotion, intuition and subjectivity. The demand is for the re-insertion of these values into concepts of professionalism, which is evident in the trend towards the 'reflective practitioner.' This is a practitioner who is encouraged to reflect and utilise subjective emotions and tacit knowledge (Benner 1984, Boud et al 1985). Thus, the interactions between the personal and professional have been intrinsic to a continuing debate within nursing.

Historically these 'personal' qualities were, of course, an essential part of being a 'professional' nurse. For example, in 1881, Florence Nightingale wrote 'What a District Nurse is to be' and talked at length about the character and qualities a district nurse must possess. These were women of education who were,

'Independent, enterprising, of indomitable pluck and self reliance, capable of training all powers to the best efficiency [This] combines the servant with the teacher [.] with the educated woman.'(1881:6)

These were qualities that continued to be valorised into the twentieth century. Merry & Irvine (1948) described the personal attributes of a district nurse as being more important than her professional attainments. She was to possess,

'Human understanding, tact, and a good sense of humour, and be able to bring cheerfulness and an interest of outside events to those who are sick or lonely in the home.' (1948:33/34)

Indeed, the extent to which these personal qualities underlined this work can be seen in the description of the district nurse visit, defined as far more than a clinical event. It was a social occasion, with nurses being reminded to ensure conversations were 'of the right

type, adapted to each individual patient.' These were seen to be of therapeutic value. Indeed, it was the duty of the district nurse to,

'Realise her responsibilities in this and to interest herself in matters outside her profession, which will bring fresh topics to her patients as well as recreation to herself.' (1948:44)

Whilst historically this personal self was seen as desirable, the requirements to be docile, servile, caring and selfless were later argued to reinforce the fit between a good nurse and a good Victorian woman (Davies 1980, 1988, Gamarnikow 1991, Witz 1992). These were qualities that reflected and reinforced nineteenth century dominant ideologies of femininity. As Witz argues, the enforced obedience and disciplined work meant that,

"The Nightingale philosophy had constructed a discourse of nursing that was a gendered discourse which placed the unique moral qualities of the woman-as- nurse at the centre of this discourse [.]Discursively the nurse and the woman were one and the same, whilst the qualities of a good nurse were those of a good woman" (1992:142).

Moreover, similar processes were found to be at work in health visiting. In her study of the role transition from sanitary inspector to health visitor, Davies (1988, 1995) has shown how the work of the health visitor was described, not in terms of the public world of work. Instead, this was a role defined with reference to the world of the private and the domestic and the health visitor's innate 'womanly qualities' (1988:57). Therefore, historical endorsements of *personal* qualities were far from neutral.

Consequently, valuing 'the personal' creates something of a double bind. These are selves to be suppressed and reaffirmed; yet, both these process reinforce the gendered positioning of nursing. These are similar gendered positions found in the different 'speaking positions' that Pringle (1998:221) identifies, when women doctors talk of their relationship to medicine. Within these narratives of equal opportunities, the personal selves who were invoked in relation to the professional rational selves were positions defined by the nurses as problematic. These were positions taken up by the community nurses, partly in response to and in conflict with these 'official' professional selves and it is this process and interaction that I examine next.

5.5 Personal Selves

These personal selves struggled with the dominant discourses of professionalism and education in particular. Personal selves invoked similar examples of life and work experience but these qualities were positioned as potentially more difficult and in conflict with the professional selves. In this struggle, personal selves were invoked both as a more concealed and dangerous self and as a partial or subjective moral and ethical self. Here we see identities and subjectivities formed in interactions with dominant discourses and selves to constitute identities that were considered more 'personal'. Thus, there was talk of being a woman and a mother and a worker, or of being political and having one's own values and beliefs, or one's own moral code. Thus, talk of liberal equality invoked not only professional but also complex and diverse personal selves.

5.5.1 A Concealed Self

For those more sceptical of equal opportunities as a professional practice, the intrusion of a concealed self was inevitable but more difficult, both for themselves and others. This was due to the cultural expectations of 'being professional' and was a phenomenon especially evident in health visiting. This implied the need for the suppression or indifference to a personal self. Jackie explained,

'Their own [other students] experience it comes up, and if you're in an environment where you've not got time to look it you deal with it[.] Perhaps it was my own stuff, I never felt safe to talk about how I felt about things, I don't know [.] To talk about ourselves, it was very much professional training on top of that and we're not going to look at all that, we are just going to do the health visiting bit on top.'

The bit on top was described as, 'How to be a health visitor, the professional bit' when in fact, Jackie felt strongly that her own experiences of being a mother and having children impinged on her work,

'Where we are and what we experience has an effect on what we do. There's this idea that you can go and talk to a mother say on breast feeding or postnatal depression, I mean quite a few people have struggles, me included, and I'm going to talk to mothers struggling, and I can feel it comes up for me, and you have to push it down [.] It's part of this culture of, 'we're not going to look at our reactions to people and the way we are and the fact that the way we are effects other people'. 'And we are just going to be professional' [.] That's the danger [.] That we think that we can, because you're dropping bits of yourself all over the place.'

More worryingly, this suppression or indifference to the personal was apparently reinforced through the education process. Jackie explained how she felt it was impossible for education to prepare practitioners for work in diverse areas and this was compounded by lecturers' reluctance to deal with the personal. She argued,

'I think the course assumed you had the skills not to get drawn in and not to use stereotypes [.] If issues like this came up we couldn't' go into it. The tutor would say there is no time which I found frustrating and said it at the time, because you know it's vital, you could feel all this tension rising up for people but there wasn't enough time.'

Moreover, this concealed personal self often collided with the professional practitioner being endorsed. This was especially so, again in health visiting, and was considerably difficult for some. Mary, a student health visitor, found her personal self at odds with the expectations of how to be professionally. She described this professional self as both gendered and classed and implicitly racialised. As she had previously said,

'I think what we are going to get rid of is the middle class right, the twin set and pearls [.] And I still feel its kind of 1950's woman, but I think it's the professional health visitor, and when I came in to it I didn't realise what I was letting myself in for really.'

This also involved certain expectations about the way she looked, which she also found difficult:

'I often feel that I am preparing for a performance everyday. I thought, oh good, health visitors wear jeans, I'll just wear any old clothes, it would be really good because the clients don't really care what you look like. But around here they expect you to look like you have just come out of a John Lewis' shop window.'

For Mary, these difficulties in accepting a dominant cultural persona were possibly compounded by her previous experiences and her own views on how she practised. She spoke further about how, 'myself comes into it as well, my own values' and how the area in which she worked, and client' expectations, shaped her interactions and care. She said,

'I am a single parent myself, I am very conscious not to divulge that round here. If somebody feels that in the conversation, then will I stop to say I understand? They wouldn't want me, they'd want my CPT because she goes to church.'

For Chris, an experienced district nurse, 'being professional' also entailed a performance and was an indication of the different position she took up in relation to clients,

'You have to adjust psychologically or mentally each time you approach a doorway, or you know, ring a doorbell. You're a different person, it's almost like being an actress.'

These debates between professional and personal selves show the two sets of selves to be intimately linked and contingent upon each other. The professional self is drawn from a professional nursing discourse identified in Chapter Three. These personal selves are less easily defined but their formation is in part both an endorsement and a resistance to this dominant discourse. Furthermore, these concealed selves related to aspects of the personal, the nurses and I have referred to as being, or were implied to be dangerous. These were selves thought to potentially threaten equality in health care, as they were implicated in perpetuating oppressive care and reinforcing inequalities.

5.5.2 A Dangerous Self

The community nurses talked of how they were implicated in making discriminatory judgements about their clients and the delivery of care. This meant that they, and nurses in general, were described as culpable of oppressive care and potentially active in perpetuating discriminatory practices. This construction of dangerous selves was drawn from those essentialised and common sense discourses discussed in Chapter Four. Here, an individual's background, their families, their friends were in part implicated in the construction of these dangerous selves. When Kathleen, a health visitor student, argued that the presence of individualised practices was indicative of a dangerous self, she stated,

'The type of service and the type of care you give is entirely, it's a very individual thing, but you know you might think well, you know, I don't actually like that person so I'll only spend two minutes with them and I'll do the basics and then I'm out.'

Consequently, those community nurses who acknowledged these dangerous selves as questionable, talked of the need to 'keep checking' themselves, or confronting prejudice or discrimination, or their personal selves. Denise, a health visitor practice teacher said,

'I think you have to learn to face it, you know try, try and try and get through it really, very, very difficult to totally get rid of it, but you must, you must keep facing it and looking back and thinking [.] Trying to sort out your feelings, to come to terms with your own feelings and actually deal with it [.] Keep facing it, looking at it as it creeps, it does creep in.'

Mary's discussion demonstrated the degree of interaction and movement between the various selves when she argued prejudice could be hidden. Here she invoked and suppressed this dangerous personal self while reasserting a professional self, she said,

'I'm sure I'm prejudiced sometimes, but it doesn't show. I think that is what you can get rid of, is the showing of it and you should be able to deal with that patient [.] You might think it, but not allow it to show and I think that's when professionalism comes into it.'

She also suggested that working with different clients produced a different practice and could produce different care, she implied this was not quite acceptable when she said,

'It is not just saying you will fit into a box, but it's really difficult, but you do change according to whom you are addressing.'

An interesting strategy was to draw on both professional and personal selves and acknowledge how these become a dangerous self. As Chris, a district nurse practice educator, stated,

'I think as individuals we say things, or we pre judge, or we stereotype, whether it's our colleagues or relatives or friends, patients, what have you, it's in us and what we have to be careful of, is it doesn't encroach on our practice. I think this is when it becomes dangerous, or the individual becomes dangerous, you know you have to be professional and be open minded at all times.'

The discursive constitution of these dangerous selves emanates, in part, from the racist discourses of essentialised differences and 'otherness' that Hall (1990) and Rattansi (1994) discuss. These selves also seem to be derived from discourses of care that positions care as potentially more controlling and damaging to clients. However, the commitment to help, or meet the needs of clients requires caring practices that comfort and empower vulnerable others (Benner 2000). When these needs cannot be met, or when caring becomes more concerned with control than comfort, then the nurses faced moral and ethical dilemmas.

5.5.3.A Partial Ethical and Moral Self

The relationship between caring and ethics is seen to be a central feature of nursing practice (Leininger 1981,Tschudin 1992, Benner et al 1996, 2000, Bowden 2000). Nursing scholars have extensively debated this relationship and the use of 'an ethic of care' as a more appropriate framework for explaining and understanding nursing ethics. An ethic of care places an emphasis on empathy, intuition, compassion and commitment, as well as recognising that care and dependency is central to all human

relationships (Gilligan 1982, Ungerson 1987, Toronto 1993, Sevenhuijsen 1998). The impartial moral and ethical self discussed previously, was drawn from an ethic of justice, where reason and impartiality are assumed to act as guarantors of universal principles (Mouffe 1994). Conversely, the ethic of care is an ethics based on the experience of care. This is a theory of ethics rooted in receptivity and affiliation, where principle moral categories are care and responsibility. This reverses the principles of rights and obligations of Kantian contractual theory, where moral problems are presented as a conflict between abstract rights and rules (Mouffe 1994; Sevenhuijsen 1998). An ethic of care deals with conflicts of responsibility in specific contexts. It is a position that emphasises the balancing of one's own integrity and caring about and for others. An ethics of care is, Sevenhuijsen (1998:51) suggests, 'a particular manner of perceiving and deliberating' which refuses to separate needs from people. It is position that is attentive and open to others and recognises the centrality of care and dependency within human relationships.

In the community nurses' narratives, these aspects of an ethic of care were evident when the nurses spoke of their concerns, commitment and personal responsibility towards their clients and towards developing or sustaining a fair and just health service. They spoke, for example, of establishing a rapport or a relationship with a client and their family. As health visitor practice teacher Jan, stated, establishing this relationship meant putting, 'a lot into the first contact visit.' Chris, a district nurse practice teacher, spoke of her responsibility of doing something for clients beyond clinical care, 'you go speak on their behalf or you [.] write a little note to take to the doctor.' More specific to equality and ethics in health care, Chris implied compassion and commitment when she argued emphatically that equal opportunities meant that, 'we can't just fold up our arms, that would be ridiculous [.] Then you'd really have a two tier society.' She reconfirmed her moral position on this when discussing how this indifference would reinforce discrimination, she said,

'It would mean I'd go down the road and just because she hasn't got carpets on her floor or what have you, my care would be less, then no that would be wrong, that would be morally wrong.'

Further expressions of empathy and compassion were evident in the practitioner's recognition of how vulnerable their clients were. As Brenda, a district nurse practice

teacher said, she used, 'intuition, life long experiences, looking at the situation' to respond to different needs. She identified one group who were especially susceptible, she said,

'The elderly who aren't able to speak for themselves I think, who certainly, some of them are frightened, some are not able to, and some don't even know what they're entitled to.'

Or as Leanne, a health visitor student, commented several groups were vulnerable, and often experienced discrimination, as she said,

'They're frightened, people are frightened about getting old, they're a forgotten group really, and the gay group just ignorance again, it's not the way its supposed to happen, they're breaking the rules as to what a normal family should be really. So, they're stigmatised.'

This recognition of vulnerability and expressed commitment and compassion to care for those less powerful was evident in Beatrice's story of her work with refugee families. She talked of the particular needs and vulnerability of this group. She spoke of how seeing these people raised ethical and moral issues,

'The whole family, they often come in bits and pieces really, you know one parent and one child and the rest join them. A lot of their problems are that they have been split up and they have had to leave a crisis [.] I often find it disturbing [.] some times you go to them and you don't realise the situations they have had to leave behind and you just think oh gosh, and you don't realise and they just come into clinic and nobody has a clue. There are a lot more hidden things.'

However, these differences also provoked more personal, ethical dilemmas over caring, especially when their own vulnerability was exposed. This is evident in Jayne's account of her visit to one of her clients. She said,

'I'd gone into a family about a year ago where the father was high on drugs, the baby was propped up, the mum was scolding the toddler and I felt quite threatened by the man because he was very high, trying to find the child's book and I think, should I have mentioned the, it's going to make this man cross really, do I aggravate things and actually put myself at risk here?'

She continued, 'the mother was just chatting to me, wasn't even watching baby who could choke to death, so you know do you say, it's dangerous, and then I had to ask her did she think it was dangerous and she said oh you know [.] I mean it's hard for the baby who was in a chair, it was 2 weeks old and it had a bottle propped [.]Do you want to rush in and out, and do a developmental check and not ask too many questions?'

Many community nurses expressed concerns over the more personal ethical dilemmas they experienced in the context of scarce resources, which was seen to compromise the care they could give. As Claire stated,

'You could spend time with the patients, often that's a problem, you run and run out again, and you know Mrs so and so wants to talk, and you're running to a meeting and so, so it [more resources] would alleviate some of that stress.'

Further aspects of a partial ethic of care were also evident when the community nurses related their own philosophical views regarding justice. Though this may not constitute a definitive move away from an ethic of justice, some of the community nurses certainly challenged the assumptions of impartiality. This meant they positioned themselves in a more complex way with regard to this form of ethics. This positioning was less defined, but at times, resembled the use of an ethic of care discourse. Penny spoke of her own views and position on this and invoked racialised and classed identities as she did so,

'I don't necessarily think I have a right as an individual to have all my needs met by the health service [.] But I don't think there should be a huge difference between what I can access, being middle class, white, to someone who isn't middle class or white.'

Jenny argued for a personal moral responsibility to others when discussing her view of justice in health care,

'I believe very strongly in the NHS and it being what it was meant to be, and it being free at the point of delivery, and it being accessible to everyone, and I believe in everyone being able to get good health.'

There were community nurses who expressed concerns for others by taking responsibility for greater equity in health care. Promoting access to health care was seen as the first, albeit problematic step, to achieving equality and justice in health and health care. Although this was extremely difficult to achieve, it was their responsibility, as Georgina explained,

'Because obviously some of it is beyond the scope of the health visitor. But maybe what we need to be doing is to see it in a very sort of incremental way, start at stage one, making sure that there's equality of access and build it up.'

Likewise, for Sharon, equal opportunities in health care was a moral responsibility described as a process that repaired other injustices,

'I look upon it in terms of sort of like picking up the pieces that are caused by other sorts of social inequities. So I don't particularly look upon health care as sort of redistributing that sort of justice, I just think it's just being there, to kind of patch up the bits that have happened, for social and economic reasons.'

For Victoria, inequality and injustice in the rules governing access to health care were to be condoned. She had clear views on why this was so and endorsed a moral responsibility to help those less fortunate. Like Penny, this again invoked racialised discourses as she constituted her own and her clients' identities, she said,

'I feel very strongly that you can't pre plan where you will be born in the world, you don't know, and I don't see why somebody being born here, you have free access to what is notoriously the best in the world, and why someone born in Ethiopia, and so disadvantage in that way. And it's impossible to have it the world over but if they come to England then they should have free rights to that health care. And if the government is letting them in, then they should provide a service to match their needs [.]They can't have one rule for one group and another for a different group.'

These narratives illustrate references to talk of equal opportunities and equality and equity in health care as talk of moral judgements that invoke moral identities. This involves ethical decision-making in the context of scarce resources but this conflicts with their moral responsibilities to fight injustice and inequality. Unlike the impartial moral self, this moral self is implicated in contesting perceived injustices rather than always accepting these an inevitable features of practice. This positioning involves a partial moral self that becomes involved in the care of clients and expresses compassion and empathy for them. This is related to but different from an ethic of justice and impartial care.

Postmodern feminism proposes we do not decide upon an ethic of care over and above an ethic of justice, as this perpetuates a futile choice. As I have discussed previously, postmodern critiques show 'either/or choices' neither revoke nor challenge the hierarchical binaries upon which such theories of ethics are based. Mouffe (1994) and Sevenhuijsen (1998) both identify the inherent dangers and futility of such debates. For to replace justice with care, merely continues to essentialise difference and simply inverts the oppositional thinking embedded in these conceptualisations. Advocates of a postmodern ethics argue for a different starting point for moral subjectivity. This involves the recognition of the particularity and historical specificity of ethics and for the re-imagination of an ethics. This is an ethics that would acknowledge the partiality of truth and reason and the contingency of binaries like care and justice.

Drawing together the politics and an ethic of care, Sevenhuijsen (1998) argues for a form of 'judging care' with which to enrich notions of justice. This is not justice premised upon rationalistic theories or rules, but justice as processes, which both construct and sustain fluid subjectivities. This is premised upon a notion of a relational self, formed in specific cultural and historical contexts. Sevenhuijsen talks of a self, as a moral agent, embedded in concrete relationships with other people who acquire their moral identity in their interactions and everyday practices. This is a self that is continually developed and revised. She utilises the poststructural notion of the 'processual self' (1998:56). Thus far, these professional and personal selves have demonstrated how that processual self is constituted. More importantly, however, these are not abstract or free-floating selves or identities. These selves are also embodied. The significance of different classed, gendered and racialised bodies have already been alluded to above. These embodied selves intersect with both professional and personal selves and have an important impact on the discursive constitution of these selves and the narrations of equal opportunities.

5.6 Embodied Selves

Previously in Chapter Three, the community nurses often talked of separating out health need from significant bodies. Yet, the importance and consequence of being female or male, working class, from an 'ethnic minority', or of being black or disabled, old or gay, impinged upon these accounts throughout. Indeed, for the community nurse these were their own embodied differences, as well as those of their clients, which together constituted their understandings of equality. Laura spoke of her own experiences of embodied difference,

'My own background and being black myself, I suppose gave me some insight, although some people say [x hospital] is very racist and I was lucky to get in there and well, they say it's because you're so fair it's advantageous to you. [.] But I have come across nurses and myself, and the problems of being a minority coming up through the education system because I did have the experience of a mainly white school and I was put in the lower classes. But as soon as I went to a school that was multicultural I was put up into a higher class. And that was my first inkling.'

For others it was their nationality or religion that mattered. As Karen demonstrated,

'Well you can't really discriminate just because I'm Irish, for example. They can't really discriminate just because my religion is, or the colour of my skin is.'

Mary clearly described her own embodied differences when she described her own experiences, as she said,

'I've come across quite a lot of racial prejudice myself, obviously from Scotland [.] they automatically assume I come from Edinburgh because my accent has modified over the years, and I say no, I come from Glasgow actually and they go, oh God ! You know?'

She also invoked her own classed position, when she referred to her political views, drawing on her own politics and personal beliefs when she said,

'[I was] active politically and that kind of thing, before I even came on this course, [.] My eyes were opened quite early on [and] I was very radical in my teens.' Later she added, 'we cannot turn everyone socialists over night.'

The nurses often used an example to illustrate or an anecdote to tell these stories of embodied selves and equal opportunities. Shirley was able to cite an example of this when discussing equal opportunities in relation to her colleague applying for a job. She said,

'Because her name was,[..] at the time she got short listed, but she was waiting outside to be interviewed and they kept walking past and ignoring her and eventually she said, I'm here for interview and in the end, she may have had it wrong, but they ignored her because they assumed Ms W. was white.'

Brenda spoke of being the only, 'ethnic minority' in her team and how she had no problems there. However, when discrimination was practised, she argued that it was up to 'people like us to prevent it.' It was not clear whether the 'us' referred to being a professional nurse or belonging to an ethnic minority group. She also had many examples of her own experiences of overt racism and racial abuse, where her own embodied differences mattered enormously. She said,

'I have had all sorts of things, I have had, I have had a slap on the face and things like that. One very affluent family [.] because of my surname they thought they were waiting for a Scottish nurse and when she opened the door and saw me she said 'we are waiting for Sister' and slammed the door.'

For Claire, racialised bodies mattered too. She had defined equal opportunities as a minimalist strategy that protected some of the people, some of the time. However, certain bodies came into her justifications of care. She had spoken previously of how 'I may not chat but they get the same care', and she continued, 'You have to do something even if you don't like them, because they're black, Chinese, whatever.' She also related

how these embodied differences affected other colleagues. This was especially so when clients were expecting a white nurse, she said,

'You do get patients say, I much prefer it when you come, or I'm not very keen on so and so. A lot of elderly patients will say, 'is she black? Oh, I don't want anybody coming here'. You know, you have to say, I'm sorry, we work a as team and I can't say she wont be coming here. In some ways it's more important to send that person in, although I'm not saying send them in to a load of abuse.'

This evidence of racism shows how embodied selves, both the nurses' own and the clients, played a very significant part in the construction of equal opportunities. In recent postmodern and poststructural critiques, bodies are never simply the grounds upon which gender, race or class are draped. Bodies are a field or site created by the interaction of particular discourses (Butler 1992). Bodies become gendered, classed or racialised through these processes and public bodies, like those of the clients and nurses, always signal difference. In these accounts, all these selves are embodied selves and are constituted by particular discourses, so that difference, far from being suppressed, is continuously invoked.

Together, this analysis suggests embodied personal and professional selves overlap and co-exist. There is no neat mapping between these selves and the various narratives of equal opportunities and anti-discriminatory practice. Although, it would seem that when stories coherent with liberal equality appear, professional selves tend to predominate. This might be expected; given that discourses of professional practice are endorsed through education and this reinforce some degree of objectivity, rationality and impartiality. However, while these professional selves seem to be the more dominant, more complex, personal selves challenge, compete and contest these positions both directly and by implication. Accordingly, these professional and personal selves, variously invoked, are not static or secure but are selves in process. The community nurses take up these identities both temporarily and more decisively, as they choose, endorse, change and reject these positions. These are embodied selves that are discursively invoked at varying times in these narratives, producing unstable positions that challenge, displace and simultaneously reinforce liberal equality.

5.7 Conclusion

This chapter has explored the significance of the discursive constitution of certain selves. These selves were drawn from a range of discourses and were actively constituted by the community nurses. I have argued this mix of selves produces the diversity of community nurses' narratives of equal opportunities. Gendered, classed and racialised discourses, including those of liberal equality, professional practice, ethics and organisational discourses of economic rationalism all serve to construct a number of subject positions I have labelled collectively as professional and personal. I have shown these selves to be contingent, interacting in ways that are significant. The result is a complex notion of both embodied personal and professional selves. These are positions that remain differentiated and partial, potentially open to challenge and change. These are selves in process, appearing and developing, overlapping and mixing throughout the community nurses' narratives of equal opportunities. It is this interaction and movement that creates both the coherence and the ambiguity and ambivalence, I discussed in Chapters Three and Four. However, having explained the presence of the diverse narratives through these discursively constituted selves does not, as yet, clarify why these selves are indicative of the possibilities for equality. In the next and final chapter, I explore more fully how these discursively constituted selves are indicative of the different grounds and possibilities for re-imagining equality in community nursing.

CHAPTER SIX

DEVELOPING A POSTMODERN EMANCIPATORY PROJECT

6.1 Introduction

In this thesis, I have used a postmodern analysis to explore the discursive constitution of equal opportunities. I demonstrated this through an examination of community nurses' narratives and argued that whilst these appeared at first to be discursively *coherent* with liberal equality, there co-existed a more diverse collection of narratives. These accounts destabilised discourses of liberal equality and revealed narratives that were far from homogeneous. This included *contradictory and competing* accounts that both challenged and were more sceptical of liberal equality. I argued this seriously undermined both the feasibility and dominance of liberal equality in community nursing for two reasons. First, these accounts suggested that whilst modern liberal equality discourses appeared dominant and stable, these foundations were instead more provisional, fragmented and diverse than previously considered. The revealing of other accounts displaced and destabilised these apparently secure liberal foundations. Second, these other accounts implied various discursive constructions of equality as something other than liberal equality. These possibilities were argued to be present in the ambivalence and ambiguity expressed towards equality as both a principle of practice and more generally as a social or political goal. Furthermore, in order to understand the presence and particular form these diverse accounts took, I argued for a contingency with a set of discursively constituted selves. In sum, I argued this research revealed a degree of complexity surrounding talk of equal opportunities that discouraged simplistic or superficial interpretations. The implications of these diverse accounts and the more significant *fragmented selves* now need to be considered more fully.

I will argue the presence of these selves and resultant narratives imply both *limits* and *possibilities* for equality in community nursing. This thesis demonstrates that there is a discursive ambivalence and ambiguity towards modern liberal equality, evident in the diverse narratives, which implicate the self. An understanding of this self as fragmented and in process is necessary in order to comprehend the very

different subject positions the nurses occupy in the telling of their stories of equal opportunities. I contend that to develop egalitarian care or emancipatory practice further, these selves need to be engaged with. There is need to recognise the way these embodied selves are inscribed and are inscribing narratives of equal opportunities. There is also a need to recognise the ways in which these selves enter into dialogue with the various discourses, and in particular, the engagement and dialogue with the inherent limits of a liberal equality discourse. I propose that as a result of this acknowledgment, an alternative concept of equality will be needed, with possibly differing measures of its success or limits. I also confirm the need for a variety of practical strategies to allow for movement beyond the stalemate of political either/or choices. Thus, community nurses seeking to promote equality and respond to difference must continually engage with and deconstruct both the subject positions they take up and the dominant discourses of liberal equality. This will allow for a re-imagined equality with which to develop emancipatory and egalitarian politics and practice in community nursing.

6.2 Possibilities for Re-imagining Equality

I have argued that liberal equality discourses were neither totally dominant nor inevitable and I have shown these to be partial and provisional. In undermining and displacing liberal discourses, other narratives of equality were found to be present. These ambivalent and ambiguous forms of equality revealed the inherent limits of liberal equality discourses. This produced provisional accounts of equal opportunities, less determined or fixed by liberal equality and therefore not always limited to the same ways of excluding and oppressing. However, where this leaves equality, as the grounds for emancipation, or as the rationale for tackling inequalities in health is less clear. My response to this question is to argue that the diverse accounts can only be understood by examining the particular selves invoked in their name. Therefore, my principal argument is that these selves highlight the *possibilities* for re-imagining equality in community nursing. This is the argument I now intend to explore more fully.

6.3 The Fragmented Self

It is evident in Chapter Five that these diverse selves severely disrupt the coherence of liberal equality discourses, giving rise to multiple contradictory and competing accounts. Interesting though these disruptions are in their own terms, I am arguing that the significance of this is far reaching. The selves I have identified and the subsequent accounts of equality are seen to both reinforce and subvert liberal discourses. The engagement with these discourses was shown to shape and influence the subsequent accounts and the injunction 'to become' a certain self. The examination of these community nurses' narratives reveals a continuous movement between various selves whose subject positions are far more ambivalent and ambiguous. I have demonstrated how, in taking up subject positions or identities within these narratives, the nurses positioned their 'selves' in plural, contradictory and provisional ways. In many respects, these selves enter into a dialogue with these discourses. Thus, the positioning of these selves was generated from those engagements and dialogue with the discursive field constructing equality in health care and in particular the dominant liberal equality discourse with its inherent flaws. This dialogue was evident, either more directly, as witnessed in the competing accounts, or in more implied ways, as seen in the contradictory accounts. Obviously, as active readers of discourses, the community nurses positioned their selves and were positioned. However, these positions and identities were, for the majority of community nurses, neither fully rejected nor fully endorsed. This suggests a discursive ambivalence and ambiguity evident at the level of the self.

This is an aspect of the fragmented or diverse self that is implied in postmodern feminist or post structural feminist accounts. In a feminist Foucauldian approach, decentred subjectivities remain sites of struggle and potential change (Weedon 1997:40). As a self in process, this is achieved through being constituted and reconstituted over and over again through discourse and discursive utterances. Butler (1990) talks of this self in process as the performing, gendered self, a self continually achieved through repeated performances shaped through discourses. This creates the 'illusion' of a coherent and unified sense of subjectivity and identity. As Butler argues,

'The action of gender requires a performance that is repeated. This repetition is at once a reenactment and reexperiencing of a set of meanings already socially established; [.] Gender ought not to be construed as a stable identity or locus of agency from which various acts follow; rather, gender is an identity tenuously constituted in time, instituted in an exterior space through a stylised repetition of acts.' (1990:140)

She argues that identity is a signifying practice and subjects are the effects of rule-bound discourses, though the subject is not determined by the rules of discourse as signification is 'not a founding act. Rather, there is a, 'regulated process of repetition that both conceals itself and enforces its rules precisely through the production of substantialising effects'(1990:145). I am interested in Butler's notion that the injunction,

'To be a given gender produces necessary failures [.] and in its place are a variety of incoherent configurations that in their multiplicity exceed and defy the injunction by which they are generated.' (1990:145)

The failures Butler documents are achieved through parody and irony and are seemingly voluntary and decisive. That is, subjects are free to take up these positions in resistance to those injunctions. I am arguing that the injunction 'to be' a given identity, be it class, race, gender, or indeed 'professional community nurse' also produces failures. However, unlike Butler, these positions do not always seem so voluntary or decisive. This thesis shows how failures occur in relation to the embodied professional self through the discursive constitution of embodied personal selves, generating the levels of multiplicity Butler suggests exists. More significantly, I also establish how these plural identities are constituted through the injunctions to work with a liberal equality discourse. In rejecting or questioning this discourse, the nurses enter into a dialogue with their 'selves' in order to take up certain positions. The empirical effects of those actions and failures are to be found in the range of incomplete and less certain narratives that result.

To understand this process further, it is useful to draw on Bakhtin's notion of a *dialogic self* (Bakhtin 1981). This is a view of the subject or self as relative to and always in relationship to some other. This is, as Josselson (1995) argues, a self that always exists in relation to another person or other parts of the self, or to society and one's culture (1995:36). This is a multiple self in process, existing in complex relationship to the present, past and future. She argues, that those places in narratives where the self is

most clearly in dialogue with itself are ' moments of crisis' which represent 'nodes of change in which the individual becomes other than he or she was' (1995:37). These dialogic moments expressed in narrative are, Josselson states, the 'personal keys to meaning–making'. Thus, the significance of the dialogic self is in the discursive working through of contradiction, for this reveals processes of revision in identity and subjectivity (Josselson 1995). These processes of revision are in evidence in Chapters Four and Five in the contradictory and competing narratives and the nurses' discursive constitution of their various selves.

Whilst drawing on this dialogic self and 'nodes of change' I also use Mouffe's conception of particular selves, which is similar to a dialogic self. She argues,

'The subject is always constituted by an ensemble of subject positions that can never be totally fixed in a closed system of differences, constructed by a diversity of discourses among which there is no necessary relation, but a constant movement of over determination and displacement.' (1994:318)

Moreover, Mouffe insists this plurality of subject positions does not merely co-exist, one by one. She argues that it is the,

'Constant subversion and over determination of one by others, which make possible the generation of totalising effects within a field characterised by open and indeterminate frontiers.' (ibid:318)

Thus, the presence of these diverse selves in the community nurses' narratives are indicative of those 'moments of crisis' when the self is in dialogue with itself and the making of meaning is occurring. This discursive working through of contradiction was evident in the levels of interaction between personal and professional selves. I propose, therefore, that it is the working through of the contradictions experienced when engaging with the inherent limitations of a liberal equality discourse that these selves become positioned and are positioning the community nurses. More importantly, in that *process*, a revision of identity and subjectivity becomes possible, these selves become something other, and this may represent the first step in challenging dominant discourses of equality in order to bring about social change. Mouffe argues that it is the recognition of various subject positions, possibly previously considered apolitical, that can become the foci for conflict and produce political mobilisation. Thus, these dialogic selves, in questioning and doubting liberal equality discourses, have the *potential* to

produce other selves and narratives and discourses of emancipatory and egalitarian practices. It is the nature of these possibilities I now wish to explore further, as I discuss the discursive dialogic space in which such practices could evolve.

6.4 A Discursive Dialogic Space

The interrogation of community nurses' talk of equal opportunities has revealed an ambivalence and ambiguity at the level of the self. This has introduced doubt, indecision and uncertainty into the discursive construction of equality as a set of principles underpinning practice. However, these less than fully determined selves suggest possibilities for equality, as this ambivalence and ambiguity at the level of the self indicates *a lack of foreclosure and a process of revision*. This offers a *discursive space* in which to address the foundational fictions of modern equality and begin to develop a postmodern emancipatory politics. This is a space that offers opportunities for the necessary interrogation and dialogue with modern discourses and subjectivities and identities with which to establish a postmodern emancipatory politics. These changes will involve several simultaneous strategies based in practice and education. One practical strategy I wish to propose is that community nurses engage with and deconstruct these subject positions and narratives of equal opportunities through the telling of stories.

6.4.1 Transforming Practice and Telling Stories

I propose that *telling stories* of these diverse selves and of equal opportunities could be a powerful tool for transforming practice, as the level of ambivalence and ambiguity found to be present is indicative of frustrations with the 'old story'. Abma (1999) notes how the opportunity for transforming practice is greatest when the 'standard story' of professional practice no longer works and a new story is needed. In discussing the transformation of therapists' practice and referring to the old story as a threadbare fabric, she argues,

' The once-so strong texture had finally worn out, holes had began to appear in the fabric, colors had faded, and the usual repairs no longer worked. Other stories had to be woven into the existing texts to give color and solidity again' (1999:186).

She argues stories are powerful tools in change because they are the means by which we construct personal experiences. In her research, therapists who no longer believed in the old story listened to patients' stories and were enabled to act and establish new stories of practice and new identities and roles (1999:192). In relation to this thesis, I have no clients' stories but the nurses' own stories could be shared with each other. This would provide a means of producing further stories and identities and developing a dialogue between and with their selves. This re-telling of stories would allow the nurses to recognise the 'moments of crisis', the contradictions and challenges as a process of revision, in order to become, or occupy different positions in relation to equality and difference. This would allow the resultant ambivalence and ambiguity to be recast as a positive opportunity for change.

Second, and more practically, in re-telling these stories the process of reflection could be employed. This is a process that already forms a central part of a professional practice discourse, as all nurses are encouraged to become reflective practitioners in and of practice (Schon 1983, Benner 1984, Boud, Koegh & Walker 1985, Reed & Proctor 1993, Boud & Walker 1998). In developing reflective practitioners, it is the use of experiential knowledge rather than technical rational knowledge that is considered valuable. (Fish & Cole 2000:292). Thus, the use of emotion, intuition and tolerance of ambiguity is to be encouraged. Reflection allows for a deliberate meditation upon an incident, albeit challenging, disturbing or rewarding, in order to understand and learn through a formal process and to take actions towards developing practice. However, this is not to endorse or accept reflection uncritically. Indeed, there is an opposing critique that finds the wholesale adoption of this process within nursing rather disturbing. Interestingly, it is lack of clear definitions or boundaries and uncertain frameworks for implementation, and ethical concerns that has led to criticism, suggesting this is a flawed strategy (Hargreaves1997). Boud & Walker (1998) document this critique but disagree with it. They argue that reflection is of value but as a process that is context specific rather than rule bound. This is a practice that should be deployed in a flexible manner. This mirrors the 'professional artistry' view of practice, where context specific, tacit knowledge is used to convey the subtleties and 'ineffable aspects of life' (Fish & Coles 2000:293). Although Fish & Coles argue that professional artistry is more than

reflective practice, it seems similar to Boud and Walker's (1998) notion of faded rules and a practice that is messy, unpredictable, uncertain and unexpected.

However, a more serious limitation to endorsing either of these approaches is that both professional artistry and reflection assume a liberal humanistic subject and autonomous self. This is a self that would need to be critically interrogated and displaced in the re-telling of stories, in order to allow diverse, ambivalent selves to be listened to. This would mean asking the community nurses to listen to the stories and to reflect on the meanings of equality, or equal opportunities and anti-discriminatory practice being offered to them. As Weedon (1997) and Kenway et al (1994) remind us, the self is an active reader of culture and interpreter of discourse, and these discourses have a material force. They can constrain and enable us and they shape our identities continuously. As subjects we are offered many ways of seeing and being ourselves and we respond in various ways; that is we can reject or accept, and in doing, we can use these discursive resources in particular ways to create new meanings. This would mean encouraging students and practice teachers, as critical readers of these narratives and discourses, to reflect on those positions on offer. It would also involve reflection upon those discourses that are silenced or marginalized and thinking about the ways in which dominant discourses are successfully legitimised. In this way, students and practice teachers could be encouraged to analyse language and meanings, identify interests and the various subject positions employed. In deconstructing their own and others' stories, they will need to confront uncomfortable and disturbing, as well as challenging meanings. The aim would be to revitalise work for change, to encourage practitioners to see anew, to not only acknowledge contradictions but to work with these and enable them to remake meanings for themselves (Kenway et al 1994, Cameron et al 1995). The frustrations with the 'old story' would provide the impetus for this work. This is a twofold task of engaging with and deconstructing discursively constituted selves and narratives.

6.4.2 Engaging with and Deconstructing Modern Liberal Equality

I am proposing that one necessary task in developing a postmodern emancipatory project will be for community nurses to engage with and deconstruct liberal equality

discourses. This is an important task, as this discourse, though displaced and challenged in these narratives, will need to be continually engaged with. The engagements with the inherent limits of modern discourses were much in evidence throughout this thesis. For example, treating everyone the same did not guarantee equal access or treatment. As Young (1998) has argued, this tendency to stress what people have in common in liberal political theory suppresses or sustains this indifference to significant differences. This is further compounded by concepts of universal citizenship that promise inclusion and the participation of everyone (Young 1998, Lister 1997). Thus, the idea of citizenship as an expression of general will has tended to promote assumptions of homogeneous citizens and principles of equal treatment have tended to result in perpetuating oppression and disadvantaged (Young 1998). In community nursing this has served to perpetuate a status quo and reinforce an indifference to oppressive care. This use of a liberal discourse has promoted an acceptance of the inevitable presence of inequalities in health care, and reinforced and sustained social exclusion. Thus, the use of a liberal equality discourse was far from neutral in effect.

As I have argued, postmodern critiques suggest these limitations are inevitable precisely because of modern political epistemology and ontology. In Chapter One, I demonstrated why these foundational theories were inherently limited. I argued a postmodern analysis offered a different explanation than those implied in previous studies (see Chapter Three). These studies argue that causes of inequality in health care are to be found in an individual's unconscious or conscious intentions or motivation, and/or as the underlying logic of structures and unequal power relations. Namely, inequality is caused by individual nurses' attitudes and behaviours, and/or because of the totalising effects of a cultural inertia or hegemonic hold of vested interests. These explanations rely upon grand narrative accounts of systemic ideological control and structural constraints. However, valuable though these analyses are, they do not critique nor make explicit the "foundational fictions" (Butler1990:3) at the heart of modern epistemology and ontology upon which political theory and concepts like equality are based. These are fictions exposed in a postmodern analysis and are especially evident when emancipatory appeals to political systems are made. These systems sustain subordination and oppressive

practices and relations, thus these appeals are self–defeating. These are systems, which discursively constitute the very subjects they exclude, thus,

'The subjects regulated by such structures are, by virtue of being subjected to them, formed, defined, and reproduced in accordance with the requirements of those structures.' (Butler1990:2)

Hence, Western political systems are premised on exclusions, producing and reproducing subjects who are unequal (Butler 1990, 1992, Yeatman 1994) As a subject is required before it can be represented politically, an emancipatory politics arguing for the system to include those subjects it requires to be excluded is severely limited and self defeating (Butler1990). Therefore, the subjects of equal opportunities are discursively produced and constrained by the very political system community nurses seek to emancipate clients with and eradicate inequality.

The limits to modern political theory form part of a relatively well-established feminist debate. Indeed, many feminists have sought to address these limits by degendering and engendering both theories of the state and politics and occupational accounts of professionalism (Franzway et al 1989, Cockburn 1991, Phillips 1991, Pringle & Watson 1992, Scott & Butler 1992, Savage & Witz 1992, Halford 1992, Yeatman 1994, Davies 1995). While this thesis has confirmed these limits, it contributes further to these debates by demonstrating how limitations take particular forms and have specific effects. Through talk of equal opportunities, I have shown community nurses utilise discourses that were not only gendered, racialised and classed but were gendering, racialising and classing of their various selves *and* the political subjects they seek to 'emancipate'. This revealed how equality was both reinforced and undermined. This reinforcement was particularly evident in Chapter Three, it was undermined in Chapter Four and Chapter Five revealed how fragile and unstable this discursive hold was.

However, this engagement with and deconstruction of modern liberal equality discourses also points to possibilities. It suggests that it is the frustrations with and the continued, *uncritical* use of these discourses that needs to be addressed. As I argued in Chapter Five, deconstructive work entails a critical stance towards all meaning making systems. There is a need to identify how particular meanings or stories remain dominant

and others marginal. It means teasing out these meanings, positioned as hierarchal binaries, to reveal hidden or suppressed oppositions and insisting on the interdependency of the two related terms. There is a need, therefore, to develop critical interrogations of all the discourses evident in the community nurses' narratives. As Sawicki (1996) argues, to develop a political project means we must enter into struggles over meaning. This struggle is similar to the discursive re-shaping Crowe (2000) argues nursing must engage with, in order to displace constraining discourses. At best, the uncritical uses of liberal discourses perpetuate an indifference to systemic inequalities, and at worst, actively reinforce this disadvantage. This uncritical use of discourse also serves to perpetuate and sustain entrenched inequalities and disadvantage (Rattsini 1994). This need to rethink and engage with modern political projects and the discourses that perpetuate inequality requires the location of a space in which this dialogue can begin. This needs to be located in both education and practice.

6.4.3 Developing Contestory Political and Public Spaces

There is, therefore, the potential for this engagement with and deconstruction of selves, narratives and discourses to develop in the contestory space that Yeatman (1994) argues for. She argues for the conception of a dialogic space premised on a postmodern emancipatory vision. This is not a vision of utopian freedom for all individuals. Instead, the development of *contestory political and public spaces* allow for challenges and resistance to current intolerable and oppressive conditions and practices (Yeatman 1994, Sawicki 1996). Thus, the aim of these contestory public and political spaces is not to ensure the complete eradication of discrimination as a measure of success. Rather, it is intended to provide an ongoing imaginative and creative form of positive resistance to various types of domination (Yeatman 1994:9). This alters both the measure of equality and the nature of the public space in which assumptions and values of any polity or politics can be contested. Thus, a further aim would be to allow for the development of this space through a *dialogic approach* to questions of equality. It is recognition of this deconstructive, historically contingent and perspectival set of processes that lies at the heart of furthering a postmodern emancipatory politics.

Recognising the potential of this space and dialogue would move debates in health care beyond the impasse or stalemate of previous false choices between demands for *either* liberal inclusion *or* the valorisation of difference strategies. This dialogue would displace modern political discourses of liberal and radical equality in order to allow alternative conceptions of equality to evolve. This would, however, mean that we tolerate less secure, but possibly more open and dialogic conceptions of *equality and difference* (Butler 1990, Nicholson 1990,Yeatman 1994).

In this study, there was evidence of a contingent, provisional and differentiated use of equality and difference. In the community nurses' narratives equality was indeed contingent upon difference and upon a particular mix of selves being invoked. The contingency of equality upon difference was particularly evident. Likewise, a concept of difference was used variously, often defined as non -equivalence, deviance and unfairness and oppression as suggested by Mens-Verhulst (1998:197). However, difference was not always constructed as deviance or as 'other'. It was also a quality to be valorised. These differentiated uses of equality and difference revealed fluid rather than fixed notions of equality and difference. Difference was also more likely to be defined as 'other', a deviance from an unexamined norm, yet there was recognition of that norm.

In a similar way, the community nurses' implicit constructions of power were also partly dependent upon a differentiated use of difference. The nurses' endorsement of the stereotypes, perpetuated by the day- to-day culture of community nursing was not completely successful. Challenges to these norms of practice were evident and indicated moments when power appeared more diffuse, capable of discursively producing community nursing practice that became potentially emancipatory, rather than remaining minimalist or oppressive. These varying uses produced or constructed certain choices for the community nurses and these choices included the choice to challenge, dismiss or suppress the worst effects of their practices and care. However, these uses also implied that conceptions of equality *and* difference were provisional, in that these differentiated uses were always contingent upon particular social and historical contexts.

Therefore, a more fluid, dynamic notion of equality would focus instead on the discursive activities involved in its construction. This would move towards a view of equality as more than an end goal but rather as a *process,* always becoming, never finally fixed or closed and subject to constant revision and change (Scott 1992, Mouffe 1994). To view *equality as a process* opens up possibilities for re-imagining equality and means that uses of equality can be identified, debated, revised or changed. Subsequently, this will mean both old and new orders of inclusions and exclusions will be debated, negotiated and established. The interplay between equality and difference means arguing for a strategic use of these terms, or a 'universal differentiation' dependent on purpose and context. This retains an impulse toward universality, but with a reinscription of modern concepts (Young 1990, Phillips 1992, Butler & Scott 1992, Yeatman 1994, Lister 1997, Fraser 1998).

Central to this task will be the need to reveal the full use of difference. For example, Phillips (1992) argues for the need to disentangle differences that are inevitable from those that are chosen or are 'simply imposed.' Mouffe (1992, 1994) argues for the need to reveal and understand the diversity of power relations and identities embedded in notions of difference. Whilst Scott (1989,1992) is arguing for the end to the disabling choice of either equality or difference and argues for a concept of equality premised upon difference. Furthermore, as Young argues, difference is relational and emerges, 'Not as a description of attributes, but as a function of the relations between groups and the interactions of groups within institutions' (1990: 171). The achievement of these ends will require a strategy that will uncover how difference is constructed in its varying ways and reveal how it is dependent upon context.

In this thesis, these narratives show how these relations between subjects and selves do utilise difference and do not always position difference as descriptive. There is recognition of the normative and relational function of difference between groups. However, this alone does not produce egalitarian care. Action is needed if a postmodern form of politics is to develop. It will require Lister's (1997:198) notion of a 'synthesis and fuzzy logic' rather than for absolute 'either /or' choices. The first step, she argues, has been to expose the false universals and the second is to:

'Refashion the yardstick so that universal and particular are combined in an unbiased way: a differentiated instead of a false universalism.'(1997:200)

She suggests, as do Flax and Yeatman, that the tension between the universal and the particular be viewed as *creative* rather than destructive. The underlying principle she advocates is one of a 'differentiated universalism' that enriches an understanding of concepts like citizenship (1997:197). These strategies are, as Phillips (1992) suggests, an aspiration toward universality if only for strategic purposes; here the development of coalitions, or a temporary fixing of commonality or solidarity would be necessary to pursue an emancipatory politics for strategic purposes.

6.5 Deconstructing Politics

There is, however, a fear that deconstructing subjectivity and identity in the way I am advocating may lead to the deconstruction and hence the destruction of politics. The proliferation of so many plural and diverse identities could suggest subjects devoid of identity altogether. This implies there is no subject upon which to ground a politics. However, Butler has questioned whether we need a common or essentialist notion of identity to ground this action. I would support her conviction that multiple categories present both the opportunity for political mobilisation and the possibilities of constraints. Nevertheless, the postmodern insistence on so much plurality can be thought to avoid important issues such as the different investment individuals may have in particular identities (Rattansi 1994:271). This is especially important in understanding collective identities, like those of 'the new ethnicities' and in decentring and de-essentialising racist identities (Hall 1990).

The need to de-centre racist identities and subjectivities has produced an understanding of collective identities as products of a cultural politics of representation. As Hall (1990) argues cultural identities are not an essence but a positioning, framed by and in dialogue with 'axes or vectors' of similarity and difference. In terms of cultural identity, the community nurses were not all white, and even those who were, identified themselves as different from other white nurses by being Irish or Scottish. This was especially evident in Chapter Five in discussing embodied personal selves. These identifications cut across other available identities, as the nurses recognised or were

successfully recruited to a particular discourse of racialized disadvantage, subordination, or domination and in the case of one nurse, violence. Yet, the focus of most deconstructive work like this has been to insist on the local or smaller, every day struggles. However, as Rattansi (1994) argues,

'An emphasis on historical and cultural specificities in the working of power relations does not necessarily condemn struggles to the desert of infinite difference and permanent fragmentation.'(1994:278)

He continues, citing Spivak, as he argues for the need to develop 'strategic essentialisms' as,

'The emphasis on the significance of new hybrid and syncretic identities shows the potential for crossover identities which destabilize old ethnic absolutisms'(ibid:280).

These strategic essentialisms and crossover identities, endorse a view of equality Mouffe (1994) argues for and is one I wish to endorse in this thesis. This is a view of equality as a vanishing point, a social imaginary that can never be finally achieved. Furthermore, if equality and the common good are always open to competing interpretations then it is impossible to have a totally inclusive political community, for every 'we' is a frontier and assumes and positions 'a them' (Mouffe 1994). This highlights the provisional nature of inclusions and yet also suggests possibilities for change (Mouffe 1994:325). However, whilst we can suggest that inclusions are never totally fixed, being subject to continual change, it would seem some inclusions appear more permanent than others. Rattansi (1994:278) suggests, for example, that racialised discrimination operates within recognisable patterns of power and domination that are consolidated over long periods of time. These patterns take different forms and employ various strategies and procedures. Both dominant and subordinate agents, using institutional resources, can activate these. He argues that, whilst deconstructing and de-totalising social structures is vital work, there are institutional forms of 'bio power and material effects of discursive regimes of power, which inscribe bodies, and subjectivities of individual subjects' which still require continued examination and understanding (1994:278). These community nurses' narratives revealed that these institutional resources are mobilised, and racism and discrimination are endemic to the discursive constitution of equal opportunities. I agree with Rattansi's argument and would add that a postmodern analysis does not deny these broader structures of racism or oppression. It argues instead that these structures are no longer seen as totalising and

universal. Rather, it is the various, plural forms and the diverse mechanisms through which all oppressions or all racisms are perpetuated that require examination and understanding.

6.6 Equality as a Principle of Practice

These are important concerns and within nursing, there is a demand to develop practices that are able to respond sensitively to the diverse needs of communities. Therefore, as a result of this thesis' findings, a further task would involve the reassessment of equality as principles of professional practice. However, in the demand for nurses to ensure their practice is sensitive there is often an implicit assumption that a fixed prescription for practice can be taught and, in the current NHS, can be standardised, measured, monitored and evaluated. This is the techno-rationality model of nursing care and not the 'professional artistry' view as argued earlier. In addition, egalitarian principles in nursing practice are often assumed to be a benign force when this, and other research, shows a practice that encourages surveillance and control that can be as oppressive as the very practices it seeks to revoke. Furthermore, these modern conceptions of egalitarian practice often assume uncritically that clients want to be included regardless, and that the authority and nature of those inclusions are unproblematic. A good example of the recent interest and growing emphasis on sensitive and egalitarian care can be found in concepts of 'trans-cultural care' and 'cultural safety'. These approaches seek to ensure practitioners are enabled with knowledge and skills in their interactions with clients (Narayanasamy 1999, Josipovic 2000).

Concepts of trans-cultural care are forms of practice premised upon competency-based models of learning, which focus on the eventual measurement of outcomes. This may be a necessary first step in order to clarify a 'trans-cultural form of care' but there are dangers. Such strategies can imply that culture is static, a fixed entity to be finally known, rather than as a process which is dynamic and continually moving and changing. There needs to be, therefore, a process of continual engagement with and knowing about these diverse cultures or new ethnicities. Thus, prescriptions for the acquisition of skills or competencies may be a first step but should be developed cautiously. For as this thesis has shown, the degree of complexity involved in

constituting equality and difference and inequality means no simple instrumental or competency orientated practice will tackle or deal with these complexities. Competency based egalitarian practice will also remain trapped within a modern liberal discourse, promising either inclusion or the re-valourisation of significant differences according to a predetermined norm. This would not challenge or shift that norm, nor would it recognise that to include those excluded requires the establishment of a new order of inclusions. This will always entail 'others ' being excluded and this needs to be made explicit and addressed.

Finally, it is necessary to consider the policy implications from this and the overall arguments I am proposing in this thesis. I will attempt to clarify the policies that would be needed to ensure the development of this postmodern emancipatory project in community nursing.

6.7 Policy Implications

The implications of postmodern theory have led to a revived policy debate concerning the merits of universalism and particularism. These debates reflect the wider theoretical concerns I have discussed previously regarding the apparent demise of universalism. The key concern is to safeguard basic provision and respond to particular needs. However, the loss of faith in and failings of collective provision has meant that, currently, welfare is far more about meeting the specific needs of particular groups than universal provision (Williams 1992, Hewitt 1995, Thompson & Hoggett 1996, Taylor 1998). However, some commentators remain optimistic about the possibility of developing a 'sophisticated universalism' that is committed to equality, but sensitive enough to respond to diversity by incorporating elements of both universalism and particularism (Thompson & Hoggett 1996:21).

Indeed, this Government is currently very concerned with universalising principles of equality throughout the NHS. From a position of relative inaction, it has launched a series of initiatives aiming to place equality at the centre of the NHS agenda. Many of these programmes were identified in Chapters One and Three, and were seen, for example, in the Equalities Framework. The Framework promises to

'Deliver high quality services that are accessible and responsive and appropriate services to meet the diverse needs of different groups and individuals.'(2000:2)

These developments form part of the drive for competent and efficient and accountable practice and are moves that must be continually engaged with in order to re-shape meanings. These models of practice will discursively constitute different orders of inclusions and exclusions and these movements and orders need to be debated and challenged. This is a dialogue that must include clients *and* community nurses so that competencies devised in a top down manner from education or governments can be contested, negotiated, revised and regenerated.

Therefore, policies for new practices of justice must involve those who work closely with clients and users of public welfare services (Flax 1993, Yeatman 1994). A dialogue is essential to establish new orders of inclusions and exclusions. This will require different strategies in practice, for different ends, in different contexts (Yeatman1994). This means the community nurses may need to deploy a liberal form of equality in certain situations but for strategic ends for the clients and patients, they work with. Policies will need to account for this, as it implies there is no genuine equality, all accounts or stories of equality involve partial truths and the staking out of interests. This open acknowledgement of interests destabilises liberal equality and allows for the,

'Contestory political and public spaces [.] Where the ongoing, imaginative and creative forms of positive resistance to various types of domination can develop.' (Yeatman 1994:9)

This positive resistance and engagement must be endorsed through policy. More specifically, this would lead to a more dialogical or more responsive service that would be different. It would respond to the expressed needs of all the individuals using it. It would aim to become a service orientated to the particularity of individual and group needs based upon principles of service delivery (Yeatman 1994:86). This would ensure flexible and participative working and openness in order to develop an approach that works with *and* invites contestation, conflict and challenge (Yeatman 1994:88). As Yeatman argues, this is an arena where different conceptions of justice would find a voice and justice would not be simply the outcome of a rational consensus but a negotiated compromise.

The discursive space presented by the ambiguous and ambivalent selves and narratives offers the potential to develop these relations and processes of a postmodern emancipatory politics. This debate and negotiation, concession and compromise would involve community nurse students and practitioners, clients, teachers of practice and education and colleagues and managers. The task would be to develop and nurture such a space. This may be extremely difficult given the pressures and priorities of practice. However, the impetus is there in government requirements to include and develop a user perspective in, for example, service planning and policy-making. As Pringle and Watson (1992) suggest, we must remain open to the strategic possibilities available at any one time, as these will vary. Currently the welfare state, as a set of diverse discursive arenas or forums offers possibilities for new forms of equality to emerge.

However, a note of caution is necessary. For whilst the dialogue between client and nurse would avoid fixed prescriptions for practice or for equality, this contestory discursive space implies a degree of openness, which is *as likely* to generate egalitarian as well as oppressive care. For example, talk of equal opportunities and equality and difference appeared in these narratives as stories that ensured equal opportunities was neither completely accepted nor completely ignored. In these accounts, difference was neither entirely suppressed, nor wholly attended to, and oppressive or discriminatory care was neither fully condemned, nor fully endorsed. Given the overall political thrust of my argument, I would not want to argue that oppressive practice is acceptable, but I would insist oppressive care, as one process of exclusion, be acknowledged and openly debated, contested and negotiated. This would involve an acknowledgement of the selves presented in these findings, which would be discussed as a means to developing an equalities agenda.

Furthermore, to suggest that ambiguity and ambivalence are qualities with which to develop a re-visioning of equality may seem at odds with conventional thinking The implied indecision and uncertainty may just as easily produce apathy and inaction as well as interest or concern. However, when this indecision and confusion is deconstructed, as it is in this thesis, the potential revisions of identities and subjectivities and the possibilities for change are revealed. The normative criterion of rationality is displaced. Yet to destabilise and displace rationality or coherent, unified concepts does

not imply a doing away with these, nor that there is no ability to act or speak. Rather, it is to recognise that all concepts and meanings need to be deconstructed and that all actions and speech will produce differing grounds from which diverse actions and various forms of social change can evolve.

Nicholson & Seidman's (1995) argument for a social postmodernism and deconstruction are relevant to the change I am advocating. They argue there is the need for the re-inscription of key political concepts but they are adamant that there is a need to connect this deconstruction to broader social and historical processes and contexts. They argue in favour of the retention of an institutional and cultural analysis so that the interrelations between micro and social patterns can be explored and analysed. This, they claim, as I have argued in Chapter One, can be achieved without becoming totalising because of the provisional and contingent nature of these interrelations. Furthermore, Nicholson and Seidman (1995: 26) view their use of postmodernism as an opportunity for a reinterpretation of the social (1995:26). With regard to this thesis, this would mean this and future research should aim to locate this micro-analysis to those broader debates and patterns of equality and inequality. This would enable both emancipatory and oppressive structures to be revealed and the opportunities for challenges and change to be identified. This the position I would advocate, as this does not revert to endorsing totalising structures nor rejects the advantages of a deconstructive or critical interrogation of modernism. A social postmodern feminist critique would, therefore, offer a position from which to deconstruct and re-interrogate modern discursive practices and relations and relate these to a reinterpretation of the social.

6.8 Conclusion

In this thesis, I have shown how community nurses discursively construct equal opportunities and anti-discriminatory practice. I have revealed that this varied talk actively endorses, contradicts and challenges modern strategies of equality. I have shown how dominant liberal discourses do not inevitably determine these narratives, as these discourses co-exist and are displaced by the presence of other stories. I have argued this diversity is indicative of the *limits and possibilities* for equality. These limits

were evident in the continued uncritical endorsement of modern liberal equality, while possibilities were contingent upon the various selves invoked within these narratives. These discursively constituted selves were significant because they revealed how the nurses were actively involved in positioning themselves whilst talking about equal opportunities. This demonstrated a range of complex professional and personal selves, interacting together to produce the ambivalent and ambiguous narratives. This complexity refuted any simplistic interpretations and appears to contest the assumptions of hegemonic hold, protecting the status quo within community nursing. To assume all nurses are discriminatory or oppressive denies the complexity revealed in these narratives and the genuine attempts to bring about change. However, this is not to deny that racism and other forms of oppressive care were also very much in evidence.

I proposed this ambivalence and ambiguity were grounds upon which to begin to develop a postmodern emancipatory project. This led to the proposition of a processual, dialogic self, produced in those 'moments of crisis' with the 'old story'. I proposed that in this interaction and dialogue with liberal equality in particular, a discursive space opens up, in which challenging the old stories of equality would become a key task. This re-telling of the 'old story' would allow for the critical interrogation of both subject positions and modern discourses. I suggested, therefore, that these selves constituted provisional identities that offered a discursive space in which liberal equality could be further challenged and contested. I also argued these less secure positions and identities meant that equality was discursively constituted as a more dynamic, fluid and multiple concept, a form of equality in process as Mouffe (1994) suggests and this thesis demonstrates. It was not therefore a set of fixed rules or an end goal, but a continually constituted set of meanings and purposes, always changing, always in flux. As such, future political strategies will need to demand a continuous movement between strategies of equality and difference as circumstances and contexts require and dictate. I then argued there was a need to link these microanalyses to broader patterns of inequality, whilst refusing to endorse these as fixed, totalising, or universally applicable. Rather these were seen to form part of the dynamic discursive arenas in which discourses of liberal equality and difference exist and where a postmodern emancipatory politics could potentially form.

In conclusion, the demand to respond to diversity and ensure equality in community nursing practices will require a diverse application of various strategies at different times and places. How this is to be achieved with any certainty is debatable for, as Butler (1992) suggests, when identity is no longer the common ground to constrain politics then the form that politics takes remains less obvious. In this era of uncertainty, it may be more appropriate to develop strategies that explicitly seek to engage with and deconstruct discursively constituted selves and narratives and discourses of equal opportunities and anti-discriminatory practice. I have shown there is a need to demand a re-inscription of these values and emancipatory goals whilst continuously engaging in a dialogue with modern political projects. Together, this thesis has shown both the limits and the possibilities for this work.

APPENDICES

APPENDIX ONE

Respondents Biographies

1. Inner City University – Community Practice Teachers

Laura is a very experienced black health visitor working in an inner city health centre who has worked in the area for a long time. She came to the City to complete her nurse training because her mother was a nursing officer at the hospital near home and she felt she needed to get away. She returned to this inner city area to do her community health visitor training and at the time of interview had just completed her community practice teacher course. The area in which she worked was described as very deprived, with most families living in council housing. This was a very transient population with large numbers of lone parents, refugees, unemployed and most of Laura's work was with clients who were poor and had multiple needs.

Jan is a white health visitor, based in health centre, who had always wanted to be a nurse. She discovered health visiting during her training and wanted to train immediately. At the time of interview she had been a health visitor for twenty-two years. She had worked in the practice area for eighteen years and enjoys health visiting because it allows her to work with a variety of clients. The area was described as 'commuter country' with a mix of local people with good family networks and those new to the area who were described as isolated. Overall clients were described as well educated, articulate, older (thirties to forties) and wealthy.

Shirley, a white health visitor, had been a paediatric nurse and ward sister previously. In that senior role she had moved from clinical work to teaching and liaison referral work, so health visiting seemed 'the next step'. At the time of interview Shirley was a community practice teacher based in a health centre. The practice placement area was described as inner city, deprived, with an ethnic mix of clients, Shirley described this mix as British, Irish, African, Asian, Chinese, and Portuguese. Isolation, communication, poverty, housing and childcare were identified, as the key health needs.

Chris is a white community practice teacher for district nurses, who had been previously working in acute clinical care in a hospital. She enjoyed district nursing because it involved giving hands on care as well as problem solving and used a holistic approach with clients. She described the practice placement and area where she worked as affluent, with elderly people living fairly independently. Needs had been revealed through use of the 'over 75s check' which had uncovered undetected numbers of people with hypertension and diabetes, as well as carers needs, especially the low take-up rates for benefits.

Brenda, who identified herself as Asian, had worked in the practice placement area for five years. As a community practice teacher for district nurses, she had trained, had her children and then returned part time to the community at a time when district nurse training was non-mandatory. She enjoyed it so much that she stayed. Based in a health

centre, the area in which she worked was described as a 'mixed bunch', fairly "affluent as well as ordinary average people". The local population were mostly working, or retired people, predominately homeowners, with little council housing. This was a congested area where parking was difficult and car use high.

Georgina is a white health visitor based in a general practice. She had previously wanted to be a teacher but at the time she thought teaching wasn't the career to go into. A local Trust offered joint pre- registration training with an integrated health visiting qualification, which she completed and worked as a health visitor for a year. She then decided to do a degree and then masters and then undertook the health visitors tutors course and went into a further education college to teach access to health courses. Although she enjoyed the teaching, she didn't enjoy the educational environment. She has since returned to practice and has been working as a CPT for the last three years. The practice area was described as middle class, professional, mainly white population, where isolation was a problem. Asthma, pollution, breast cancer and obesity were the key needs, there were, however, pockets of deprivation where drugs were a problem and high rise flats, situated on a major road, were considered a 'no go area'.

Leanne is a white health visitor based in a general practice. She has been a health visitor for fifteen years and a community practice teacher for ten years. To keep up to date she felt the need to undertake a degree herself, as most of her students were now doing degrees. She completed a nurse practitioner degree, a very different role from health visiting, and combines this work with her full time health visiting community post. The practice area was described as middle class, professionals with some 'bed and breakfast places'. Louise described the major needs as alcohol related, including domestic violence, isolation, pollution, post natal depression and the quality of housing for refugees

1.1 Inner City University – Students

Victoria, who was a white student health visitor, was based in an inner city health centre. Through her nurse training she developed an interest in preventative work, which she felt was restricted once qualified and was working in accident and emergency. Prior to the course she had applied for school nursing, which she did for three months to gain community experience, especially in child protection work. However, the main benefits from this experience were described as working as an autonomous practitioner and being self- directed. She chose her practice area because of the diverse ethnic mix, which she found more interesting, especially as she had travelled to many developing countries previously. In the placement area she identified many refugees who subsequently had difficulty accessing GPs and many vulnerable families. Victoria described a high incidence of sickle cell amongst Afro -Caribbean clients and diabetes amongst Asian clients and enormous housing problems. Many lived in poor housing or were homeless, living in cramped conditions in temporary accommodation.

Jenny was a district nurse student at the time of interview. During her nurse training she had the opportunity to shadow health visitors and district nurses and had thought the role interesting. On qualifying, she worked at the Centre for Tropical Diseases for a year

and a half. Then a job came up in the community and she really enjoyed the work and described herself as lucky to get sponsorship six months after starting, especially as she had only been qualified for a total of three years. Jenny described the placement area as "quite a white middle class area". Clients were not considered to be living in deprivation and many were elderly.

Claire was a district nurse student at time of interview, who had already worked as a district nurse in the community. She originally started on nights, as it fitted with family commitments. When the children were older she joined the day service as she felt the children needed her around more. She had worked as an enrolled nurse for five years, moved to days for three years, and then moved to her current trust. She described her practice area as affluent, with an ethnic mix, mainly Asians, and areas of deprivation with a lot of rented accommodation, single parents, unemployed young people.

Kathleen, a white student, was undertaking the health visitor pathway and was based in a general practice. She had always wanted to be a health visitor since her general training. Since qualifying she had focused on women's health issues as a staff nurse on a gynaecological ward, then had moved on to midwifery training. Unfortunately, as a qualified midwife, she didn't enjoy the hours or working conditions and she knew health visiting was more regular, nine to five, Monday to Friday. She described the practice placement area as suburban or rather affluent, working with mainly white, middle class families living in 'expensive houses'. The main problems experienced by clients were described as post-natal depression, isolation and loneliness.

Sheena was a black health visitor student, based in an inner city general practice. She had always wanted to be a health visitor, even before she came into nursing. Once qualified and within three months, she had moved into the community as a staff nurse. The practice placement area was described as being very different form her previous experience in the community. This area was very mixed in terms of social class and ethnicity. Sheena defined this mix as a range of professional working people to people on low incomes, living in poor housing, teenage mothers living in high-rise flats, and lots of 'Greeks, Africans and Caribbean's'.

Mary was an experienced general nurse now training to be health visitor student. She is white and defines herself as Scottish. She had started training in the late 1970s and had initially thought she would do nursing for six months and then look for something else and, as she said, " twenty years later I am still here." She had worked in accident and emergency for fourteen years and then went into a senior management role, which included project management work. She undertook what was a stressful role for two years and then decided to move away form acute care into the community. Her practice placement area was described as relatively affluent, with bankers and stockbrokers, high rates of marriage, very white, very middle class. This was an area described as desirable in terms of schools, houses; Mary defined living in the area as a sign of having "made it". There was, however, a great deal of social isolation, post natal depression, and competitive pressures between parents trying to ensure their children were in the right nursery or school.

Sharon was a white student health visitor, based in a busy health centre. She had always wanted to be a health visitor and saw it as a natural progression seeing it as "less

adrenaline pumping sort of stuff". She undertook a degree and left nursing and went into research, which she did for three years. Unfortunately, this involved a great deal of computer work with little job satisfaction, so she returned to nursing and decided to become a health visitor. She actually lived in her practice placement area so felt she knew it quite well. She described it as very white, mostly class 3, alongside a "respectable working class area" and problems were identified as isolation, lack of family support and a high incidence of bottle-feeding and thrush.

2. Small Town University – Community Practice Teachers

Beatrice is a white health visitor, based in a busy general practice, in a very deprived small town. She had previously worked as a Sister on a coronary care unit for fifteen years. She had chosen health visiting because she wanted no more weekends, nor did she want a job that involved "just leg ulcers" although her district nurses colleagues had assured her their role isn't just this. She chose health visiting loves her job and moved into teaching, which she had previously undertaken on the wards, and had been a CPT now for six years. As a health visitor, she was attached to the general practice and was surgery based. She described the area as " hugely deprived" being one of the most deprived in the local health authority area. With very little purpose built council accommodation and too many converted Victorian houses, often with no central heating or double-glazing, and little local transport, the population were described as poor, very transient, moving from partner to partner and building up huge debts. Smoking, lack of safe play areas, speech delay and seasonal unemployment were described as the main problems.

Linda is a community nurse for people with learning disabilities and a community practice teacher. She described herself as of Asian origin. She had originally trained as a general nurse eighteen years ago and practised as a staff nurse for a few years before moving to a small community hospital. She was promoted to Sister and ran a community – based project for three to four years. When the funding ran out she was placed in a community team, she then undertook further training and moved to a post nearer home. She now lives in the practice area, which she described as "sedate" in comparison to where she worked previously. She was the only female nurse in the team and the district based service for clients with learning disabilities for both adults and children aims to provide support at home and in residential settings. The main needs of clients were described as behaviour management and responding to the needs of carers.

Catherine is a white community practice teacher for health visitors. She came into health visiting seven years ago, having previously had some involvement with the psychiatric nursing service and worked nights on the community. She felt she was well placed, given her own family and life experience, to become a health visitor. Catherine had now worked in the practice area for two years, which she described as rural, with a number of small villages and hamlets, isolated farmhouses and tied cottages. She described the population as middle class, older in age, "low social class" very mixed with very few " ethnic minority groups". Post natal depression, isolation, lack of family support, parenting issues and poor transport were identified as key problems.

Frances is a white health visitor who had always wanted to be a nurse from an early age. During her training she discovered health visiting, preferring the focus on women's health and health promotion rather than illness. On graduating, she decided to leave nursing and went to work as a health promotion worker on a breast-screening project. One year later she applied for health visitor training and, at the time of interview, had been a health visitor for six years and a CPT for one year. She had worked for a year in what she described as a known retirement area with a large number of elderly people. There was also a large number of under- fives population with a mix of new housing estates and council housing, good local transport and more "middle, upper class" retired families living on the outskirts of the town.

Denise is a white health visitor, working in a busy small coastal town. She had previously worked in a nursery school with children and had studied childcare at college. Both her sisters had become nurses and this seemed to her an easier route at the time than "something in child development". So she completed her general training, then qualified as a midwife before coming into health visiting. She had now been a health visitor for twenty years and a community practice teacher for twelve years. The area was described as rural, though on the outskirts of the small town, with a mixed population, ranging from wealthy clients to gypsies. People commuted and worked locally, it was a retirement area yet still popular with families. She described the ethnic mix of the population as ranging from White, Romany, Asian, Thai and Chinese. She worked closely with a settled Romany community of fifteen to twenty families. Main problems included claiming benefits, obesity, and immunisation coverage and behaviour management of children.

Jayne is a white community practice teacher for health visitors. During her general nurse training she realised she did not want to work in acute or chronic care. She applied for health visiting training before she finished her course. She had been a health visitor for eighteen years and a CPT for fifteen of those years. She felt there were two main options for career progression in nursing and, having chosen education over the nurse management route, was going on to do her degree the following September. The area was described as "having it's own problems" but was seen as relatively affluent, with good housing, low Jarman indices, with "very few ethnic minorities". There were, however, high numbers of lone parents, a high incidence of domestic violence, problems with drug use and teenagers and a number of isolated elderly people.

Sandra was a white district nurse CPT who had moved into the community for a job that didn't have weekends. She had previously worked as a sister on an elderly care unit for ten years. She described her self as loving her work and had been a CPT for 'six or seven years'. She worked 'attached' to a GP practice in a densely populated area, with many retired people, some fairly affluent, others relatively less well off. She enjoyed working with older people and loved her teaching role and meeting new students.

2.1 Small Town University – Students

At the time of interview **Lesley** was a part time student on the learning disabilities community nurse pathway. She is white and had been working in the community for eight years, two years as a community nurse and six years as a learning disabilities nurse. She was based in a busy day centre, located in the centre of a small town in an

office with a team including psychologists, psychiatrists and speech and physiotherapists. She described herself as a charge nurse with a caseload of fifty five to sixty people with learning disabilities, whom she visited in their homes or in residential settings. She described her role as assisting with the development of social behaviour skills and the expression of sexuality, treating medical conditions like epilepsy and offering training for other staff and carers. In terms of caseload, she identified her work as involving " cradle to grave" care although most of her clients were adults in their middle years, with only one client under sixteen. There were slightly more men than women, mainly white, and work with carers was mainly with older parents and women in particular. Key issues were access to respite care, stress and general access to health services for clients with learning disabilities.

Elaine was also a part time student on the learning disabilities community nurse pathway. She is white and had been working in Scotland in a large old hospital with 1,500 residents and at the time of the NHS and Community Care Act she moved south and obtained a post in the community and worked in the field for eight years. She was working in the same day centre as Lesley at the time of interview. She described her clients as mixed, men and women, young and old who need a service that assists them with developing relationships, behaviour skills, providing medication and help accessing health care. She felt clients' health needs were " the same as everybody else".

Helen was a health visitor student. She had qualified as a midwife and prior to the course had gained community experience through working as a Sister in a nursing home. She is white and described her client population as white, young, single unsupported parents, living in unsafe. Converted multiple occupancy homes. Key needs were described as the availability of nursery places and a lack of local transport.

Janet was a student district nurse who had completed her nurse training as a mature student. She had been a nursing assistant in hospital and with her family growing up she felt the need to consider her future career. On finishing her general training she worked in private hospitals for two years, though she'd always had a desire for community nursing. She gained a community post by covering for maternity leave and then went onto do the degree in district nursing. She chose this pathway because she felt experienced in working with older people. She described the practice area as affluent, with pockets of deprivation; she and her clients were mainly white and female both in terms of clients as well as carers.

Jackie was a health visitor student who had previously worked in many areas of nursing. She had gained community experience as a staff nurse specialising in work with elderly people. She undertook the health visiting training, which she knew to be generic but actually focuses on families and children under the age of five. She had found being a full time student especially hard with children and was now starting a part time post, which she found more manageable. She described her practice area as large, with no real identity; there were large council estates with new families, single parents and those who had lived in the area all their lives. She is white and described the ethnic mix of the area as mainly white with some Chinese families. In terms of needs, post natal depression, relationship problems and difficulties with parenting were mentioned. There were also issues with poor housing, transport and unemployment

Marion was a white district nurse student who had trained as an enrolled nurse over twenty years ago. She had her family and put off conversion to registered nurse until later. On completion, she worked as a staff nurse for three years and then applied for the degree course, which she had just completed and was now looking for a job. She was based in small town in a community trust and had worked in the practice area for a number of years. She described a mixed client group, lots of commuters, middle class, white, with pockets of deprivation. These areas included low -income families, travelling families and elderly people who lived in poor quality rented accommodation.

Penny was a white community mental health nurse who specialised in forensic psychiatry. She had received a recent promotion as a manger of a large caseload and had applied to do the degree. Her role involved working with clients who have mental health problems and offend and whose care needs overlap several agencies' responsibilities including psychiatry, police and social services. Her patch covered a large geographical area and key needs were seen to be co-ordinating care, maintaining medication, dealing with acute or crisis interventions and assessments, as well as having similar needs to everyone else, that is health care, housing, money and family support. She described her clients as predominately vulnerable individuals, mainly men, with no family or support networks, who have often been damaged by the system or their illness, having had lots of contact with the police and the courts

APPENDIX 2

Interview schedule – Introduction

Thank you for agreeing to take part in this research and interview. I am in interested in talking to nurses about their work with clients with different needs and how inequalities in health may have an impact on both your clients and your work with them. Then I would like to talk to you more specifically about how equal opportunities (and/or anti-discriminatory practice) may be used in that work and how that may be, especially when working with so many different clients with many health needs.

Biography & work

1. So first of all could you tell me about yourself, how you became a community nurse and what your job is now.

2. Could you tell me something about the area you work in? What is it like?

3. What are your clients' needs? Any social problems in this area?

4. Do you think these needs/problems lead to inequalities? – If so, why do you think that happens? –

5. So you see many clients with different needs, what are the differences or do you find differences between them of any sort?

Education and training

With these differences and difficulties your clients face, I would now like to ask you some questions about your training and education and how that was relevant to you and your work with clients.

1. How well do you think your training and education prepared you for working with or dealing with so many different clients needs or problems

2. What was helpful, what wasn't? Can you give me an example?

3. So did you cover anything on equal opportunities or anti discriminatory practice in your training? – Give examples, what was useful, what not?

4. What about multi cultural services? Did you ever look at how health services could be delivered so that they respond to so many needs?

5. Do you think there is a problem with the services available to people from many different backgrounds? Is it possible for health services/community nursing to do this?

6. Given that your training may not have been helpful in preparing you for work with clients with different needs does your trust give you guidelines, does it have an EO policy?

7. What expectations are made of you as a result f this policy/guidelines?

8. What about your managers or your contract? Any requirements or statements from professional organisations or trade unions? (CPHVA/RCN)

Practice

Given that there may (may not) be much help form your training or your trust in dealing with these issues or inequalities and having to work with clients with different needs, I would like to ask you

some questions about practice an dhow you decide who you see, how you prioritise and what you can do to ensure equality in health care.

1. How do you decide whom to see- what happens to those you don't see?
2. If your client said they were being discriminated against, what would you do?
3. Do you think some of your clients are more discriminated against?
4. Where do you think discrimination comes from?
5. Can you say how you would promote equal opportunities (adp)
6. So who do you think is the focus of or target of EO?
7. Do you think Eos has gone too far?

Theory of EO

I would like now like to talk to you more generally about health and equality in community nursing' work.

1. So thinking about equality and health more broadly, do you think it's correct to suggest that everyone has equal rights to healthcare. And do they have equal access? (Who/examples)
2. Given that some may not have access, do you think community nurses should do anything about this?
3. What can they do? – For example HV/DNs ? Can you give an example?

(If unable to answer - For example could they do anything about the language they use, their own attitudes or behaviour, challenge others,)

4. Do you think nurses are ever part of the problem? - Examples?
5. If you had all the resources, what would be the main changes you would make in the work you do to develop EO for clients? – Examples- what is there is your practice now?
6. When would you know that equal opportunities had been achieved?

Thank you for your time.

BIBLIOGRAPHY

Abma, T. A. (1999) Powerful Stories, The Role of Stories in Sustaining and Transforming Professional Practice within Mental Hospitals in Josselson, R. Lieblich, A eds. *Making Meaning of Narratives in The Narrative Study of Lives Volume Six.* London: Sage.

Acheson, D. (1998) *The Independent Inquiry in to Inequalities in Health.* Leeds: DOH

Agnew, T. (2000) Down Equality Street. *Health Service Journal*, 6th April, Vol. 110, No. 5699, p.12-13.

Ahmad, W.I.U. ed. (1993) *Race and Health in Contemporary Britain.* Buckingham :Open University Press.

Alcoff, L. & Potter, E. eds. (1993) *Feminist Epistemologies*. London: Routledge.

Allen, G. & Skinner, C. eds. (1991) *Handbook for Research Students in the Social Sciences*. London : Falmer Press.

Annandale, E. Hunt, K. eds. (2000) *Gender Inequalities in Health.* Buckingham: Open University Press.

Anthias, F. & Yuval-Davis, N. (1992) *Racialised Boundaries, Race, Nation, Gender, Colour, Class and the Anti Racist Struggle*. London : Routledge.

Armstead, C. (1995) Writing Contradictions: Feminist Research and Feminist Writing. *Women's Studies International Forum.* Vol. 18, No. 5-6, p. 627-636.

Armstrong, D. (1983) The Fabrication of Nurse-Patient Relationships. *Social Science and Medicine,* Vol.17, No. 8, p.457-60.

Armstrong, D. (1994) Bodies of Knowledge/Knowledge of Bodies in Jones, C. Porter, R. eds. *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge.

Atkinson, P (1990) *The Ethnographic Imagination: Textual Constructions of Reality.* London: Routledge.

Bacci, L.C. (1996) *The Politics of Affirmative Action: 'Women', Equality & Category Politics*. London: Sage.

Bagihole, B. Stephens, M. (1999) Management Responses to Equal Opportunities for the Ethnic Minority Women within an NHS Hospital Trust. *Journal of Social Policy*, Vol. 28, p235-248.

Bakhtin, M.(1981) *The Dialogic Imagination*. Texas: University of Texas Press.

Barnes, C. (1992) *Disabled People in Britain*. London: Hurst

Barrett, M. Phillips, A. eds. (1992) *Destabilising Theory*. Cambridge: Polity Press.

Bartley, M. Blane, D. Davey Smith, G. ed. (1998) *The Sociology of Health Inequalities.* Oxford: Blackwell.

Beishon, S. Virdee, S. Hagell, A. (1995) *Nursing in a Multi- Ethnic NHS.* London: Policy Studies Institute.

Beishon, S.(1997) Equal Opportunities in Nursing. *Health Visitor*. Vol. 70, No. 2, p. 62-3.

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

Benner, P. Tanner, C. Chesla, C. (1996) *Expertise in Nursing Practice, Caring, Clinical Judgement and Ethics*. New York: Springer.

Benner, P. (2000) The Roles of Embodiment, Emotion and Lifeworld for Rationality and Agency in Nursing Practice. *Nursing Philosophy.* Vol. 1, No.1, p.5-19.

Benhabib, S. (1995) Feminism and Postmodernism in Benhabib, S. Butler, J. Cornell, D. Fraser, N. *Feminist Contentions: A Philosophical Exchange.* London: Routledge.

Benhabib, S. Butler, J. Cornell, D. Fraser, N. (1995) *Feminist Contentions: A Philosophical Exchange.* London: Routledge.

Biggs, S. (2000) User Voice, Interprofessionalism and Post modernity in Davies, C. Finlay, L. Bullman, A. eds. *Changing Practice in Health and Social Care.* London: Sage.

Blakemore, K. Drake, R. (1996) *Understanding Equal Opportunities Policies*. London :Prentice Hall -Harvester Wheatsheaf.

Bloor, M. McIntosh, J. (1990) Surveillance and Concealment: A Comparison of Techniques of Client Resistance in Therapeutic Communities and Health Visiting, in Cunnigham-Burley, S. McKegany, N. eds. *Readings in Medical Sociology.* London:Tavistock.

Boud, D. Koegh, R. Walker, D. (1985) *Reflection: Turning Experience into Learn*ing. London. Kogan Page.

Boud, D. Walker, D. (1998) Promoting Reflection in Professional Courses: the Challenge of Context, *Studies of Higher Education.* Vol. 23, No. 2, p. 191-206.

Bourdieu, P. (1977) *Outline of a Theory of Practice.* Cambridge: Cambridge University Press.

Bowden,P. (2000) An 'Ethic of Care' in Clinical Settings: Encompassing 'Feminine and Feminist' perspectives. *Nursing Philosophy*. Vol. 1, No. 1, p. 36-49.

Bowes, A.M. Domokos, T.M (1993) South Asian Women and Health Services: A Study in Glasgow. *New Community*. Vol. 19, No.4, p. 611-626.

Bowes, A. M. Domokos, T. M. (1998) Health Visitors' Work in a Multi-Ethnic Society: a Qualitative Study of Social Exclusion. *Journal of Social Policy*. Vol. 27, p. 489-506.

Bowler, I. (1993) They're Not the Same as Us. *Sociology of Health & Illness*. Vol. 15, No2. p.157-178.

Brah, A. (1992) Difference, Diversity and Differentiation, in Donald, J. Rattansi, A. eds. *'Race' Culture and Difference*. London: Sage.

Braham, P. Rattansi, A. Skellington, R. (1992) *Racism and Anti Racism: Inequalities, Opportunities and Polices*. London: Sage & Open University Press.

Brooks, A. (1997) *Postfeminisms: Feminism, Cultural Theory and Cultural Forms.* London: Routledge.

Bryman, A. & Burgess, R eds. (1994) *Analysing Qualitative Data*. London: Routledge.

Bulmer, M. ed (1984) 2nd ed. *Sociological Research Methods: An Introduction.* London: Macmillan.

Bulmer, M. Rees, A.M. eds. (1996*) Citizenship Today*. London: UCL Press.

Burr, V. (1995*) An Introduction to Social Constructionism*. London:Routledge.

Butler, J (1990) *Gender Trouble; Feminism and the Subversion of Identity*. London: Routledge.

Butler, J. (1992) Contingent Foundations: Feminism and the Question of "Postmodernism" in Butler, J. & Scott, J. eds. *Feminists Theorise the Political*. London: Routledge.

Butler, J. (1993) *Bodies That Matter: On the Discursive Limits of Sex.* London: Routledge.

Butler, J. & Scott, J. eds. (1992) *Feminists Theorise the Political*. London: Routledge.

Bywaters, P. McLeod, E. (1996*) Working for Equality in Health*. London: Routledge.

Cameron.E. Badger, F. Evers, H. (1989) District Nursing, the Disabled and the Elderly: Who are the Black Patients? *Journal of Advanced Nursing*. Vol. 14, No.5, p. 376-82.

Cameron, P. Willis, K. Crack, G. (1995) Education for Change in a Postmodern World :Redefining Revolution. *Nurse Education Today*. No 15, p.336-340.

Carter, H. (1994) Confronting Patriarchal Attitudes in the Fight for Professional Recognition. *Journal of Advanced Nursing*. Vol. 19, No. 2, p.307-372.

Cheek, J. (1999) Influencing Practice or Simply Esoteric? Researching health Care Using Postmodern Approaches. *Qualitative Health Research* Vol. 9, No. 3, May, p.383-392.

Cheek, J.(2000*) Postmodern and Poststructural Approaches to Nursing Research.* London: Sage.

Cockburn.C. (1991) *In the Way of Women*. London: Macmillan.

Coffey, A. Holbrook, B. Atkinson, P. (1996) Qualitative Data Analysis: Technologies and Representations *Sociological Research Online*, Vol.1, No.1, 1p.1-16.

Commission for Racial Equality (1991) *NHS Contracts & Racial Equality: A guide.* London: CRE.

Cowley, S. Casey, A. (1995) The Language of Community Nursing, in Littlewood, J. ed. *Current Issues in Community Nursing:Primary Health Care in Practice.* London: Churchill Livingstone.

Crowe, M. (1998) The Power of the Word: Some Post Structural Considerations of Qualitative Approaches in Nursing Research. *Journal of Advanced Nursing.* Vol. 28 No.2, p.339-344.

Crowe, M. (2000) The Nurse-Patient Relationship: A Consideration of its Discursive Context *Journal of Advanced Nursing*. Vol. 1, No. 4, p. 962-967

Culley, L. (1996) A Critique of Multiculturalism in Health Care :The Challenge for Nurse Education. *Journal of Advanced Nursing.* Vol. 23, No.3, p.564-570.
Culley, L.(2001) Equal Opportunities Policies and Nursing Employment within the British National Health Service. *Journal of advanced Nursing*. Vol.33, No.1, p.130-7.

Cunnigham-Burley, S. McKegany, N. eds. (1990) *Readings in Medical Sociology.* London:Tavistock.

Davies, C. (1980) ed. *Rewriting Nursing History*. New Jersey: Barnes & Noble.

Davies, C. (1988) The Health Visitor as Mother's Friend: A Woman's Place in Public Health 1900-1914. *Social History Medicine.* No 1. p. 39-60.

Davies, C. (1992) Gender, History and Management Style in Nursing: Towards a Theoretical Synthesis in Savage, M. Witz, A. *Gender and Bureaucracy*. Oxford: Blackwell.

Davies, C. (1995) *Gender and the Professional Predicament in Nursing.* Buckingham: Open University Press.

Davies, C. (2000) Care and the Transformation of Professionalism in Davies, C. Finlay, L. Bullman, A. eds. *Changing Practice in Health and Social Care.* London: Sage: Open University Press.

Davies, C. Finlay, L. Bullman, A. eds.(2000) *Changing Practice in Health and Social Care.* London: Sage:Open University Press.

De Certeau, M. (1984) *The Practice of Everyday Life.* London. University of California Press Ltd.

Denzin,N.K. (1997) *Interpretative Ethnography: Ethnographic Practices for the 21st Century.* London. Sage.

Department of Health. (1997) *The New NHS Modern: Dependable* Cm3807 London: The Stationery Office.

Department of Health. (1998) *A First Class Service: Quality in the NHS.* London: The Stationery Office.

Department of Health. (1998) *Our Healthier Nation, A Contract for Health: A Consultation Paper. Cm 3852.* London: The Stationery Office.

Department of Health.(1998) *NHS Equality Awards.* London: DOH.

Department of Health.(1999) *Tackling Racial Harassment Action Plan.* HSC 99/60. London. DOH.

Department of Health. (2000*) The NHS Plan: A Plan for Investment, A Plan for Reform.* London: The Stationery Office.

Department of Health (2000) *Vital Connections: An Equalities Framework for the NHS: Working together for quality and equality.* London: The Stationery Office.

Derrida, J. (1978) *Writing and Difference.* London: Routledge.

Dey, I. (1993) *Qualitative Data Analysis:A User friendly Guide for Social Scientists.* London. Routledge.

Dingwall, R. Rafferty, A.M. Webster, C. (1988) *An Introduction to the Social History of Nursing.* London :Rouledge.

Dominelli, L. (1988) *Anti-Racist Social Work.* London: Macmillan

Dominelli,L. (1996) Deprofessionalising Social Work :Anti-Oppressive Practice, Competencies and Postmodernism. *British Journal of Social Work.* No.26, p.153-175.

Donald, J. Rattansi, A. eds. (1992) *'Race' Culture and Difference.* London: Sage.

Douglas, J. (1992) Black Women's Health Matters: Putting Black Women on the Research Agenda in Roberts, H. ed. *Women's Health Matters.* London: Routledge.

Doyal, L (1979) *The Political Economy of Health.* London: Pluto Press.

Doyal, L. (1995) *What Makes Women Sick.* London: Macmillan.

Dyck, I. Lynam, J. & Anderson, J. (1995) Women Talking: Creating Knowledge through Difference in Cross-Cultural Research. *Women's Studies International Forum* Vol. 18, No. 5-6, p.611-626.

Eisenstein, Z.R (1993) *The Radical Future of Liberal Feminism.* Boston:Northwestern University press.

Eisenstein, Z.R.(1994)*The Color of* Gender:*Reimaging Democracy* London: University of California Press.

Elison, M. J.(1996) Lesbian and Gay Family Issues. *Journal of Family Nursing.* Vol. 2, No.1, p.10-29.

English National Board (1990) *Regulations and Guidelines for the Approval of Institutions and Courses.* London: ENB.

English National Board (1995) *Creating Lifelong Learners: Partnerships for Care, guidelines for the implementation of programmes leading to the qualification of specialist practitioner.* London: ENB.

English National Board. (1998) *Recruiting Ethnic Minority Groups in Nursing, Midwifery and Health Visiting.* London: ENB.

Essed, P. (1991) *Understanding Everyday Racism; An Interdisciplinary Theory.* London:Sage.

Fahy, K. (1997) Postmodern Feminist Emancipatory Research: is it an Oxymoron? *Nursing Inquiry.* Vol. 4, p. 27-33.

Fairclough, N. (1992) *Discourse and Social Change.* Cambridge: Polity Press.

Fairclough, N. (2000) *New labour, New Language?* London: Routledge.

Fish, D. Coles, C. (2000) Seeing Anew: Understanding Professional Practice as Artistry, in Davies, C. Finlay, L. Bullman, A. eds. *Changing Practice in Health and Social Care.* London: Sage: Open University Press.

Finlayson, L. Nazroo, J. (1998) *Gender Inequalities in Nursing Careers* London: Policy Studies Institute.

Flax, J. (1990) Postmodernism and Gender Relations in Feminist Theory in Nicholson, L. ed. *Feminism/Postmodernism.* London: Routledge.

Flax, J. (1993) *Disputed Subjects: Essays on Psychoanalysis, Politics and Philosophy.* London: Routledge.

Foolchand, M. K. (1995) Promoting Racial Equality in the Nursing Curriculum. *Nurse Education Today.* No15, p.101-105.

Forbes, I. (1992) Equal Opportunity: Radical, Liberal and Conservative Critiques in Meehan, E. Sevenhuijsen, S. eds. (1990*) Equality, Politics and Gender.* London: Sage.

Foster, M. (1988) Health Visitors Perceptions on Working in a Multi -Ethnic Society *Health Visitor.* Vol 61, p. 275-278.

Foucault, M. (1970) *The Order of Things:An Archaeology of the Human Sciences.* London: Tavistock.

Foucault, M. (1974) *The Archaeology of Knowledge.* London: Tavistock.

Foucault, M. (1976) *The Birth of the Clinic.* London: Routledge.

Foucault, M. (1979a) *Discipline and Punish :The Birth of the Prison.* Harmondsworth: Penguin.

Foucault, M (1979b) *The History of Sexuality Volume One. An Introduction.* Harmondsworth: Penguin.

Foucault, M.(1980) *Power/Knowledge. Selected interviews and other writings 1972-1977 by Michel Foucault, Gordon, C ed.* Brighton: Harvester Press.

Foucault, M (1986) *The History of Sexuality, Volume Two. The Use of Pleasure.* Harmondsworth: Penguin.

Foucault, M (1988) *The History of Sexuality, Volume Three. The Care of the Self.* Harmondsworth: Penguin.

Fox, N. (1993) Postmodernism, Sociology and Health. Buckingham: Open University Press.

Francis, B. (2000) Poststructuralism and Nursing: Uncomfortable Bedfellows? *Nursing Inquiry.* No.7, p.20-28.

Franzway, S. Court, D. Connell, R.W.(1989) *Staking a Claim: Feminism, Bureaucracy and the State.* Cambridge: Polity Press.

Fulton,Y.(1997) Nurses Views on Empowerment :a Critical Social Theory Perspective. *Journal of Advanced Nursing.* Vol. 26, No. 3, p.529-536.

Fuss, D. (1989) *Essentially Speaking: Feminism, Nature and Difference.* London: Routledge.

Gamarnikow, E. (1991) Nurse or Woman: Gender and Professionalism in Reformed Nursing 1860-1923 in Holden, P. Littlewood, J. eds. *Anthropology and Nursing.* London: Routledge..

Gastaldo, D. Holmes, D (1999) Foucault and Nursing: A History of the Present. *Nursing Inquiry.* No.6, p. 231-240.

Gergen, K.J. Gergen, M. (1991) Towards Reflexive Methodologies, in Steier, F. *Research and Reflexivity, Inquiries in Social Construction.* London: Sage.

Gerrish, K. (2000) Individualised Care: its Conceptualisation and Practice within a Multi-Ethnic Society. *Journal of Advanced Nursing* Vol. 32, No. 1, p. 91-99.

Gerrish, K. (2000) Researching Ethnic Diversity in the British NHS: Methodological and Practical Concerns. *Journal of Advanced Nursing.* Vol. 31, No. 4, p.918-925.

Gerrish, K. Husband, C. & Mackenzie, J. (1996) *Nursing for a Multi-Ethnic Society.* Buckingham: Open University Press.

Giddens, A. (1991) *Modernity and Self Identity: Self and Society in the Late Modern Age.* Cambridge: Polity Press.

Giddens, A. (1998) *The Third Way: The Social Renewal of Democracy.* Cambridge: Polity Press.

Gill, R. (1994) Discourse Analysis: Practical Implementation in Richardson, J. T. E. ed. *Handbook of Qualitative Research Methods for Psychology and the Social Sciences.* Leicester: BPS.

Gilligan, C.(1982) *In a Different Voice.* Cambridge: Mass. Harvard University Press.

Gilroy, P. (1992) The End of Anti Racism in Donald, J. Rattansi, A. eds. *'Race' Culture and Difference.* London: Sage.

Gladwin M. (1996) *Movements for Equality: The Nature of Equality Politics in Britain.* PhD Thesis, Southampton University: Unpublished.

Griffiths, J. (1996) *An Ethnographic Study of District Nursing Work.* PhD. Thesis, University of Liverpool: Unpublished.

Grosz, E. (1993) Bodies and Knowledges : Feminism and the Crisis of Reason in Alcoff, L. & Potter, E. eds. (1993) *Feminist Epistemologies.* London: Routledge

Guba, E. Lincoln, Y. (1989) *Fourth Generation Evaluation.* Newbury park Ca. :Sage

Halford, S. (1992) Feminist Change in a Patriarchal Organisation: the Experience of Women's Initiatives in Local Government and Implications for Feminist Perspectives

on State Institutions, in Savage, M. Witz, A. *Gender and Bureaucracy.* Oxford:Blackwell.

Halford, S. Savage, M. Witz, A. (1997) *Gender, Careers and Organisations : Current Developments in Banking, Nursing and Local Government.* Basingstoke: Macmillan.

Halford, S. Leonard, P. (2001) *Gender, Power and Organisations.* Basingstoke: Palgrave.

Hall, S. (1990) Cultural Identity and Disapora, in Woodward, K. ed.(1997) *Identity and Difference.* London: Sage.

Hall, S. (1992) New Ethnicities, in Donald, J. Rattansi, A. eds. *'Race' Culture and Difference.* London: Sage.

Hammersley, M. (1992) *What's Wrong with Ethnography?* London: Routledge.

Hammersley, M.(1993*) Social Research: Philosophy, Politics and Practice.* London: Sage.

Harding, S. (1987) *Feminism and Methodology; Social Science Issues.* Milton Keynes: Open University Press.

Harding, S. (1993) Rethinking Standpoint Epistemology: What is Strong Objectivity? in Alcoff, L. & Potter, E. eds. *Feminist Epistemologies.* London: Routledge

Hargreaves,J. (1997) Using patients: Exploring the Ethical Dimension of Reflective Practice in Nurse Education. *Journal of Advanced Nursing.* Vol. 25, p.223-228.

Hartsock, N. (1990) Foucault on Power: A Theory for Women? In Nicholson, L. ed. *Feminism/Postmodernism.* London: Routledge.

Hartsock, N. (1996) Postmodernism and Political Change: Issues for Feminist Theory in, Hekman, S. ed. *Feminists Interpretations of Michel Foucault.* Pennsylvania: Pennsylvania State Press.

Health Visitors Association (1987) *Working Party on Racial Issues.* Acc634: 13, Working Party Files, London: Wellcome Institute.

Hedge, A.H. (1996) *Talk about Discrimination: An Analysis of the Language we use to Talk about Equal Opportunities.* PhD. University of London. London. Unpublished.

Hekman, S. (1990) *Gender and Knowledge.* Cambridge: Polity Press.

Hekman, S. ed (1996) *Feminists Interpretations of Michel Foucault.* Pennsylvania: Pennsylvania State Press.

Henderson, A. (1994) Power and Knowledge in Nursing Practice: The Contribution of Foucault. *Journal of Advanced Nursing.* Vol. 20, No. 5, p.935-939.

Henwood. K. & Pidgeon, N. (1994) Beyond the Qualitative Paradigm : A Framework for Introducing Diversity within Qualitative Psychology. *Journal of Community and Applied Social Psychology*. Vol. 4, p. 225-238.

Henwood, K. Griffen, C. Phoenix, A. eds. (1998) *Standpoints and Difference: Essays in the Practice of Feminist Psychology*. London: Sage.

Hewison, A. (1995) Nurses Power in Interactions with Patients. *Journal of Advanced Nursing*. No. 21, p.73-82.

Hewitt, M. (1995) Social Policy and the Question of Postmodernism in Page, R. Baldock, D. eds. *Social Policy Review 6*. Canterbury: SPA.

Hill Bailey, P (1997) Finding Your Way Around Qualitative Methods in Nursing Research. *Journal of Advanced Nursing*. Vol.25, No. 1, p. 18-22.

Hillyard, P. Watson, S. (1996) Post modern Social Policy: A Contradiction in Terms? *Journal of Social Policy*. Vol.25, No.3, p.321-346.

hooks, b (1990) *Yearning:Race, Gender, and Cultural Politics*. Boston MA: South End Press.

Holden, P. Littlewood, J. eds.(1991) *Anthropology and Nursing*. London: Routledge.

Hugman, R. (1991) *Power in Caring Professions*. London: Macmillan.

Hurry, J. B. (1898) *District Nursing on a Provident Basis*. London: The Scientific Press.

Iganski, P. Spong, A. Mason, D. Humphreys, A. Watkins, M. (1998) Evaluation of Equal Opportunities Policy: The Recruitment of Minority Ethnic Groups into Nursing, Midwifery and Health Visiting. *Research Highlights 30- May* London: ENB.

Inner City University(1998a) *BSc (Hons) Postgraduate Diploma in Community health Care 1998-99, Professional Practice Book- Nursing in the Home- District Nursing.*Inner City. Inner City University

Inner City UniversityUniversity (1998b) *BSc (Hons) in Community health Care: Social and Political Perspectives in Primary care (THC-3-103) Unit Guide.*Inner City. Inner City University

Jewson, N. Mason, D. (1992) The Theory and Practice of Equal Opportunities Polices: Liberal and Radical Approaches in Braham, P. Rattansi, A. Skellington, R. *Racism and Anti Racism: Inequalities, Opportunities and Polices*. London: Sage & Open University Press.

Johnson, M. (1993) Equal Opportunities in Service Delivery: Responses to a Changing Population in Ahmad, W.I.U. ed. *Race and Health in Contemporary Britain*. Buckingham :Open University Press.

Jones, C. & Porter, R. ed. (1994) *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge.

Josselson, R. (1995) Imagining the Real: Empathy, Narrative and the Dialogic Self in Josselson, R. Lieblich, A eds *Interpreting Experience: The Narrative Study of Lives*. Thousand Oaks: Sage.

Josselson, R. Lieblich, A eds (1999*) Making Meaning of Narratives in The Narrative Study of Lives Volume Six.* London: Sage.

Josipovic, P.(2000) Recommendations for Culturally Sensitive Nursing Care. *International Journal of Nursing Practice.* Vol.6, No. 3, p. 146-152.

Kendall, G. Wickham, G. (1999) *Using Foucault's, Methods*. London: Sage.

Kenway, J. Willis, S. Blackmore, J. & Rennie, L. (1994) Making Hope Practical rather than Despair Convincing : Feminist Post Structuralism, Gender Reform, and Educational Change *British Journal of Sociology of Education.* Vol. 15, No.2, p.187-210

Kermode, S. Brown, C. (1996) The Postmodern Hoax and its Effect on Nursing *International Journal Nursing Standard.* Vol. 33, No 4, p. 375-384.

Kings Fund Equal Opportunities Task Force (1987*) A Model Policy for Equal Opportunities in Employment in the NHS. Occasional Paper No1*. London: King Edward's Hospital Fund for London.

Kings Fund Equal Opportunities Task Force (1990) *Racial Equality: The Nursing Profession. Taskforce Position Paper,* Occasional Paper No. 6, London: King Edward's Hospital Fund for London.

Kings Fund (1999) *Local Inequalities Targets*. Available from http://www.kingsfund.org.uk/targets/

Langridge, C. (1993) Women on the Edge of a Workforce Breakthrough. *Health Service Journal* 7th Oct p. 28-30.

Lather, P (1991) *Getting Smart: Feminist research and Pedagogy With/In the Post modern.* London: Routledge.

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

Lawler, J (1999) De(con)struction of Nursing Work: Economic Rationalism and Regulation. *Nursing Inquiry*. No.6, p.141-142.

Lawless, S. Kippax, S. Crawford, J. (1996) Dirty, Diseased and Undeserving :The Positioning of HIV Positive Women *Social Science and Medicine.* Vol 43, No 9, p. 1371-1377.

Lee R.M. (1993) *Doing Research on Sensitive Issues.* London: Sage.

Leininger, M (1981) *Caring: An Essential Human Need.* New Jersey: Slack.

Lemke, J. (1995) *Textual Politics: Discourse and Social Dynamics.* London: Taylor& Francis.

Liaschenko,J. (1999) Can Justice Coexist With the Supremacy of Personal Values in Nursing Practice? *Western Journal of Nursing Research.* Vol. 21, No.1, p.35-50.

Lipsky, M. (1980) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services.* New York: Russell Sage Foundation.

Lister,P. (1997) The Art of Nursing in a Postmodern Context. *Journal of Advanced Nursing.* Vol.25, No.1, 25, p.38-44.

Lister, R. (1997) *Citizenship,Feminist Perspectives.* London: Macmillan.

Lister, R. (1998)Vocabularies of Citizenship and Gender in the UK. *Critical Social Policy.* Vol.18, No3. p.303-331.

Littlewood, J. ed. (1995) *Current Issues in Community Nursing : Primary Health Care in Practice.* London: Churchill Livingstone.

Lookinland, S. Anson, K. (1995) Perpetuation of Ageist Attitudes among Present and Future Health Care Personnel: Implications for Elder Care. *Journal of Advanced Nursing.* Vol.21, No. 1, p. 47-56.

Luker, K. Orr, J.(1992) *Health Visiting: Towards Community Health Nursing* 2nd ed. Oxford: Blackwell Science.

Lupton, D. (1994) *Medicine as Culture: Illness, Disease and the Body in Western Societies.* London: Sage.

Lyotard J.F. (1986) *The Postmodern Condition: A Report on Knowledge.* Manchester: Manchester University Press.

Mackay,L. (1989). *Nursing a Problem* Milton Keynes: Open University Press.

Macpherson,W. (1999) *The Stephen Lawrence Inquiry*: London. The Stationery Office.

Mama, A. (1992) Black Women and the British State: Race, Class and Gender Analysis for the 1990s in Braham, P. Rattansi, A. Skellington, R. *Racism and Anti Racism: Inequalities, Opportunities and Polices.* London: Sage.

Manufacturing, Science and Finance (1997) *The Tables are Bare A Briefing on the Continuing Inability of the NHS to Meet its Own Equal Opportunities Goals in Respect of Ethnic Minority Staff.* London: MSF.

Marshall,H (1994) Discourse Analysis in an Occupational Context in Cassel, C. Symon,G. *Qualitative Methods in Organisational Research: A Practical Guide.* London: Sage.

Marshall, T. H. (1950) *Citizenship and Social Class and Other Essays.* Cambridge: Cambridge University Press.

Mason,D. Jewson, N. (1992) 'Race', Equal Opportunities Policies and Employment Practices: Reflections on the 1980s, Prospects for the1990s. *New Community.* Vol. 19, No. 1, p. 99-112.

May,C. (1992) Nursing Work, Nurses' Knowledge, and the Subjectifcation of the Patient. *Sociology of Health & Illness.* Vol.14, No.4, p.472-487.

McNay,L. (1992) *Foucault and Feminism.* Oxford: Polity Press

Meehan, E. Sevenhuijsen, S. eds. (1990*) Equality, Politics and Gender.* London:Sage.

Meehan, E. (1992) EC Policies on sex equality. *Women's Studies International Forum.* Vol. 15, No.1, p.57-64.

Mensah, J.(1996) Everybody's Problem. *Nursing Times* May 29th, Vol. 92, No.22, p. 26-27.

Mens-Verhulst, J. (1998) Beyond Innocence: Feminist Mental Health Care and the Post modern perspective in, Henwood, K. Griffen, C. Phoenix, A. eds.*Standpoints and Difference: Essays in the Practice of Feminist Psychology.* London: Sage.

Merry,E.J. Irven, I. D.(1948) *District Nursing: A Handbook for District Nurses and For all Concerned in the Administration of a District Nursing Service.* London: Balliere Tindall.

Mies, M. (1983) (1993) Towards a Methodology for Feminist Research in Hammersley, M. ed. (1993) *Social Research :Philosophy ,Politics & Practice.* London: Sage.

Miles, A. (1991) *Women, Health and Medicine.* Milton Keynes: Open University Press.

Miles, M. & Huberman, M. (1994) 2nd ed. *Qualitative Data Analysis.* London: Sage.

Miller, J & Glassner, B. (1997) The "inside " and "outside" Finding Realities in Interviews in Silverman, D. ed. *Qualitative Research, Theory, Method and practice.* London: Sage.

Morse, J. M. Field, P.A. (1996) 2nd ed. *Nursing Research. The Application of Qualitative Approaches.* London. Chapman & Hall.

Morris, J. ed. (1996) *Encounters with Strangers*. London: The Women's press.

Mouffe, C. (1994) Feminism, Citizenship, and Radical Democratic Politics in Nicholson,L. Seidman, S. ed. *Social Postmodernism: Beyond identity politics.* Cambridge: Cambridge University Press.

Narayanasamy, A. (1999) Trancultural Mental Health Nursing 1: Benefits and Limitations. *British Journal of Nursing.* Vol. 8, No. 10, p. 664-668.

Narayanasamy, A. (1999) Trans-cultural Mental Health Nursing 2: Race, Ethnicity and Culture. *British Journal of Nursing.* Vol. 8, No. 11, p.741-774.

National Association of Health Authorities (1998*) Action Not Words: A Strategy To Improve Health Services for Black Minority Ethnic Groups.* Birmingham: National Association of Health Authorities.

National Health Service Executive (1996) *Women in the NHS Opportunity 2000.* Leeds: HMSO.

National Health Service Executive (1998) *Equal Opportunities and Monitoring in NHS Trusts: A survey of 420 NHS Trusts in England and 25 cases of good practice in equal opportunities*. HSC 1998/148. Leeds: DOH.

National Health Service Executive (1999) *Tackling Racial harassment in the NHS- A Plan for Action.* HSC 1999/060. Leeds: DOH.

National Health Service Management Executive (1993) *Ethnic Minority Staff in the NHS.* London: NHSME/DOH.

Nettleton, S. (1995) *The Sociology of health and Illness*. Cambridge: Polity pres.

Nicholson, L. ed. (1990) *Feminism/Postmodernism*. London: Routledge.

Nicholson, L. (1999) *The Play of Reason: From the Postmodern to the Modern.* Buckingham: Open University Press.

Nicholson, L. Fraser, N. (1990) Social Criticism Without Philosophy: An Encounter Between Feminism and Postmodernism in Nicholson, L. ed. (1990) *Feminism/Postmodernism*. London: Routledge.

Nicholson, L & Seidman, S. eds. (1995) *Social Postmodernism.* Cambridge: Cambridge University Press.

Nightingale, F. (1881) *On Trained Nursing for the Sick Poor*. London: Spottiswoode.

Northway, R. (1997) Disability and Oppression: Some Implications for Nurses and Nursing. *Journal of Advanced Nursing,* Vol.26, No.4, p.736-743.

Nursing Times editorial (1999) Furore Over Congress Race Resolution. *Nursing Times.* March 17th, Vol. 95, No11, p. 8-9.

Oakley, A. (1980) *Women Confined: Towards a Sociology of Childbirth.* Oxford: Martin Robinson.

Oakley, A. (1984) The Professionalisation of Nursing. *Nursing Times.* Dec 12th p. 24-27.

Oakley, A. (1998) Science, Gender, and Women's Liberation: An argument Against Postmodernism. *Women's Studies International Forum.* Vol. 21, No. 2, p.133-146.

O'Neal, S. (1996) *Academic Trade Union Equal Opportunities Polices & Anti-Racist Initiatives in Higher Education.* PhD Thesis. University of London. Unpublished.

Oppenheim,A.N. (1992) *Questionnaire Design, Interviewing and Attitude Measurement.* London:Pinter.

Pateman, C. (1989) *The Disorder of Women: Democracy, Feminism and Political Theory.* Cambridge: Polity Press.

Pearson,M. (1985) *Racial Equality and Good practice.* London: HEC.

Pereira, J. (1993) What does Equity in Health Mean ? *Journal of Social Policy* Vol. 22, No. 1, p.19-48.

Phillips, A. (1991) *Engendering Democracy.* Cambridge: Polity Press.

Phillips, A. (1993) *Democracy and Difference.* Cambridge: Polity Press.

Phillips, A. ed. (1998) *Feminism and Politics.* Oxford: Oxford University Press.

Phillips, A. (1999) *Which Equalities Matter.* Cambridge: Polity Press.

Pilgrim, D. Roger, A. (1999) *The Sociology of Mental Health and Illness.* Buckingham: Open University Press.

Porter, S. (1993) Critical Realist Ethnography: The Case of Racism and Professionalism in a Medical Setting. *Sociology.* Vol. 27, No. 2, p. 591-609.

Porter, S. (1998) *Social Theory and Nursing Practice.* London: Macmillan

Potter, J. Wetherell, M. (1987) *Discourse and Social Psychology.* London: Sage.

Potter, J. (1996) Discourse Analysis and the Constructionist Approaches: Theoretical Background in Richardson, J. ed. *Handbook of Qualitative Research Methods for Psychology and the Social Sciences.* Leicester: The British Psychological Society.

Pringle, R. Watson, S. (1992) Women's Interests and the Post Structural State in Barrett, M. Phillips, A. eds. *Destabilising Theory*. Cambridge: Polity Press.

Pringle, R. (1998) *Sex and Medicine: Gender, Power and Authority in the Medical Profession.* Cambridge: Cambridge University Press.

Rabinow, P. ed.(1984) *The Foucault Reader*. Harmondsworth: Penguin.

Ramazanoglu, C. ed. (1993) *Up Against Foucault: Explorations of some tensions between Foucault and feminism.* London: Routledge.

Rattansi,A. (1994) Just Framing ;Ethnicities and Racisms in a "Post Modern Framework" in Nicholson, L. Seidman, S. ed. *Social Postmodernism: Beyond identity politics*. Cambridge: Cambridge University Press.

Razack, R. (1999) Anti-Discriminatory Practice: Pedagogical Struggles and Challenges. *British Journal of Social Work.* No. 29, p.231-250.

Reed, J. Proctor, S. (1993) *Nurse Education:A Reflective Approach*. London: Edward Arnold.

Reinharz, S. (1992) *Feminist Methods in Social Research*. Oxford: Oxford University Press.

Roberts, H. ed. (1992) *Women's Health Matters*. London: Routledge.
Robinson, J. (1991) Educational Conditioning: Working with Doctors. *Nursing Times*. Vol. 87, No. 10, p. 28-31.

Robinson, J. Gray, A. Elkan, R. eds. (1992) *Policy Issues in Nursing*. Milton Keynes: Open University Press.

Robinson, K. (1991) The Nursing Workforce: Aspects of Inequality, in Robinson, J. Gray, A. Elkan, R. eds. *Policy Issues in Nursing*. Milton Keynes: Open University Press.

Rolfe, G. (1996) *Closing the Theory-Practice Gap: A New Paradigm for Nursing.* Oxford: Butterworth-Heinemann.

Rolfe, G. (1999) The Pleasure of the Bottomless: Postmodernism, Chaos and Paradigm shifts. *Nurse Education Today*. Vol. 19, No. 8, p. 668-672.

Royal College of Nursing. (1996) Race, Ethnicity and Mental Health: The Nurse's Responsibilities. *Issues in Nursing and Health.* London: RCN.

Salvage, J. (1992) The New Nursing: Empowering Patients or Empowering Nurses? In Robinson, J. Gray, A. Elkan, R. eds. *Policy Issues in Nursing*. Milton Keynes: Open University Press.

Savage, M. Witz, A.eds. (1992) *Gender and Bureaucracy*. Oxford: Blackwell.

Sawicki, J. (1991) *Disciplining Foucault: Feminism, Power, and the Body.* London: Routledge.

Sawicki, J (1996) Feminism, Foucault and the 'Subjects' of Power and Freedom in Hekman, S. ed *Feminists Interpretations of Michel Foucault.* Pennsylvania: Pennsylvania State Press.

Scambler, G. Higgs, P. (1998*) Modernity, Medicine and Health.* London: Routledge.

Scanlon, J. (1993) Challenging the Imbalances of Power in Feminist Oral History: Developing a Give and Take Methodology. *Women Studies International Forum.* Vol. 16, No. 6, p 639-645.

Scheurich, J. (1997*) Research Method in the Postmodern.* London: Falmer press.

Schon, D. (1983) *The Reflective Practitioner:How Professionals Think in Action.* New York: Basic Books.

Schott, J. Henley, A (2000) Culture, Religion and Patient Care. *Nursing Management.* Vol. 7, No 1, p.13-16.

Scott, C. (1998) Specialist Practice: Advancing the Profession? *Journal of Advanced Nursing.* Vol.28, No.3, p.554—562.

Scott, J. W. (1988) Deconstructing Equality-versus-Difference :Or the Uses of Post Structuralist Theory for Feminism. *Feminist Studies.* Vol.14, No. 1, p. 33-50.

Scott, J. W. (1992) 'Experience' in Butler, J. & Scott, J. *Feminists Theorise the Political.* London: Routledge.

Seibold, C. (2000) Qualitative Research from a Feminist Perspective in the Post Modern Era: Methodological, Ethical and Reflexive Concerns. *Nursing Inquiry.* Vol.7, p.147-155.

Seidman, S. ed.(1994) *The Post modern Turn: New perspectives on Social Theory. Cambridge: Cambridge* University Press.

Sellers, S. (1991) *Language and Sexual Difference.* London. Macmillan.

Sevenhuijsen, S. (1998) *Citizenship and the Ethics of Care: Feminist Considerations on Justice, Morality and Politics.* London: Routledge.

Shusterman, R. ed. (1999) *Bourdieu: A Critical Reader.* Oxford: Blackwell.

Silverman, D.(1985)*Qualitative Methodology & Sociology.* Hampshire: Gower.

Silverman, D.(1993) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction.* London: Routledge.

Silverman, D. ed. (1997) *Qualitative Research: Theory, Method and Practice.* London: Sage.

Silverman, D (2000) *Doing Qualitative Research.* London: Sage.

Sines, D. (1995) *Community Health Care Nursing.* Oxford: Blackwell Science.

Skellington, R. & Morris, P. 2nd ed. (1996) *'Race ' in Britain Today.* London: Sage.

Smaje, C. (1995) *Health ,Race and Ethnicity: Making Sense of the Evidence.* London: Kings Fund Institute & Share.

Small Town University (1998) *BSc(Hons) Professional Practice Community Nursing Course Handbook.* Small Town. Small Town University

Small Town University (1997) *Equal Opportunities Policy: Working for equality of opportunity.* Small Town. Small Town University

Smart, B. (1985) *Michel Foucault.* London;Routledge.

Smart, B. (1993) *Postmodernity.* London: Routledge.

Solomos, J. Back,L. (1996) *Racism and Society.* London. Macmillan.

Somers, M. (1994) The Narrative Constitution of Identity: A Relational and Network Approach. *Theory and Society.* No.23, p.605-649.

Spitzer, A. (1998) Nursing in Healthcare Systems of a Postmodern World: Crossroads, Paradoxes, and Complexity. *Journal of Advanced Nursing.* Vol 28, No1, p. 164-171.

Stanley, L. & Wise, S. (1993) 2nd ed. *Breaking Out Again.* London: Routledge.

Strauss, A. & Corbin, J. (1990) *Basics of Qualitative Research:Grounded Theory Procedures and Techniques.* London: Sage.

Swain, J. Olivier, M. French, S. Finkelstein, V. (1993) *Disabling Barriers: Enabling Environments.* London: Sage.

Tawney, R.H. (1964) *Equality.* London: Unwin Books.

Taylor, D. (1998) Social Identity and Social Policy: Engagements with Postmodern Theory. *Journal of Social Policy.* Vol.27, p.329-350.

Thomas, D. (1996) Making Differences Matter: A New Paradigm for Managing Diversity. *Harvard Business Review.* Vol.74, No.5, p.79-91.

Thomas, V. Dines, A. (1994) The Health Care Needs of Ethnic Minority Groups: Are Nurses and Individuals Playing their Part. *Journal of Advanced Nursing*, No,20. p.802-808.

Thompson, N. (1995) *Theory and Practice in Health and Social Welfare.* Buckingham: Open University Press.

Thompson, N. (1997) 2nd ed. *Anti-Discriminatory Practice.* London: Macmillan.

Thompson, N. (1998) *Promoting Equality: Challenging Discrimination and Oppression in the Human Services.* London: Macmillan.

Thompson, S. Hoggett, P. (1996) Universalism, Selectivism and Particularism: Towards a Post Modern Social Policy. *Critical Social Policy.* Vol.16, No.1, p.21-43.

Thorne, S. E. (1999) Are Egalitarian Relationships a Desirable Ideal in Nursing ? *Western Journal of Nursing Research.* Vol.21, No.1, p. 16-34.

Tong, R. (1989) *Feminist Thought: A Comprehensive Introduction.* London: Routledge.

Toronto, J (1993) *Moral Boundaries: A Political Argument for an Ethic of Care.* London: Routledge.

Townsend, P. Davidson, N. (1982) *Inequalities in Health:The Black Report.* Harmondsworth: Penguin.

Traynor, M (1997) Post Modern Research: No Grounding or Privilege, Just Free Floating Trouble Making. *Nursing Inquiry.* No. 4, p. 99-107.

Trust A. (1998) *Policies, Procedures & Guidelines: Equal Opportunities.* Trust A.

Trust.B (1998) *Ethnic Health Standards.* Trust B.

Trust C (1998) *Equal Opportunities Policy* Trust C.

Trust D (1992a) *Equal Opportunities in Service Provision.* Trust D.

Trust D (1992b) *Towards Equality: Equal Opportunities Policy Key principles: equal opportunities in employment.* Trust D.

Trust D (1998) *Equal Opportunities & Harassment At Work Policy Statement.*Trust D.

Trust E (1993) *Equal Opportunities: Personnel Policy.* Trust E.

Trust E (1998) *Disciplinary Procedures: Personnel Polic.* Trust E

Trust F.(1993) *Equal Opportunities Policy.* Trust F.

Trust F .(1997) *Harassment at Work Policy.* Trust F.

Trust. G (1996) *Equal Opportunities Policy.* Trust G.

Tschudin, V. (1992) *Ethics in Nursing:The Caring Relationship.* London: Heinemann.

Turner, B. S. ed.(1990) *Theories of Modernity and Postmodernity.* London: Sage.

Turner, B.S. (1986) *Equality: a Sociological Inquiry.* London: Tavistock Publications.

Twinn, S. Roberts, B. Andrews, S. (1996) *Community Health Care Nursing: Principles for Practice.* Oxford: Butterworth-Heinemann.

Ungerson, C. (1987) *Policy is Personal: Sex, Gender and Informal Care.* London: Tavistock.

Ungerson,C. Kember, M. eds. (1997) *Women and Social Policy*: A reader. Basingstoke: Macmillan.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) *Project 2000:A New Preparation for Practice.* London:UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) *Code of Professional Conduct.* London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) *The Scope of Professional Practice.* London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1993) *The Councils Proposed Standards for post registration Education.* London:UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1994) The Future of Professional Practice-the Council's Standards for Education and Practice following Registration. *Standards for Specialist Practice.* London:UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1995) *PREP and You.* London:UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1996) *Guidelines for Professional Practice.* London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997) *The Nursing and Health Visiting Contribution to the Continuing Care of Older People.* London:UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997) *The Future of Professional Regulation*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Register.* Summer, No. 28. London: UKCC.

Vaughan, J. (1997) Is there Really Racism in Nursing *Journal of Nurse Education.* Vol. 36, No. 3, p. 135-139.

Vydelingum,V. (1998) *We Treat Them All the Same. The Experiences of Nursing Staff and of South Asian Patients in a General Hospital.* PhD thesis. University of Southampton. Unpublished.

Walby,S. Greenwell, J with MacKay,L. Soothill,K. (1994) *Medicine and Nursing :Professions in a Changing Health Service.* London: Sage.

Ward,L. (1993) Race Equality and Employment in the National Health Service in Ahmad, W.I.U. *Race and Health in Contemporary Britain.* Buckingham. Open University Press.

Wasoff, F. Dobash, E. (1992) Simulated Clients in Natural Settings – Constructing a Client to Study Professional Practice *Sociology.* Vol.26, No. 2, p.333-349.

Wedderburn Tate, C. (1996) Race into Action. *Nursing Times.* Vol. 92, No.22, p.1 28-30.

Weedon, C. (1997) 2nd ed. *Feminist Practice & Poststructuralist Theory.* Oxford: Blackwell.

Weedon, C. (1999) *Feminism, Theory, and the Politics of Difference.* Oxford: Blackwell.

Whitehead, M. (1987) *The Health Divide.* London:HEC.

Whitehead, M.(1990) The Concepts and Principles of Equity in Health. World Health Organisation, Regional Office for Europe. Copenhagen. *In Kings Fund (1999) Local Inequalities Targets* available from http://www.kingsfund.org.uk

Williams, A. (1993) Diversity and Agreement in Feminist Ethnography. *Sociology.* Vol. 27, No. 4. p.575-589.

Williams,C. (1999) Connecting Anti–Racist and Anti-Oppressive Theory and Practice :Retrenchment or Reappraisal? *British Journal of Social Work,* No.29. p.211-230.

Williams, F. (1989) *Social Policy: A Critical Introduction.* Cambridge: Polity Press.

Williams, F. (1992) Somewhere Over the Rainbow: Universality and Diversity in Social Policy in Page, R. Baldock, J. eds. *Social Policy Review 4.* Social Policy Association.

Wilson, A. Beresford, P. (2000) Anti-Oppressive Practice: Emancipation or Appropriation. *British Journal of Social Work.* Vol. 30, p. 553-573.

Wilson, G (1995) A Postmodern Approach to Structured Dependency Theory. *Journal of Social Policy.* Vol. 26, No. 3, p.341-350.

Witz, A. (1992) *Professions and Patriarchy.* London: Routledge.

Women Health Officer. (1948) Mrs Martin describes a busy day in the life of a superintendent health visitor in *Women Health Officer: Magazine for Women Public Health Officers Assistant.* Vol. xx1, No.7. (ref.SA/HVA H21).London: Wellcome Institute for the History of Medicine

Women Public Health Officers Assistant and Public Health Section of the RCN (1943). *Duties of the Health Visitor in the National Health Service Revision of Pamplet. (Ref:*SA/HVA/D.2/5). London: Wellcome Institute of the History of Medicine.

Woodward, K. ed.(1997) *Identity and Difference.* London: Sage.

Woodward,V. M. (1997) Professional Caring :A Contradiction in Terms. *Journal of Advanced Nursing.* Vol.26, No.5, p.999-1004.

World Health Organisation (1985) *Health For All by the Year 2000.* Geneva: WHO.

Yardley, L. ed. (1997) *Material Discourses of Health and Illness.* London: Routledge.

Yeatman,A. (1990) A Feminist Theory of Social Differentiation in Nicholson, L. ed. (1990) *Feminism/Postmodernism.* London: Routledge.

Yeatman, A. (1994) *Postmodern Revisionings of the Political.* London: Routledge.

Yin.R.K.(1989) *Case study Research: Design and Method*s. London: Sage.

Young, I. M. (1990) *Justice and the Politics of Difference.* New Jersey: Princeton University Press.

Young, I.M. (1998) Polity and Group Difference: A Critique of the Ideal of Universal Citizenship, in Phillips, A. *Feminism & Politics.* Oxford: Oxford University Press.