FRAGMENTED, FRUSTRATED AND TRAPPED:

Nurses in Post-Apartheid Transition at

King Edward VIII Hospital, Durban.

By

JUNE ANNE WEBBER

A thesis submitted in partial fulfilment of the requirements for the

Degree of Doctorate of Philosophy

Department of Sociology

THE UNIVERSITY OF NATAL, DURBAN

2000

ABSTRACT

This ethnographic study of nurses at King Edward VIII Hospital in Durban, South Africa was designed to seek insights into the lives of women as nurses during the socio-political transition of the 1990's. It suggests that this period of dramatic political change in the country created spaces for redressing uneven social relations and chronic disparities faced by nurses in their personal and professional lives, particularly those constructed through the social engineering of apartheid policies. The study describes the particular evolution of nursing in South Africa, the process undertaken to unify the professional nursing associations formed through the 1980's and the national labour unrest that rippled through the health care system between 1994 and 1996. It considers the diverse locations of nurses as the backbone of the healthcare system, primarily in their capacities as professionals, managers, care-providers, team-players and colleagues and describes practices that operate to constrain nurses as women and health care practitioners.

Feminist, post-structural perspectives framed the theoretical approach taken in this qualitative study. These were guided by Foucauldian theories of knowledge, power and discourse, and feminist contributions regarding resistance and agency. Over the course of four years in the field, methods of participant observation and in-depth interviews were employed to develop insights into the subject locations of nurses in their private and public lives. Twenty-six nurses of the professional and subprofessional categories contributed to the main narratives. In addition, a series of interviews were undertaken with key informants from the medical, paramedical, nursing and administrative services.

The study illustrates the practices of patriarchal, institutional and organisational relations of power that intersected and dominated the realities of the nurses in all spheres of their day-to-day lives. Within the post-colonial moment in South Africa, these were conceptualized as subaltern institutional relations. The study found that as a consequence of their subjugation within the subaltern institutional relations, the realities of nurses were diverse, divergent, and fragmented. It argues that these relations imbued a lack of professional and personal coherence that impaired the capacity of nurses to contest the chronic professional and work place disparities. Often multiple and compounding in their manifestation, these relations and practices reinforced the isolation of nurses, compounding their incapacity to meaningful challenge professional and personal obstacles during the socio-political transition of the 1990's.

Declaration

I, June Anne Webber, declare that this thesis:

Fragmented, Frustrated and Trapped: Nurses in Post-Apartheid Transition at King Edward VIII Hospital, Durban

is my own work. Research material and contributions by others have been properly acknowledged. The thesis has been submitted in the Department of Sociology in the Faculty of Human Sciences at the University of Natal, Durban, for the PhD degree. It has not been submitted before for any other degree or examination at any other university.

Signed   Date

(signature)   .3. December. 2000
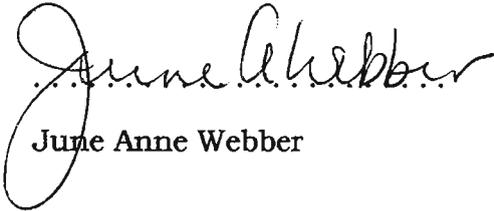
June Anne Webber

Acknowledgements

Bringing this research process to a close is a bittersweet experience, primarily as it coincides with my return to Canada after seven years of living, studying and, for the most part, researching and working on issues related to nursing at this most interesting time in the profession's history in South Africa. At this time, I would like to acknowledge a number of colleagues, friends and acquaintances who have contributed in some way to this research process.

First of all, for his supervisory role, Ari Sitas inspired a tremendous amount of movement in this work with his insights, critiques, intellectual agility and political rigour. For his time, energy and interest I wish to sincerely thank him.

I would like to express my appreciation to the members of the Durban Women's Narrative Group for their thoughtful commentaries since our formation over the past two years. The group's investment of time and their concern for rigour, creativity and relevance in writing ensured that WNG's regular meetings were spirited, supportive, intellectually stimulating and cherished events which did much to inform methodological, theoretical and observations through this work. My sincere appreciation is extended to Catherine Burns, Janet Giddy, Bongiwe Bolani, Vanessa Noble, Julie Parle, Allyn Diesel, Anne Shadbolt, Mumsy Malinga, Janet Twine and Fiona Scorgie.

In addition, Catherine's thorough reading of this and other work fuelled valued debates, observations and the ongoing, shared interest in healthcare, nursing, its constituencies and practitioners. Janet Giddy brought an even and well-grounded medical perspective in response to many of my observations, while Angela Impey's valued insight into many aspects of this work through papers and academic presentations was most supportive. Tessa Carlisle-Mitchell's friendship and encouragement have been a valuable form of sustenance. Regular beachfront walks with Astrid von Kotze provided space and energy for creative ideas, support and encouragement. Additionally I wish to extend my gratitude to Ron Burnett, whose interest in ethnography helped me locate important literature. I would also like to acknowledge the interest and encouragement of friends and sociologists, Gerhard Maré, Debbie

List of Tables

LIST OF ABBREVIATIONS

ANC	African National Congress
BK	Bachelor of Curationis
BNA	British Nursing Association
CONSA	Concerned Nurses of South Africa
COSATU	Congress of South African Trade Unions
CPN	Chief Professional Nurse
CWF	Central Workers Forum
DENOSA	Democratic Nursing Organisation of South Africa
EN	Enrolled Nurse
ENA	Enrolled Nursing Auxiliary / Assistant
FEDSAW	Federation of South African Women
GNU	Government of National Unity
HOSPERSA	Hospital Personnel Union of South Africa
HWA	Health Workers Association (Transvaal)
HWO	Health Workers Organisation (Natal)
ICN	International Council of Nurses
INB	Interim National Board
KEH	King Edward VIII Hospital
KNO	KwaZulu Nursing Organisation
LONASA	League of Nursing Associations of South Africa
NAMDA	National Medical and Dental Association
NEHAWU	National Education, Health and Allied Workers Union
NHPD	National Health and Population Development
NPFF	Nurses Planning For the Future

OASSSA	Organisation of Appropriate Social Services for South Africa
OPD	Out-Patients Department
PN	Professional Nurse
PSBC	Public Service Bargaining Council
PTS	Preliminary Training School (Certificate)
RN	Registered Nurse
Sabinet	South African Bibliographic Information Network
SACP	South African Communist Party
SACTU	South African Council of Trade Unions
SADNU	South African Democratic Nurses Union
SANA	South African Nurses Association
SANC	South African Nursing Council
SPN	Senior Professional Nurse
TNC	Transitional Nurses Committee
TURP	Trade Union Research Project
UDF	United Democratic Front
UND	University of Natal (Durban)
UNISA	University of South Africa

TABLE OF CONTENTS

CHAPTER THREE
THEORY: EXPLORING SUBALTERN REALITIES

CHAPTER FOUR
FROM ETHNOGRAPHY TO NARRATIVES

CHAPTER EIGHT
COMPLEX SUBJECTIVITIES: UNDERSTANDING NURSES FAILURE TO
SEIZE THE TRANSITIONAL MOMENT

CHAPTER NINE
CONCLUSION AND RECOMMENDATIONS

APPENDICES

Chapter One

Introduction

1.1 Background of the Research: Nurses, Crisis and Resistance

South Africa has been in a state of active political and social transition since the release of Nelson Mandela in 1990. That moment was attained through sustained pressure by liberation organisations, working nationally and internationally to end apartheid rule. Successful social movements enable societies to shift relations of power, even those like South Africa that was entrenched for more than 40 years in the malevolent policies of apartheid governance. The success of such movements can be measured by the degree to which collective action and agency sustain and propel strategies toward acceptable and meaningful outcomes. The political transformation in South Africa represents a remarkable example of the accomplishments of the liberation process as a social movement, however, it marks only one moment in the more protracted transition of relations of power.

The heightened resistance to apartheid of the 1980's provided the terrain for contestation within many public and private sector settings. During these years labour unrest and protest action rippled through a number of health care settings nationally, frequently interrupting the delivery of service while destabilising the historically precarious foundation of

nursing, already compromised by years of chronic, unresolved disparities and contradictions to its professional ethic[1] (Critical Health, 1988). For years, nurses complained of issues related to staff shortages, poor conditions of work, low remuneration and, as the profession was persistently racialised, gross disparities in the education, resources and health care between black and white nurses and patients. These factors combined with the dropping registration to schools of nursing to lead critical scholarship to depict the 1980s as an era of crisis within the profession (Hammond, 1982, Rispel, 1989, Myburgh, 1990).

Opposition to the disparities within the health care system continued into the 1990s (Rispel & Schneider, 1989; Myburgh, 1990; Rispel, 1990, Marks, 1993, 1994; Webber, 1994; Kunene, 1995). Workers of all categories expected that political transition would expedite the resolution of their issues (Bonnin et al., 1994:77). Nurses were among the most vocal in the public sector. Between 1994 and 1996 they engaged in strike action in an attempt to resolve their grievances. King Edward VIII Hospital (KEH), a central referral facility for regional hospitals and clinics, was among the many KwaZulu-Natal hospital settings where nursing staff joined other workers to demand the resolution of issues and improvements within the workplace (Von Holdt, 1994:15; Bonnin et al., 1994)[2].

---

[1] These issues will be elaborated in the next chapter.
[2] Bonnin, Gwagwa, Isaacs and Sitas (1994) provide a detailed account of the grievances, employee demands and outcomes in their articles on the 1994 strike-wave.

Initially the Central Worker's Forum (CWF) united the various employee groups like the National Education, Health and Allied Workers' Union (NEHAWU), the South African Nurses' Association (SANA), and the Hospital Personnel Union of South Africa (HOSPERSA)[3]. However, the failure of the CWF to maintain broad support of employees resulted in its fragmentation and the loss of this movement's coherence.

Politicians, employers, the media, labour and professional organizations reacted critically to nurses during the post electoral labour unrest. Politicians wavered in their response, seemingly passing responsibility for nurses' grievances from one Ministry to another (Gwagwa & Webber, 1995: 80)[4]. Professional and labour organisations, that sought to represent the largest segment of the health care system, were cautious in their acknowledgement of nurses' issues, yet denounced their actions (Gwagwa & Webber, 1995).

As the labour unrest took hold at KEH, the hospital locked its gates to nurses and other protesters, leaving a skeletal staff of nurse administrators, managers, and volunteers to care for remaining patients. The media provided regular coverage of nurses' involvement in the labour unrest emphasising the immoral nature of their actions that, ultimately, contributed to their being criticised within their own communities (Von

---

[3] These are the National Education, Health and Allied Workers' Union (NEHAWU), the South African Nursing Association (SANA), and the Hospital Personnel Trade Union of South Africa (HOSPERSA).
[4] These authors chronicle the trail of delegation as the grievances of striking nurses were passed from provincial Premiers' offices, to the Ministry of Public Service and Administration to the Ministry of Health with reactions that either undermined nurses? complaints or suggested that the problem fell outside of their jurisdiction.

Chapter One: Introduction

Holdt, 1994:14; Gwagwa & Webber, 1995: 80).

Despite the involvement of nurses in the liberation struggle[5] and subsequent transitional strategies[6], the protest action failed to achieve resolution of their grievances and they returned to work without the settlement of their demands (Bonnin, et al. 1994:78; Gwagwa & Webber, 1995). The labour unrest left nurses highly fragmented, frustrated and trapped in a cycle of action that was damaging to their professional status (Gwagwa & Webber, 1995:82) and morale.

1.2   Context of Research: The Transitional Moment

This study investigates nurses within the context of social, political, and cultural contestation and change in South Africa, a period marked by the country's first democratically-held national elections of 1994. The research examines nurses at KEH in this transitional[7] moment in South Africa, from 1995 to 1999, when social movements were dismantling after successfully forcing a change of government. Actors were shifting

---

[5] Nurses were mobilised, albeit unsuccessfully, within the Federation of South African Nurses and the Federation of South African Women (FEDSAW) to protest the imposition of passes by the National Party in the late 1950s. The South Africa Nursing Council (SANC) complied with the National Party by requiring black nurses to carry passes in order to be registered with the Council; a provision included in the amended Nursing Act of 1957.(Kuper,H. 1965; Walker, 1982; Marks, 1994).

[6] Nurses opposing complicity of SANA and SANC with National Party policies have regularly sought alternative outlets for airing their disparities. In the late 1980s nurses tried to organise within NEHAWU and, when unsuccessful, launched the Concerned Nurses of South Africa, an initiate directly linked to liberation strategies (Webber, 1994)

[7] The concept 'transition' is used throughout the study to signify the period of political change and adaptation. As a concept, transition recalls a moment of "passage from one state, stage . . . or place to another"?

positions, roles, orientations and agendas, and developing new discourses. Civil society, at the centre of resistance, was a shadow of its former self, with many players absorbed into the state structures. Yet the liberation and transformation polemic was alive, still in search of outcomes expected as part of the political transition.

Within this context, two separate events occurred within the profession of nursing. The first was the unification of nurses into one professional and labour organization, the Democratic Nursing Organisation of South Africa (DENOSA). The unification process was initiated in 1992 and by January 1995 nurse leaders, representing a range of organizations formed during apartheid, held a congress where a constitution was adopted, forming DENOSA.

The second event was the mounting of protest action by the National Education, Health and Allied Workers Union (NEHAWU) in 1994, resulting in sporadic labour unrest in the hospital sector from 1994 to 1996. The strikes shifted many nurses from bedsides to streets and resulted in the temporary closure of a number of hospitals.

Both are complex processes, with histories rooted in the nursing profession and the labour movement. The outcomes have been less than satisfactory for nurses and the nursing profession through the 1990's.

1.3   Statement of Problem

The research problematic was framed by a sociological and political
interest in understanding the obstacles that challenged nurses' capacities
to alter chronic disparities and conditions during the political transition,
from one of the most active sites of labour unrest in the country between
1995 and 1998. These chronic issues impaired the provision of care and
the quality of work life experienced by nurses (Hammond, 1982; Rispel,
1989; Myburgh, 1990). The study inquired into:

*   the experiences and social relations that influence and give
     meaning to the lives of women in the occupation of nursing;

*   forms of power relations and their impact upon women's locations
     within their profession and within the health care system; and

*   the dynamics that were either enabling or that presented obstacles
     to the effective resolution of issues and to their empowerment.

The research pursued insights into how nurses perceived and interpreted
the many spaces they occupy, the forms of resistance they employed to
protect themselves from patriarchal and other forms of power relations
and their consequences, and the ways they upheld the rights and
achievements forged and realised in their day to day experiences.

1.4   Research Focus, Questions and Initial Statement of Findings

At the outset of this study I intended to inquire into nurses perspectives
in close relation to the transition of nursing organisations. However
through the process of reading, reflection and early discussions with key

informants it became evident that the issues central to this study extended beyond nurses' opinions and the experiences of their organisations to the many other sites and relationships nurses negotiate. I realised that in order to understand the failures, strictures and impediments to resistance it was necessary to explore the many dynamics and strategies used within social relations to gain, maintain and restore power. This included approaches used by women to gain power and ultimately alter their lives, women who, as West and Blumberg (1990:8) have argued, are generally considered powerless. The study rejects the notion that women are victims. Rather it approaches nurses as women who, despite their subordination to a number of social forces, are active players within their own realities (Glazer, 1987; Witz, 1992; Bowden, 1997).

The evolution of feminist thought and its critique of the falsely universalising, over generalising and over ambitious constructs of liberalism, humanism and Marxism have drawn feminist researchers to post-structuralist and post-modernist approaches, and an analysis of the local, specific and particular (Barrett & Phillips, 1992:1). Employing feminist, post-structuralist theoretical tools and an ethnographic methodology, I pursued the research problem and the associated questions. The research question that guided this study was:

> *Why have nurses been unable / unsuccessful in altering their circumstances in an environment of considerable social and political transformation?*

This question was approached through a number of closely related research questions that focussed on realities within the work environment, organisational relationships, transition and protest. These were:

- What does the experience of nursing involve from the point of entry to the college-based programme, to the initiation of day-to-day experience in the work environment?

- What power relations, discourses and practices are evident and how do they impact upon the capacity to nurse effectively?

- How do nurses describe their relationships with the former professional organisation (the South African Nurses Association) and other labour and professional organisations?

- How has the labour unrest affected nurses' public and private lives?

- How have nurses perceived the outcomes of the unification process and of the labour unrest?

Questions that focussed on interactions within the health care system were:

- What does the notion of 'care' mean to nurses?

- What do nurses say regarding the care they provide patients?

- How do nurses interact with doctors?

A central assumption was that the real story rested within the larger lives of nurses: their histories, their relationships, and the 'chaotic unity' (Harvey, 1990) between their personal and public lives. Thus, the focus of the research naturally expanded to include personal dimensions and

perceptions. The research questions extended beyond the institutional background, to include related contexts, experiences and moments:

- What inspired them to enter nursing and how do they relate to that decision?
- What are their personal realities and how do nurses view themselves within their personal (private) domains?
- How do they relate to their personal contexts and their historical realities?

The study found nurses isolated, vulnerable and fragmented as a work force. Marked disillusionment and demoralisation were noted throughout the occupational categories and ranks. Despite this, nurses assumed divergent and disparate forms of resistance in their public and private spheres. Even so, they expressed widespread reluctance to remain within or return to the protest arena. In particular, nurses were unnerved at the thought of being labelled as resistors or trouble makers. The study explains that the key to understanding nurses' failure to alter their disparate conditions lies in the relations of power that operate to constitute nurses as subjects. Complex relations of power entrenched nurses in their day-to-day experiences as women and as health care providers, resulting in their overall inability to sustain involvement in the protest arena in a coherent and unified way. The intersection of a range of key power relations are noted in what I have termed, subaltern institutional relations.

The fragmentation of nurses is explained by analysing the variety of subject locations nurses navigate. Diverse forms of normative and disciplinary discourses and practices are identified, as are the contradictions dissecting various spheres of their lives. I argue that discourses and practices operate to subject nurses to a number of divergent locations within institutional relations of power, and as women, within organisational and patriarchal relations of power.

1.5   The Personal and the Political

This research was motivated by a long-standing interest in nurses and resistance, driven by personal and political perspectives. Practice as a registered nurse and experiences at different hierarchical levels of an acute care teaching hospital within the Canadian context provided insights into the power relations and forms of control that constrain nurses as women, as health care providers, and as collaborative and recognised members of health care teams. My experience and that of colleagues is marked by the range of interactions, both facilitative and restrictive, that confounded creativity while at times enabling growth.

While in South Africa, the impact of political transition on nursing and nurses became an area of focus, particularly the 1990's process to unify nursing organizations of the apartheid era and the national labour unrest of 1994 to 1996. These moments in South Africa seemed to present opportunities to change existing power relations. Additionally, the policies promoted in the African National Congress health plan (ANC,1994), that aimed to shift the health system from the imperatives of the biomedical

model to one that established primary health care as a priority, presented a space for South African nurses to play leadership roles, as is the case with their counterparts globally. Conversely, the profession and the individuals within were neither prepared nor strategically placed to take up many of these issues. Rather, they were engulfed by the tensions and rumblings of a fragmented profession.

This work builds upon research into the process undertaken to unify nursing organisations in South Africa (Webber, 1994). The ethnographic study provided insights into the challenges of the unification of nursing organisations. The study detailed the historical, interpersonal and organisational tensions that infused the process. The findings, which suggested that the coherence of the unified structure would be hampered by the deeply rooted and unresolved tensions within nursing, were initially vindicated as the process underwent a number of difficulties that delayed unification to November 1996.

Although this research provided a starting point for ongoing exploration into organisational issues, it did not inquire into the personal, more local dimensions of transition. This area became more urgent following the disappointing outcomes of the labour unrest which incited interest and concern for nurses, their agency and potential for addressing the inequitable and contradictory conditions experienced in tertiary settings and beyond.

1.6   Overview of the Chapters

This study comprises nine chapters. The introductory chapter provides an outline of the research with a partial explanation of the background issues and observations that fuelled interest in researching nurses during this period in South Africa. The introductory discussion was intended to paint the broad strokes of the research and lay the foundation for the material presented within the full study.

Chapter two presents the literature that aims to explain the development of nursing in South Africa, thus placing this moment within the larger context of socio-political change. The first section explores the historical exegesis of nursing from three perspectives, noting the discourses that influenced and shaped the occupation. The discussion considers notions of care, hierarchy and profession as concepts infused with meaning and contradiction for the occupation. The notion of nursing as a gendered profession is explored, as a field manifest with many practices that produce skilled and knowledgable practitioners, while reinforcing their subordinate locations within the health care system and to the medical profession. I then examine the literature that provides critical insights into the state of hospital and organisational nursing from the late 1980s in South Africa. The second section focuses on the social and political context of South Africa with a discussion of the liberal, progressive and radical accounts of South Africa's particular history. Within this section revisionist explanations of the intersections of race and capital, accounts of work sites and relationships from the field of labour studies, and some of the main feminist critiques of gender relations are elaborated. Notions

of difference and disadvantage are presented as concepts that, I argue, are necessary in the exploration of women's realities. Finally, the third section, which considers the terrain of social protest and social movements in South Africa, ends by examining relevant theoretical approaches to this topic. I advance the concept of historicity (Touraine, 1988) as an effective tool for capturing how society undertakes movement and change. I go on to explore mechanisms for understanding what Walker (1991) aptly described as the dialectic between `women's resistance and acquiescence to their subordination'.

Chapter three discusses the theoretical approaches used to guide this study. A feminist post-structural strategy has been used, informed primarily by the work of Michel Foucault, and complemented by a number of feminist writers who responded to and elaborated his work[8]. In particular, the concern with how subjects are constructed informs the problematic. Feminist critiques of Foucault's post-structuralism have been central to challenging his anti-humanist stance, the lack of agency and the critical need to include class as an analytical concern. The chapter is concluded with a discussion of the contribution of this research to sociological knowledge.

Chapter four examines methodological approaches employed in this qualitative research. Post-modernist ethnographic methods were used to study the complex interactions. The chapter considers the debates

---

[8]

See, for example, Weedon,1987; Barrett, 1991; Sawicki, 1991; and Barrett & Phillips, 1992.

surrounding the 'crisis of representation' and methods used to enhance interpretive rigour in qualitative research. The chapter then turns to a full explanation of the research design and the analytical and interpretive process. Explanations are given for the choices made in theorising the rich testimonies drawn from the research field, through a method known as interpretive realism.

Chapter five presents a theorized, historical and institutional account of the research site, King Edward VIII Hospital in Durban. The chapter begins with a contextual account of the 'corridors' of KEH. From here Foucauldian perspectives of 'pure communities' and 'disciplined societies' intersect with the commentary on organisational and relational aspects of KEH.

Chapters six and seven comprise the analysis of the field data. In these chapters two approaches are used to present the narrative accounts. In chapter six the testimonies of four nurses are constructed to provide a chronological account of their youths, entry to nursing, training and subsequent experiences and relations within the institutional, organisational and historical fields. These stories illustrate the distinct and diverse range of experiences and perspectives of nurses while providing compelling accounts of these women's lives.

In chapter seven feminist, post-structural approaches are employed in theorizing the contextual and relational dynamics intersecting the nurses' experiences. The first section of this chapter examines what I have termed constitutive, regulatory and debilitating practices. The

inconsistencies of their workplace environment and discursive patterns that shape and frustrate institutional realities are explained. Lastly, reactions to transitional strategies are discussed, exploring the ways in which nurses approached resistance to institutional relations of power.

Chapter eight provides an interpretation of the findings of this study. I consider the forces at play within nursing, the institution and society that subject and constrain these women within diverse subject positions. Discursive arrangements and practices that reveal the substantial tensions existing within normative, often disciplinary, practices are outlined. The chapter concludes with comments about women and resistance and the challenges nurses faced to alter the inequitable conditions that frustrated them in their personal and public lives.

Chapter nine summarises the main theoretical contributions to the sociological field in a discussion of the background theory, ethnological method and the suitability of a feminist, post-structural approach to this study. The limitations of this study are considered, followed by a series of recommendations for further research. The concluding section presents a summary of the main findings of the study and concluding statements.

Chapter Two

Nurses: Context, Difference and Historicity

2.1 Introduction

Social research never occurs in a vacuum. It is conducted within the realm of the social sciences, which like any form of knowledge production is cumulative. A review of the literature is directly linked to this understanding, and is conducted with the main aim of acknowledging previous work that has investigated similar research problems. It also serves an important developmental function in that an examination of the literature delves into complex themes and issues connected to the area of research. As Becker (1986: 136) states, it sets the research within the context of others, giving the findings of the research something to be connected to, while bringing the reader up to date on previous research in this area.

This study seeks to understand the varied responses of nurses to transitional dynamics, labour unrest and organisational unification which arose during the political transformation of the early 1990s in South Africa. It was a moment in recent history when the opportunity for altering their locations and coherently bringing voice to the many issues that constrain their working and professional lives was missed. I approached this area by exploring the multiple contours of nurses' lives,

fuelled by an interest in extending the understanding of nurses beyond the terrain of the profession, the classroom and the bedside. Rather, the focus is on the many sites nurses occupy within and outside the workplace, and the demands and constraints they navigate in their day-to-day realities.

This chapter is organised into three main sections, written with an aim of situating nurses within the broader context of their lives. By doing so this chapter seeks to establish knowledge of the practices that permeate nurses' realities, shaping their experiences and enhancing possibilities while constraining choices. I will point to a range of concepts and contextual matters which, I argue, entwine in particular ways to contribute to this interplay. An ongoing dialogue between these contexts and concepts is undertaken to show the social evolution of nursing in South Africa, its interface with the social, political, economic and cultural relations that intersect lives of the black women who nurse, and reactions and approaches to resistance.

The first section (2.2) sketches the history of nursing in South Africa with its strong links to British roots and specific continuities with nursing throughout the world. Caring, hierarchies and profession are explored as key nursing discourses and practices in global operation that mark nursing as a gendered profession. The discussion goes on to consider the effects of the racial policies of exclusion on the evolution of the nursing association and its intersection with gender and class in the lives of black nurses. The close link between nursing's controlling bodies, principally the South African Nurses Association (SANA) and the South African Nursing Council (SANC), with the National Party (NP) is explored.

Writers and scholars suggest this period culminated in an eventual 'crisis' in nursing, primarily visible in hospital work environments and the fragmentation of nursing associations. The growing resistance within nursing is described, as are attempts by nurses to alter their conditions of work and to unify their divided profession.

Section 2.3 broadens the contextual base within which nurses are situated by exploring the social environment during the era of apartheid and the immediate transitional period. The section begins by providing a partial account of the historical and political legacy of South Africa. Local and international literature that provides liberal, progressive and radical perspectives are drawn upon to examine sociological and historiographic[9] accounts and debates concerning South Africa's distinctive history. Conceptual categories are traced and explored through a number of approaches, including revisionist explanations of the intersections of race and capital, the inquiry made by South African labour studies into work sites and relationships, and the main feminist critiques of South African gender relations evolving from socialist feminist work.

The third section (2.4) discusses the terrain of contestation and social movements. Here again, I have attempted to locate explanations for the outcomes faced by nurses during the period of study. The literature concerning social movements, resistance and protest action and their formulation within the context of South Africa is examined. Theoretical

---

[9] Whereas sociological literature encompasses literature elucidating the characteristics and nature of the social system, historiography represents a branch of knowledge within competing or converging bodies of historical theory. Historiography frequently pursues the examination of particular historical episode, often sociologically structured in its concern with social system questions.

perspectives forwarded through Marxist, resource mobilization and identity oriented approaches to social movements further informed this work and have contributed to overall theorising.

Finally, feminist theoretical approaches were considered. Standpoint Feminism, which acknowledges the relevance of exploring gender relations while asserting the complexity and diverse locations occupied by women, formed an important framework. The meaningful debates forwarded by South African feminist writers, who engage with the paradox of women's combined resistance and acquiescence to dominant forces, nudged the conceptualisation of patriarchal relations and nurses' forms of protest. Although this is highly relevant, I conclude by contending that a fitting framework for this research problem needs to account for the multiplicity and fluidity of women's experience and the way these are influenced by the intersection of varied relations of power that infuses their realities.

2.2   Nurses and Nursing in South Africa

A literature search was conducted via three data bases – Nexus, Sabinet and Socio File[10]. In addition, I conducted a personal search of the DENOSA library, which houses archival material and documentation of SANA from its establishment in 1943, as well as dissertations undertaken over the years by South African nurses. A number of key

---

[10]

Nexus is a data base generated by the Human Sciences Research Council, and documents South African current and completed dissertations. Socio File lists international sociological abstracts, while Sabinet – the South African Bibliographic Information Network – catalogues South African journal articles by title.

words guided the search for material on nurses, women and nursing. Key words fell into several main categories: 'social change' included social action, social movements, social agents/agency, protest action, resistance, labour unrest, strikes, and power; 'nursing' included educational process, training, indoctrination, professionalisation, hierarchies and work environments; and 'nurses as women', included domestic, community and private lives.

Dissertations that addressed some aspect of these themes numbered 376. They were written primarily by graduate nursing students with a sprinkling of studies from other disciplines, such as Psychology, Sociology and Business Administration. They were dated from 1972 to 1997. Abstracts were reviewed with little evidence of previous work that was closely aligned with this research problematic. Those few dissertations focussing on issues relating to nurses within the context of either their personal realities or the areas of resistance, protest action, labour unrest or organisational unification were requested. The majority concentrated on technical and performance aspects of the trade – for example, curriculum development, drop out rates, service delivery, career success – and rarely ventured outside the terrain of the profession or the area of specialisation to consider exterior factors potentially contributing to explanations.

Those that concentrated on relevant issues were highly valuable to informing this literature. They are drawn into the next sections that examine the evolution of nursing in South Africa and highlights central experiential categories of gender, concepts of 'care', profession and hierarchy, and within South Africa, race. They appear in sections that

explore the mounting crisis within nursing to the 1980's showing the inequities and inconsistencies that frustrated nurses; and, their work points to nurses' views on organisational affiliation and forms of resistance and co-optation that marked the transition to democratic rule.

2.2.1 Conceptual (in)consistencies within a distinct context

Like many occupations, nursing has undergone tremendous change and diversification in the 20th century. Its evolution through a range of social and political contexts has influenced the development of specific discourses that underpin the way the profession is understood. These are intersected by a variety of practices, some of which are global in nature, others quite specific to the imperatives of local environments.

The history of South African nursing has been taken up by a number of authors over the past 30 years, with varying perspectives on the growth and evolution of the profession. Three distinct approaches have dominated. First, the accounts emerging from the main architects of South African nursing and their protégées[11] produced a history which issued strong legitimising interpretations of the course of nursing from the early years of training to latter attempts to forge a profession on par

---

[11] Charlotte Searle, widely regarded as an architect of the 'profession' and the first to construct the history of nursing (1965), was joined by a number of other nursing authors and academics including Radloff (1977), Mellish (1984, 1985) and Potgieter (1992). Searle continued throughout her career to publish on the tenets of education (1975), professionalism (1987), and ethical considerations (1987). Until recent years Charlotte Searle was a key figure and decision-maker in nursing, a position she held from the early 1940s when SANA and SANC were formed and increasingly aligned with policies of apartheid. Her complicity in bringing apartheid to nursing was eventually overshadowed by the roles she played in establishing tertiary education for black nurses at UNISA, and ironically, was consequently widely regarded as the 'mother of black nursing in South Africa' (Marks, 1994:194).

with their international colleagues. Recently, Grace Mashaba (1995), presented a 'representative' history of black nursing, describing the gradual entry of black nurses to the profession, despite major obstacles, challenges and contradictions, which she does not critique, emphasise or engage.

The late 1980s and early 1990s witnessed the arrival of critical histories and analyses, in particular, works written by Shula Marks (1994), a South African radical historian with a longstanding interest in health issues in South Africa. In this work and other publications (1987, 1993), Marks applied categories of class, race and gender in describing the many contradictions and discrepancies in nursing as it evolved in South Africa. A number of other authors critically examined the intense crisis in nursing and additional relevant issues during the 1980s and 1990s, among them: Hammond (1982), Critical Health (1988), Rispel & Schneider (1989) Rispel, (1990, 1995), Myburgh (1990), Walker (1993, 1996), Webber (1994) and Van der Merwe (1996).

2.2.1.1 a gendered profession

From its very inception, nursing in South Africa maintained strong links with sister organisations in the metropole, illustrated by somewhat parallel evolutions and affinities for framing gender and occupation for similar gains and with many comparable consequences. From the earliest moments of constructing nursing in South Africa, Florence Nightingale's lasting criterion for nursing – "to be a good nurse, one must be a good woman" (Marks, 1993:342; 1994:4) – was mirrored in the discourses Stockdale applied in seeking women of "good class and high moral

values" (Searle, 1965:144). This distinguished 'lady nurses' from other nurses and working women on the basis of class and ethnicity in the case of the English: Afrikaans relations and, most profoundly, on the basis of race.

Consistent with their sister organisations in the north, this evolution was initially rooted in the Victorian ethic of 'nightingalism', bound by tenets steeped in womanly values and high principles of morality articulated through discourses of 'care' (Bowden, 1997). Increasingly, despite Nightingale's opposition, British nurse leaders sought to distinguish their trade from that of the powerful medical profession, seeking recognition and legitimation through professionalisation. At the wheel of this process was Ethel Bedford-Fenwick, the editor of the British Journal of Nursing and ex-Matron of St. Bartholomew's Hospital. Bedford-Fenwick drove the process seeking professional recognition of 'lady nurses', a goal finally realised when the British Nursing Association (BNA) was formed in 1887. In quick succession, Act No. 34 of 1891 made provisions for the licensing and registration of professional nurses in the Cape Colony, soon to be followed by the other provinces in South Africa (Searle, 1965; Marks, 1994). Fenwick was also responsible for founding the International Council of Nurses (ICN), an organisation that would set professional criteria for nurses and promote self governance of the profession throughout the colonies. South Africa was one of the first members and remained affiliated until 1973 when SANA withdrew. In 1997, the newly formed nursing organisation, The Democratic Nursing Organisation of South Africa (DENOSA), resumed membership.

Professional discourses and practices have historically been a source of considerable tension and divisions within nursing. Bedford-Fenwick's successful campaign to professionalise nursing in England was much to the chagrin of Florence Nightingale who stood opposed to this development (Witz, 1992; Marks, 1994; Bowden, 1997). Although it was awhile ago, these two discursive orientations still permeate nursing. While Nightingale's reforms altered the role of hospital matrons from that of domestic managers to managers of bodies of nursing staff, they upheld themes of gender, subservience, vocation, discipline and morality that located women as cheap labour solely within hospital hierarchies (Witz, 1992:139-140). Conversely, Bedford-Fenwick's lobby for professionalisation shifted the locus of control from hospital authorities to a supra-institutional level, creating yet another hierarchy to which nurses were accountable, while reinforcing social closure[12] through the setting of educational standards and compulsory registration to an autonomous nursing association.

From this point international nursing became firmly entrenched within professionalising[13] trends, a characteristic consistent with industrialising societies. The development of professionalising practices has been guided by the work of theorists from Flexner, early in the 20th century, to Friedson, in 1970 (McCoppin & Gardner, 1994). In South Africa criteria

---

12

In her analysis of the politics of nursing registration in England, Anne Witz (1992) states there were three key exclusionary aspects to the dual closure strategy of nurses pursuing registration: the formation of a centralised system of control, a self-governing and self regulatory capacity, and a single point of entry into nursing. She asserts that credentialist and legalistic tactics featured, characterised by uniformity and standards provided through education, and a legal, compulsory system of registration.
[13] Discursively, professionalism articulates specialised knowledge that privileges and legitimises affiliates to a terrain of practice, self-regulatory power and state recognition.

established by Flexner in 1915 became, and for years remained,[14] central to setting the traits and attributes used to measure and proclaim nursing as an 'unmistakable' profession (Flexner, in McCoppin & Gardner, 1994:34). Regulations established in the early years regarding training, entry to practice and discipline firmly set the foundation upon which subsequent practices would be added in the form of 'scientific' theories, ethical codes, specialised knowledge, professional competency, and specialised preparation.

Flexner's contributions to setting professional criteria privileged the white male elite by aiming for the construction of status and autonomy for the medical profession. This was based on the dictates of gender and class, which historically intersected with race and ethnicity. Guided by Flexner's recommendations, the medical profession was built upon practices of occupational closure achieved through restricting entry to those with specific academic, as well as, social qualifications. Adopting these imperatives, nursing was required to maintain sound links with state structures responsible for training staff, maintaining public hospitals and for supporting state regulation (Marks, 1994:4). Autonomy, recognition as a unique profession and status have endured as goals for nursing. Yet, the divergence between notions of professionalism and the reality of work settings, entrenched in hierarchical and often divisive relations and hard physical labour, continue to subject the profession to a series of contradictions internationally and, in distinct ways, in South Africa.

---

[14] For example, Mellish (1978) and Searle (1987) have continued to use these criteria in legitimising nursing as a profession in South Africa. See as well Myburgh (1990) for a discussion on how Mellish applied Flexner's attributes of a profession.

For this very reason, the positioning of nursing as a profession has been contested by a number of theorists, both within and outside its ranks. In South Africa, Hammond (1982) concluded that nursing was a 'semi-profession' as it remained 'marginalised' from professional status. Similar to many theorists grappling with the professionalising trends in nursing, Rispel and Schneider (1989) considered the process of professionalisation to be a response of the predominately female occupation to the male-dominated medical profession's power, prestige and privilege. They went on to argue that the proletarianising aspects of nursing are contradictory to notions of professionalisation.

These authors are joined from further afield by a number of international theorists who raised the ambiguities that reside between the dominant discourse of the profession in nursing and the realities of the work environment. Everett Hughes (1959), following a study of American nurses, concluded that nursing was a 'semi-profession' as nurses lacked authority and professional autonomy. Pat Armstrong (1993), a Canadian sociologist, explored the idea of nursing as a profession in a similar vein to Rispel and Schneider, arguing that preconceptions of professionalism were disputable given the gendered and proletarianised nature of the occupation. Writing about professions and patriarchy, Anne Witz (1992) acknowledged the ambiguities, maintaining that the professional project within nursing failed, primarily for its inability to usurp the control of hospitals and doctors in determining relations.

This is visible within South Africa where, for example, nursing educational practices continue within authoritarian college programmes linked to hospitals. Rispel and Schneider (1989) referred to this as the

apprenticeship system of training, where the subservience of college nursing programmes within the male medical model is entrenched. They argued that it develops little in the way of autonomy and does not adequately prepare the incumbents with the capacity to challenge the conditions within which they work.

The apprenticeship programme at the heart of nursing's professional status promotes the womanly duty to care, "turning it into obedience to external authority" (Bowden: 1997:130). As Bowden (Ibid.) explains, the apprenticeship programme

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

A recent survey of nurses showed that nurses' views of themselves within the occupation and the choice of career have changed. In 1997 the Democratic Nursing Organisation of South Africa commissioned researchers from the University of Natal (UND) to provide a profile of nurses in South Africa.[15] Of the 777 nurses who responded to the

---

15

A semi-structured questionnaire was administered by field-workers to a structured, focussed ideal sample of 1,000 nurses of all categories. The report is based on the response of 850 nurses. Questions centred on demographic and descriptive data and surveyed aspects of the respondents' home and community realities and affiliations, on their career choice and educational achievements, workplace issues and relations, and views about trade union and organisational affiliation. The report, referred to as the UND

question concerning their preferred choice of career, 67.4% chose nursing first while 33% stated they did not choose to enter nursing. A correlation was shown between the level of education achieved, age and choice to enter nursing, in that nurses who were older were more likely to hold a degree and to affirm that nursing was their first choice of career. The converse was more likely to be true among younger women and African nurses. Few young nurses claimed nursing as their first choice.

When asked whether they viewed themselves as 'professionals' or 'workers' the data showed a strong correlation between occupational rank and perceptions, with 69.3% of the respondents stating that they considered themselves to be professional. This perception was highest amongst managers (96.8%), decreasing incrementally to professional nurses, enrolled nurses, enrolled nursing assistants and student nurses, where it was the lowest (24%). The converse was true for nurses who viewed themselves as 'workers'.

Separate open questions were asked about workplace difficulties and the frustrations nurses experienced in the workplace. Responses consistently pointed to staff issues, remuneration, working conditions and institutional problems. These problems were viewed as related to a shortage of government funds, poor management, staff shortages and a perception that nurses were 'down trodden'. When asked to explain the causes of the 1994-1995 labour unrest within nursing, respondents pointed to income issues (75%) and conditions of work (41.1%), most

---

study, is listed in the bibliography under the authors' names: Sitas, Burns, Webber and Phillips.

often citing hours of work. Of the nurses surveyed 65% earned less than R4,000[16] per month and 28.8% worked in excess of 40 hours per week. There was a strong correlation between lower salaries and larger family size.

These findings point to some of the serious occupational concerns nurses have and to the divergence in how they view themselves in the occupation. While the literature related to nursing theory and practice suitable to the changing health terrain has grown within academic and research settings, the workplace experience of many nurses in hospital settings continues to run counter to professional discourses. The fusion of gender roles with professional practice contributes to this reality, forging a gendered profession riddled with discourses and practices which both suppress and capacitate the women within.

2.2.1.2 hierarchies within hierarchies

From the point of entry to hospital nursing programmes, women are socialised largely within these secluded environments. Their programmes impart not only the knowledge and skills designated by the different 'scopes of practice' specified to each category, but distinct social messages regarding their location within the nursing hierarchy, their subservience to the medical fraternity and their authority in relation to their role with patients (Rispel, 1990; Marks, 1994; Webber, 1994). One nurse summed it up by linking the passivity of nurses to their

---

[16] According to the UND survey, monthly salaries ranged from R1035 to R8800. Whereas 69.2% of private sector nurses earned less than R4000 (average wage R3382), 56.4% of public sector nurses fell into this grouping. Another 20.4% earned between R4000-5000, with 10% earning more than R5000.

educational process:

> Nursing lectures are the most degrading experience. It's
> highly regimented with no subjects taught beyond nursing.
> No interpersonal skills; political realities are not taught;
> [nursing students] don't know the national health plan.
> Nurses are not supposed to question. Four years in that
> mode and the day she qualifies she's supposed to question.
> Where is she supposed to learn questioning? (Webber,
>
> 1994:133)

Anne Witz (1992:139) suggested that although Nightingale lost the battle

over registration, her reforms left a huge mark on the role and the

institutional position of nurses, in particular, the matrons. The

managerial role of the matron was to result in the formation of a female

hierarchy that was, until recently, profoundly racialised in South Africa.

The distinctly female hierarchy was further stratified between different

categories of nurses: the lady nurses, whose qualifications enabled

hierarchical mobility, and nurses typically referred to as assistant and

practical nurses, positioned to assume the mundane, household tasks.

The hierarchical relations in institutional nursing have been the conduits

for channelling the "discipline and obedience associated with the

professionalisation of nursing" (Bowden, 1997:130). Through hierarchical

practices, contradictory discourses cement nurses to authoritarian

relations that subordinate individuals, not only to the medical fraternity

but to other nurses, presenting tremendous disadvantages to the notions

inherent in professional status (Rispel, 1990; Rispel and Schneider, 1990;

Myburgh, 1990; Armstrong, 1993; McCoppin & Gardner, 1994; Marks,

1994, Webber, 1994). Whereas adopting the discourses and strategies of

professionalism conferred social status on some nurses, the realities

within hospitals, of heavy work loads and demanding work place conditions, often blur occupational boundaries.

For the majority of South African nurses, affiliation to professional structures has been ineffectual in improving conditions of work within strict female hierarchies and constrained socioeconomic conditions. Like their colleagues globally, association to trade unions has been considered, until recently, to be inconsistent with notions of professionalism. Trade unionism, as a means of redressing inequities, was summarily dismissed by the South African nursing leadership as counter professional on philosophical grounds (Critical Health, 1988; Rispel, 1990; Myburgh, 1990; Rispel & Schneider, 1990; Marks, 1993, 1994; Webber, 1994). Although South African nurses have been free to join trade unions, SANC maintained full legislative control over the conditions of service and professional practice, thus negating the possibility of trade unions negotiating on the behalf of nurses until the early 1990's (Rispel, 1990: 35). By 1998, nursing was deemed an essential service wherein strict controls were imposed, limiting the possibilities for involvement in labour unrest.

2.2.1.3 caring practices

The dominant discourses constructing nursing as a caring profession serve to displace discussions about the inconsistencies inherent to the practice of nursing and to the realities of the women within (Gilligan, 1992; Marks, 1994; Bowden, 1997). Care is the core nursing modality projected by nursing theorists. As an attribute, there is no doubt that caring is ethically important. In the most generalised sense, it expresses

the way we matter to one another, yet its moral core is perceived in many ways and assumes a variety of forms. A number of feminist writers have attempted to theoretically engage the practice of care in an attempt to develop an understanding of its ethical parameters while heightening sensitivity to the tendencies of essentialising care as a womanly trait.

Carol Gilligan (1992) shifted approaches to caring by considering gendered differences between what she terms the *justice voice*, noted for injecting moral principles and rules, contrasted by the *voice of care* which implies a broader understanding of a moral agency situated within diverse virtuous contexts. Gilligan's conceptual enlargement of notions of care clearly contributes to the possibility of extending perceptions of care, or the ethic of care, beyond the realm of being strictly a womanly attribute or duty, to the broader socio-political context. Contextualising care in this way enables the accounting for oppressive conditions in which many practices of caring occur. Taking this debate further, Peta Bowden (1997: 6-12) writes that

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

Within the context of highly structured nursing relations, notions of caring and the performance of caring practices stands in sharp contrast to those with the "characteristic freedom that mark the possibilities of

caring in friendship" (Ibid.:101) or maternal relationships. There are overlaps between the values inherent to maternal care and those taken up in nursing practice. However, the context of nursing care is more formally regulated by external forces that displace notions of free-will to care with the responsibility to care within the parameters of a formal organisation and with public accountability: the justice voice.

In an effort to strengthen the professional terrain for nurses, nursing theorists have constructed scientific discourses of care, wherein care is posited as a central feature of expertise in nursing practice. Perhaps the best example can be found in Patricia Benner's (1984, 1990, 1996) writing, in which she illustrates how nurses navigate theory and practice to care, through discourses of 'embodied intelligence'. The characteristics of embodied intelligence imply nursing care informed by a means that extends beyond the knowledge and technical skills that are required for nursing interventions, to care derived from an automatic and a mechanical extension. This exemplifies expert care. It suggests an optimum 'distance' as the means for keeping feelings separate in clinical practice and refers to the 'unidirectional focus of caring' wherein reciprocity is an unnecessary parameter for reward. As noted by Bowden (1997:108-124) these works construct care as a concept of excellence, aiming for increased professional credibility while enhancing the value and worth of the work nurses do. However, the approach is problematic on two main counts. Firstly, these concepts contribute to the objectification of nurses and to the depersonalisation of nursing interventions, while enhancing the isolation of nurses in the work they do. Secondly, these approaches fundamentally disregard the immense complexity and disempowering practices of structural relations within

institutional settings, not to mention further gender and class constraints imposed through broad social relations.

2.2.1.4 nursing and apartheid

The discourses and practices mobilised within the ethics of care, professionalisation and hierarchical structures underpin the essence of nursing globally and do much to reinforce unequal power arrangements detrimental to the women who nurse. Within South Africa the further dimensions of racial inequity, inherent within society upheld over the years through nursing practices, meted material inequities to black nurses in the forms of segregated training facilities, lower salaries, poor working conditions and less authority within hierarchical structures. The permeation of apartheid practices throughout nursing became an unsavoury liaison culminating in isolation of South African nurses from international to local levels.

It is clear from the literature that nursing in South Africa evolved with a distinct and strict application of racialist, exclusionary discourses. From the earliest practice of nursing registration in 1891, the leadership in nursing remained aligned with discourses emanating from colonial practices of segregation. From the early days of formal nursing education, black women were systematically marginalised within nursing structures, until social, economic and political forces rendered their exclusion unfeasible.[17] Unequal access or denial of opportunities, such as

---

[17] Again, Mark's works have been the most explicit in illustrating the connections between the opening and closing of nursing's doors to black nurses, and the social forces and dominant discourses of the day.

training, professional association, recognition, authority, access to university education, and organisation of trade unions, caused considerable tensions and cleavages within nursing and the 'humanitarian universalist discourse' [18] embedded within.

By 1944 regulatory and professional bodies were formed in response to the trade union threat[19]. The South African Nursing Association (SANA) and South African Nursing Council (SANC) governed nursing for the next 50 years. From the 1950's the Nursing Act, and amendments made to it, produced regulations and recommended exclusionary legislation consistent with the dominant practices of the governing regime. Among these were the Nursing Amendment Act No. 69 of 1957, which served to set up separate registration rolls for nurses of different race groups and to prohibit black nurses from leadership positions within SANA and SANC. In the face of threatened union organisation of white auxiliary nurses not affiliated to SANA, the Nursing Amendment Act of 1972 made provisions for their mandatory membership . Nursing Act No. 50 of 1978 declared strike action by nurses an illegal offence[20] in an atmosphere of growing resistance and, in response to international pressure, allowed for representation of all race groups on the executive of SANC. The Nursing Amendment Act No. 70 of 1982 closed SANA to nurses of 'independent black states'. In line with the National Party government's policy of separate development, nurses were compelled to

---

[18] Shula Marks (1993, 1994) uses this term in her works when discussing the tensions which arose between racialist ideologies and the professional aspirations of nurses.
[19] Different versions of Jane McLarty's efforts to organise nurses are provided in a number of works, including Kuper (Kuper, H. 1965), Rispel (1989), Marks (1993, 1994) Mashaba (1995).
[20] Striking became an illegal offense subject to a fine of R500 or a one-year prison sentence or both.

form separate nursing associations. The new associations affiliated to the League of Nursing Associations of South Africa (LONASA), to which SANA also belonged.

As noted earlier, professional imperatives of gender and class assumed ethnic and racial proportions internationally, to the detriment of nurses. These practices precluded the development of intra gender sensibilities across class and racial divisions. Quoting Darlene Clark Hine's research on black nurses in the USA, Marks (1994:5) writes

> . . .impulse [to professionalise] and class divisions separating black practitioners and elite white nurses overshadowed the potentially powerful bonds of sisterhood and work in modern nursing ... the structure of the nursing profession combined with the leaders' obsessive preoccupation with status to preclude the development of a sorority of consciousness across racial and class barriers.

In South Africa, racialised practices virtually aligned elite nurses with apartheid practices culminating in SANA's eventual withdrawal from the International Council of Nurses in 1973.[21]

2.2.1.5 shifting consequences: village princesses / perpetual minors

The relations set in motion from the earliest days of forging an elite profession for 'lady nurses' in South Africa, through to those consistent with the Nationalist Party policies of apartheid, presented two distinct realities. Emerging from the descriptions of black nurses are identifiable

---

[21] In response to the Nursing Amendment Act 69 of 1957, which excluded non-European nurses from decision-making positions, the ICN Mexico meetings issued a warning to SANA to "enable non-white nurses to serve on SANA's Board" or face expulsion (Marks, 1994:268). SANA withdrew, citing financial explanations (Harrison, 1973).

differences, not only in the relations they established with nurses of other races, but also in terms of the relations that existed within their own neighbourhoods. Hilda Kuper (1965), in a survey of black nurses from 1961-1962, cited the many tensions that created divisions for nurses within their communities, work environments and relationships. Women entering nursing at this time were conferred with status and held elite positions within their communities. Although considered 'the princesses of the modern community',[22] their subordination to men as 'perpetual minors' was constant. Kuper (1965:230) explained that tension within gendered relations arose from the educational and economic advantages of nurses compared to their local male counterparts. She presented vivid examples of how less privileged local men, who were unable to accept the status held by the uniformed and employed nurses, targeted them with physical and emotional abuse. She went on to claim that the victimisation experienced by nurses often resulted in their self-alienation from their communities and a preference for professional identities. Nurses opted for status, reinforced through the pursuit of diplomas and degrees, and preferred professional identities which offset gender-based subordination central to community identities.

Work environments of the day were highly stratified along the lines of gender, race and category. Black nurses, unlike many of their own social groupings, were closely associated with professional staff of other races. Relations with different races were variable, ranging from a sense of mutual respect to feelings of strong resentment for assumptions of racial

---

[22] According to H. Kuper (1965), black women who trained and registered as nurses rose in status in their communities. To marry a nurse was considered an investment worthy of the 'bride price' of a princess, to which, Kuper adds, nurses were often willing to contribute.

superiority, privileges and different salaries and benefits enjoyed by white nurses. Many black nurses were torn in their alliances, often feeling alienated from their own communities yet not treated with equity and respect within their 'professional' environment. Kuper noted that nurses of the 1960s showed little inclination for broad political issues at a time when the social terrain was being altered at the hands of apartheid. They were "concerned only for nail polish and status" (H. Kuper, 1965: 232). To some extent, the experiences she described help to explain the appeal of status and the superficial acceptance of ' a western way of life' which distanced nurses from political and social realities in their communities.

This section pointed to many of the discourses and practices permeating the lives and occupation of nurses. Professionalism, institutional hierarchies and caring operate separately yet clearly interconnect in gendering the profession in ways which both enable and constrain nurses. In South Africa, black women found their professional status to be useful within communities where, to some extent, it displaced their subordination as black women, yet introduced serious cleavages in relations with less advantaged men. Kuper's works, although more than 30 years old, and Marks' subsequent work, provide important sign posts of the social forces and realities that fractured the lives of black nurses contributing to their experiences of alienation within work environments and their own communities and, conversely, the status which entices them as professionals. Their work, and that of other chroniclers of the evolution and practices of nursing, has been instrumental in pointing to the complex relations confronted by nurses within work environments, the profession, their communities and to the tensions and contradictions they navigate.

2.2.2 Nursing in crisis!

The mounting crisis within nursing in the last decade intensified difficult conditions that made the profession untenable for many, and the grounds for resistance for others. By the early 1980s social, political and economic inequities had reached devastating proportions for the largely black population of South Africa. Alienation from impoverished rural settings as a result of a weakened economy and unemployment estimated at between 40-70% led to heightened urban migration (Marks, 1994:195). Within the health care sector, a segregated system of care imposed both first and third world disease profiles and standards of care.[23]

White nurses were either leaving or entering the profession in smaller numbers, as more appealing employment options became available (Hammond, 1982; Myburgh, 1990; Rispel, 1990; Marks, 1994). Black nurses, especially those working within the public health care system, had been subjected to years of gross disparities in the standards of education, the lower salaries they received, and the over crowded and poor conditions they experienced within hospital settings. As a result they were, as Marks writes (1993:195), "divided and embattled as never before". This period of legislated inequities, disparities, divisions and contradictions culminated in the early 1980s, in a 'crisis' in health care, and specifically in the terrain of nursing.

---

[23] David Sanders (1985) takes up these issues stridently, as does the Race Relations Survey (in particular, 1994). Poor nutrition, inadequate housing and sanitation, and poor access to clean water were day-to-day realities for the majority of the population in South Africa.

The events of the period reflected a crisis in hegemony, when the contradictions of the colonial past were being broached by divergent strategies to reinforce dominance. Forms of coercion and co-optation were introduced by the regulatory and professional bodies in an attempt to maintain control of frustrated nurses. While nurses became more vocal about disparate salaries and conditions of work, disciplinary action meted out by SANC to nurses involved in 'illegal' strike action reached enormous proportions[24]. In some cases, strike action succeeded in altering practices, as did the labour unrest by 900 Baragwaneth Hospital nursing students which influenced the 1986 decision to equalise salaries across colour lines.[25]

This period was marked by the appearance of a range of structures lobbying and planning for change. These included organisations such as the Health Workers Association (HWA) of Transvaal, the Health Workers Organisation (HWO) of Natal, the National Medical and Dental Association (NAMDA), the Organisation of Appropriate Social Services for South Africa (OASSSA) and, in 1987, the National Education, Health and Allied Workers Union (NEHAWU). These organisations engaged in formal debate seeking alternative organisations for nurses.[26]

Faced with the impending collapse of their control, SANA moved towards reform strategies to change their relations with black nurses in order to

---

[24] SANC disciplined over 800 nurses for engagement in protest action between 1986 and 1988 (Marks, 1994:203).
[25] An interesting outcome of this appears in Rispel's 1989 national survey of nurses which showed that black nurses (59%) were more likely to say that SANA had improved their salaries than nurses of any other racial group (1990: 67).
[26] For example, a workshop in 1988 commenced the dialogue amongst these groups regarding progressive organisational options for nurses (Rispel, 1990; Myburgh, 1990).

maintain a strategic hold over their allegiance. In light of growing competition from trade unions in the late 1980s, SANA opted for recognition in 1990 as a personnel association in the public service. This allowed the organisation to enter the terrain of collective bargaining and introduced a new militancy, exemplified by a march on Parliament for improved wages for nurses (Rispel, 1990: 86). In 1991, when the policy of racial segregation in hospitals was terminated, SANA asked for a retraction of the 1978 clause that made strike action illegal. This was granted in 1992.

A review of the literature into this decade from the early 1970s points to an overwhelming tendency on the part of nurse authors to locate inquiry solely into the terrain of nursing and the tertiary system, on the whole ignoring contributing factors related to broader social, economic and political areas. Their work examines issues confronting the profession, such as burnout, low recruitment, high failure rates, and presents arguments and strategies for internal resolution[27]. Apparent within Searle's (1965) account of the evolution of nursing in South Africa, are stark indicators of the inequalities, inconsistencies and discrepancies that ultimately confounded the profession's capacity to stabilise since its inception early this century. Into the 1990's, Searle and many other nursing scholars in South Africa identified and engaged in analysis of contributing factors such as the perpetual shortage of nurses, stress

---

[27]

The degree of investigation is too large to cite in this work. However, for example, Lombard (1983), Nzimande (1993), Marais (1994) and Themba (1995) representing different university nursing programs are some of the university-based nurses investigating high nursing failure rates in the last ten years; Heighway (1990) and Van der Merwe (1993) analyse burn-out and absenteeism; while Pryed (1991) and Kirby (1992) explore marketing and recruitment strategies to draw more women into the occupation.

management and burnout, and educational concerns such as the high level of dropouts and failure rates. Whereas, their approaches may have been intent upon reinforcing nursing's ethos as an autonomous profession, failure to explore the enormous structural challenges have, arguably, contributed to the view that nurses are responsible for the failures within the terrains of care, a practice that Bowden (1997) suggests endorses and reinforces the exploitation of nurses.

Renewed protest action in the 1980's dotted the health care landscape. Research and responses to striking nurses were varied. In exploring the 1979-1980 labour unrest in Johannesburg hospitals, Hammond (1982) cites the situation as a 'crisis' in nursing. As a practising nurse, Hammond acknowledged the frustrations of low salaries, yet rooted her explanations in an analysis of staffing inconsistencies within the work environment. Her findings were limited to persistent issues within her own tertiary environments where she emphasized problems related to staff shortages, over bureaucratisation and educational shortcomings.

Nurses and their professional bodies did not waver from upholding the professional ethic following the wave of labour unrest. In response to the 1990 strikes, academic nurses expounded the negative impact of strike action primarily on patients, but also to the stature of the profession (Van Tonder, 1992; Uys, 1992). This position left little room for recognition of nurses' attempts to have their issues heard. Uys (1992:35) noted this when she wrote,

> In South Africa, nurses have indeed bent over backward to
> speak to the government and make their needs known.
> Commission after commission has looked at the problems
> of the profession and made recommendations . . . but as

long as the "no strike" policy is accepted, the policy makers
have shown themselves to be totally uninterested in
seriously heeding nursing needs.

To her credit, she broadened the lens on the issue and drew from
international experience to consider some of the prevalent debates
encompassing the ethical concerns surrounding strike action, the moral
dilemmas facing nurses, alternatives to strike action and the potential
scenarios when striking was deemed appropriate. She concluded by
noting that a total ban on strikes were not ethically necessary, however
the moral dilemmas related to striking and the alternatives required
careful consideration.

The precarious state of nursing has been critically highlighted in the
literature from the late 1980s. In 1990 Rispel and Myburgh examined
nurses' socioeconomic realities and presented organisational options for
nurses in the light of unresolved and destabilising disparities. Both of
their works elaborated the incongruities inherent to profession-centric
discourses and in the practice of nursing in terms of the racialised,
gendered and proletarianised nature of the work as described in the
previous section. Additionally, they highlighted the suitability of
organisations with strong labour relations skills as a necessity to
resolving the crisis in nursing.

In 1990, Laetitia Rispel reported on a quantitative survey conducted in
the late 1980's of 554 nurses[28] selected by a stratified random sample.
Her ultimate aim was to gather nurses' views on the type of organisations

---

[28]

Questionnaires were posted to a sample of 1200 nurses. The respondents numbered
554.

that would most adequately suit their needs and preferences. In addition to descriptive and demographic questions, Rispel surveyed the nurses' views of SANA[29], their relationship to the association, and their views of affiliation to alternative organisations, such as trade union organisations, health worker organisations, and other bodies that represent labour and professional interests of nurses.

Rispel found that nurses were for the most part satisfied with SANA as a professional organisation, but her findings showed that this was mainly due to the status achieved through affiliation and educational opportunities. Interestingly, these findings were more consistently found in older nurses and professional nurses than in younger nurses and subprofessional nurses. Conversely, in the area of appraising SANA's role in improving socioeconomic conditions (including salaries, leave, hours of duty and pensions), younger nurses showed a greater tendency to be more negative than older nurses, and, interestingly, black nurses were less likely to express their dissatisfaction than nurses of other racial groups.

Rispel surveyed attitudes to other organisations and to industrial action. She found that most nurses (60%) preferred affiliation to SANA, with 28% in favour of health worker organisation (HWO). Trade unions were considered desirable as a means of responding to socioeconomic issues, but nurses were fundamentally opposed to being members because of ethical (care-related) considerations, concerns that affiliation would

---

[29] At the time of Rispel's study, membership in SANA was mandatory for all nurses practising, and was fundamentally controlled by an all-white decision-making body. Homeland nursing associations were still in existence, as well.

tarnish the image of nurses and for religious reasons. Industrial action was overwhelmingly opposed to for the same reasons. However, 28% of nurses considered 'work-to-rule' to be an acceptable means of raising workplace issues.

Rispel found that nurses raised many concerns about having 'voice' in their organisational structure and about the opposition they felt toward 'homeland' structures. The frustrations nurses felt within the socioeconomic sphere were apparent and provided meaningful pointers for organisations wishing to organise nurses. Whereas nurses were opposed to engaging in industrial action that might compromise the 'care' of patients, the study also found that nurses had little insight into organisational options. The appeal to 'professional' benefits seemed to out weigh interests in other options, in particular for older and professional nurses.

Van der Merwe (1996) conducted an 'epistemological analysis of the power of women as nurses' among 18 black nurses in KwaZulu Natal. Her findings presented observations of the differentials in perceptions of power among nurses of professional and subprofessional categories, from rural / urban locations. Her study surfaced the voices of nurses while providing an important entry to the analysis of power in the occupational and personal terrain of women, one that merits far more elaboration.

Researching nurses' perceptions of abortion, Liz Walker (1993, 1996) pursued explanations of identities of African nurses, through qualitative analysis into their roles as nurses, mothers, wives and Christians. Walker explained the overwhelming rejection of career 'choice' to several

identity-related explanations. For example, she described the effects of nurses' gendered roles as mothers on their occupational roles, a conflation that, she argued, ascribed considerable power. She described and nurses' relations with men, arguing that the latter generally subordinated women and attempted to control their fertility. In elaborating the variety of gendered and occupational roles nurses occupy, Walker made a valuable contribution toward an understanding of the multiple terrains and power relations nurses navigate. She wrote (Walker, 1996:63)

> the gender identity of these nurses is characterised by a complex and ambiguous web of meaning. Their identities as nurses, mothers and wives overlap and intersect in often conflicting and contradictory ways.

Together with Marks (1993, 1994) these works contribute to broadening the lens used to analyse nurses and nursing. Most significantly, they emphasise the value of featuring social and occupational categories such as gender, race, profession and hierarchy as essential analytical considerations for understanding and explaining the realities of nurses and, at this time in South Africa, the 'crisis' in nursing. The next section concentrates upon the period of resistance of the 1990's central to this study. Taking the forms of the unification of nursing organisations and the outbreak of labour unrest, resistance in nursing at this time was closely linked to dominant drives for political change yet it was rife with challenges to successful or meaningful outcomes.

2.2.3 Resistance: professional unification and labour unrest

The transitional process of the late 1980s was part of the same wave of
political change in South Africa which culminated in the release of
Mandela and the unbanning of the ANC, along with other liberation
organisations. It took four years before the majority of organisations to
the right and left of the organisational spectrum participated in the
Transitional Nurses Committee (TNC), the committee established to unify
nursing associations. This was due to a number of failed strategies.
Progressive nurses failed to effectively form alternative structures within
trade union organisations, specifically the National Education and Health
Workers Union (NEHAWU). SANA failed in their attempts to introduce
reform that would appease nurses, primarily the strategy that aimed at
gainning legitimacy by developing 'trade union' capacity in 1989, and
making membership to SANA optional in 1991. SANA's reluctance to be
drawn into the transitional initiative that they did not author stalled their
involvement and commitment to the process (Webber, 1994).

In 1987, black nurses closely aligned to the liberation process sought to
organise through NEHAWU. Research had shown them that the most
pressing grievances were 'bread and butter' issues, specifically
complaints of low salaries and condition of work.[30] The relationship was
short-lived as unresolved gender and status issues between nurses and
unionists resulted in an untenable partnership. The following excerpt
illustrates the cleavages as perceived by participating nurse activists:

---

[30] Interviews held with Concerned Nurses of South Africa (CONSA) members, in Webber
(1994).

In 1988 and 1989 we were busy helping NEHAWU organise nurses. We were only able to get the activists and didn't get more than 10% of nurses . . . Professional nurses had a hard time with the notion of sitting in the same union with their bosses – the 'oppressors'. They were telling themselves they needed to find themselves with workers. . . The nursing numbers were not increasing. Nurses were not wanting to assume the roles as shop stewards. . . they did not consider themselves workers. In Durban, some of us were elected to be executives of the union but were rejected by nurses as we were too educated, so we had to step down. We could be members but not the leaders, as we would bring in politics of the educated and lead them astray. . . There were organisational problems [within NEHAWU]. As nurses are trained to be organised this posed a problem resulting in tensions between nurses and ordinary workers. We tried to change NEHAWU from within to form a nurses' desk . . . [NEHAWU] would allow workers to meet on their own, but would not trust nurses. It made us, in Durban especially, feel what we were doing would not advance nursing . . . Nurses are now analysing NEHAWU and are distancing themselves. In 1990 with the unbanning of the ANC, nurses wanted to look seriously at the future of nurses in the new South Africa and so that is where and when our initiative started (Interview with CONSA member, in Webber, 1994:102-3).

The Concerned Nurses of South Africa (CONSA) was formed as an outcome of the NEHAWU experience. It pulled together national groupings who referred to themselves as 'defiance forums' or, as CONSA members said at the time, politically oriented nurses who joined in an effort to 'raise the consciousness of nurses' (Webber, 1994:105). In 1992, CONSA took the lead in calling together liberation structures and various organisations representing nurses for a workshop aimed at unifying the profession. The First National Consultative Conference – with the theme of 'South African nurses facing new challenges' –focussed on strategising for greater and more coherent involvement of nurses in policy, as well as

addressing the recurrent issues impacting on nurses' lives (CONSA, 1993). According to participants, the early moments of the workshop introduced tensions sparked by verbal accusations directed toward SANA representatives. The comments were directed at the association's complicity with apartheid policy (CONSA, 1993). SANA responded by leaving the forum, refusing to engage in the development of resolutions. The CONSA workshop went on to support a series of resolutions calling for the consolidation and unification of nursing. Within two weeks SANA set up a parallel process through LONASA, which was called Nurses Planning for the Future (NPFF).

The NPFF adopted resolutions that parallelled those formed at the CONSA workshop, and (although they were contested by the KwaZulu Nursing Association (KNA) during the first meeting). CONSA was eventually invited to participate in the initiative. The decision to do so split CONSA, with some nurses who were adamantly opposed to joining the NPFF leaving CONSA and the unification process. Others joined, and with the NPFF held a conference in 1994 where the Transitional Nurses Committee (TNC) was formed. Its mandate was to prepare a constitution and oversee the logistics for a national unification congress in a year's time.

From the outset the transitional process was dominated by two distinct and divergent political discourses. The SANA leadership sought reform that would retain integrity of the traditional infrastructure. CONSA and its supporters aimed for transformation of the professional body that would result in a 'representative and consultative' professional organisation. Other professional groups, in particular the KwaZulu

Nursing Association, retained the middle-ground, not aligning themselves with either stance – a position that won its president the top leadership position in the transitional organisation, and later in the new national organisation.

Thus, the beginning of the unification process was marked by substantial resistance to SANA based on its historical legacy of complicity with apartheid policies. Tensions were ignited that would follow nurses through the transitional process and the subsequent unification of the profession as DENOSA. Structural imbalances between SANA and other groupings during the transitional process further compounded these. SANA's assets, earned through 50 years of mandatory membership fees, were retained and used strategically (ie legal and resource support) throughout the transitional process. The CONSA initiative survived through the logistical support provided by the Progressive Primary Health Care Network. Whereas SANA was able to support its own strategic initiatives and inform its constituency through its publications, the CONSA initiative worked through networks similar to those of the liberation movements.

The 1995 TNC Congress brought together more than 600 nurses to negotiate and ratify a new constitution and found a new unified structure. All nursing organisations, homeland structures, specialty groupings, and organisations representing nurses, participated. Representation was proportional. Thus, SANA had the greatest representation due to its high membership. By 1995, many nurses who remained SANA members expressed commitment to the unification process. As mostly black nurses, their membership to SANA serviced

their need for professional affiliation, which they were required to provide to employers for indemnity purposes. Yet they represented various degrees of cynicism and disapproval of the professional body, illustrated through the wide support for unification demonstrated at the congress.

By January 1995 a new organisation was formed, the Democratic Nursing Organisation of South Africa (DENOSA). The congress adopted a constitution, and an Interim National Board (INB) was formed. The composition of the board was an illustration of the willingness of nurses to reconstruct. It was based on broad representation from SANA, KwaZulu Nurses Association and CONSA, with two KNA and two SANA members holding the key executive positions. Organisations left with the mandate to dissolve so that national elections could occur within a year.

The new organisation battled to maintain unification objectives despite inadequate funds for promotional and visibility initiatives, such as membership drives and public forums. A year and a half passed, by which time the possibility of unification again seemed tenuous. The failure of SANA to dissolve and align with DENOSA, aggravated by structural imbalance and strain, exacerbated tensions and the unresolved distrust built through the apartheid years. It also suggested ideological divisions within SANA with the likelihood of a conservative attempt to obstruct unification.

Despite the Interim National Board's formulation of a unification agreement in June 1995, by October SANA announced to DENOSA that it was constitutionally bound to hold a dissolution vote. By this time nurses not actively involved in the day-to-day negotiations were

disheartened or confused. Only 4% of SANA's membership turned out to vote. Although 71% of these voted in favour of a dissolution (with 13% spoiled ballots and 11% opposed to a dissolution) SANA argued that this did not meet the constitutional requirement of 75% and the unification process was halted.

SANA may have been able to retain its autonomy as a separate structure had it had it not been for several emerging tensions. Between 1994 and 1996 a series of developments pressurised SANA into negotiating what they referred to as a merger with DENOSA. Firstly, as nurses were no longer bound by mandatory membership, SANA's numbers and, hence, its income from membership dues fell rapidly. Nurses, and specifically those from the subprofessional categories, were joining unions that offered the indemnity employers demanded. NEHAWU was so fortified by this new found membership that in 1996 they challenged the South African Nursing Council's regulatory autonomy, arguing that the government should be tasked with regulating nurses , a strategy that no doubt piqued the interest of nurses who had fought so hard to gain professional autonomy since the 1940s. Thus, in July 1996 SANA and DENOSA participated in a mediation process that successfully addressed remaining issues. The newly unified (merged!) organisation was launched by President Mandela in October 1996.

In the midst of this process, groups of nurses unleashed years of pent-up frustrations by joining health workers in labour unrest that rippled through the country for two years, between 1994 and 1995. Kunene (1995) conducted a quantitative study of nurses views toward the 1994 labour unrest in KwaZulu-Natal. Her study suggested the main reasons

for the unrest were the dissatisfaction with salaries and benefits and poor working conditions, exacerbated by a period of political uncertainty. She found that nurses were divided in their feelings toward the appropriateness of strike action, and harboured complex feelings toward the consequences the strikes had for their patients and their own status and dignity.

The 1994 attempts by the newly formed Public Service Bargaining Council (PSBC) to bargain with competing employees and unions in the health sector failed in addressing the demands and expectations of health workers (Forrest, 1996). These workers were already fed-up with the persistent disparities and conditions endured through the apartheid administration (Rispel, 1989; Webber, 1994). As a consequence, labour unrest regularly disrupted the health care system nationally, at times for periods of up to two and a half months, resulting in temporary closure of facilities, including King Edward VIII Hospital.

Unique to this wave of strike action was the political environment within which it occurred. Similar issues had previously been raised within an environment of a larger contestation to policies of apartheid, when inequities in salaries and working conditions of nurses had been consistent with the laws of separate development. However, from the mid-eighties the salaries of nurses of all races were legally on par, and hierarchical arrangements were no longer subjugated to laws privileging race over merit. Furthermore, the political environment had changed in 1994. Governance was now in the hands of the Government of National Unity (GNU). Thus, these strikes did not carry the same political pedigree of the former resistance. Rather, they exemplified disjunctures in expectations and fragmentation of formerly unified groups.

Academics and activists offered fairly consistent explanations during this period. Bonnin et al. (1994) suggested that the strikes occurred within a transitional environment where employer expectations embodied discourses of 'wage restraint for economic growth', whilst employee expectations called for resolution of grievances. Posited as a clash of 'two moral economies', these authors illustrated the chaos of union organisations ineffectively jostling for power while losing legitimacy and, ultimately, any gains for the nurses (Bonnin et al., 1994:78). Gwagwa and Webber (1995) emphasised the frustrations of nurses as a consequence of the labour unrest, aggravated by their discrepant location within hierarchies and professions. In particular, they pointed to the reaction by a political leadership unwilling to validate nurses' concerns, and to a media that fundamentally undermined the relevance of nurses' issues and realities by privileging the discourses central to the professional ethic and moral responsibilities. Commenting on the extreme media reaction to the labour unrest in what he framed as a 'wave of media hysteria', Von Holdt (1994) pointed to unresolved racialised relations, with workers' expectations for changes heightened, with constructive engagement considered a measure of political transformation in the country.

2.2.5 Nursing in South Africa: A Summary

Nursing in South Africa has evolved along paths similar to its global sisters, with nurses having acquired many levels of expertise and status fundamentally gained through educational accomplishments and hierarchical achievements. Nurses have historically employed legitimizing discourses to project their location in the occupational terrain as a profession. This conception has been actively scrutinised over the years

by theorists who, while acknowledging the educational strides achieved by the occupation, have noted the ambiguities inherent to prevailing practices that reinforce subordination within a male dominated system while not questioning the proletarian nature of work within authoritarian, hierarchical tertiary settings. As a gendered profession, nursing is manifest with many practices which both enable its practitioners by appointing status and authority, while suppressing them in subordinate locations within the health care system.

A further paradox experienced by South African nursing relates to the impact of racialisation, consistent with the apartheid State's evolving segregationist policies, on the occupation's development. Black women were subjected to the highly differentiated experiences and environments at work and, set apart by their educational gains, frequently felt alienated from their communities. The organisations that regulated and monitored 'professional' practice, SANC and SANA, succeeded in forging a profession with an international reputation for high standards (Marks, 1994: 207), yet fell short of upholding the universalism of the nursing ethos through the darkest days of apartheid. Thus, workplace settings and professional organisations mirrored the policies emanating from the State, marginalising black nurses materially, hierarchically and professionally until the late 1980's when active co-optation to the ranks of the profession was in keeping with the imperatives of the State.

The ultimate 'crisis' in nursing stemmed from an accumulation of unresolved social and political disparities in tertiary settings. Efforts of nurses to enter the protest arena through labour unrest and the unification process magnified the inconsistencies and disparities derived from the fragmented nature of the profession and the health care system.

By the time South Africa entered the period of political transition of the 1990's, nursing had endured years of chronic issues that constrained capacities to care. While some nurses worked toward dismantling the racial divisions separating professional groupings and the practices compromising professional integrity, many within institutions were ready to challenge the new dispensation to undertake measures to resolve chronic disparities. The transformation goals articulated by progressive nurses confronting the powerful nursing structures were soon overshadowed by mounting tensions and distrust reinforced by elite white nursing leaders intent on retaining the status quo. Understandably, similar insecurities underpinned tensions within all transforming sectors, yet within nursing they did much to obstruct a coherent drive to redress gender and class imbalances historically confining the roles and realities of the women who nurse. In this way, the profession succeeded in retaining autonomy, but at the price of entrenching practices that fail to confront obstacles or issues that pin nurses to subservient relations.

Similarly, the labour unrest occurred within the context of political transition when the new government needed to project images of stability and control. Nurses' failure to succeed might have been the result of the new government's need to highlight the successes for the new non-racial democracy, at the cost of attending to the issues in nursing. I will argue in a subsequent section that the labour unrest should not be viewed only as a clash of two moral economies, but also in terms of the location of these struggles within patriarchal relations of power.

2.3 Conceptual Interpretation within the Terrain of Domination and Inequality

An explanation of the broad social, political, economic and cultural context and the current realities of the women who nurse is key in helping to further explain the obstacles that challenge these practitioners and the evolution of the occupation. This section explores critical interpretations of South Africa beginning in the 1960s when the policies of apartheid drew mounting attention from academics and scholars. Conceptual approaches to the internal dilemmas and contradictions that were experienced as a result of racialised governance are examined. Social relations, forms and dynamics of domination and inequality are also discussed. This literature has been explored in order to situate South African women within their socio-political environment. This aims to broaden insights into the contextual terrain that frames nursing.

The section begins by examining conceptual formulations regarding the socio-historical evolution of South Africa. The relevance of class, race and gender within social relations are discussed, largely as they are denoted by capitalist, racial and patriarchal relations of power. The implication of identity and difference to the analytical categories is considered, as are theoretical approaches to social movements and the dynamic interplay of resistance and movement within South Africa, particularly from the 1980s. Finally, the work of feminist theorists concerned with the challenges faced by women in the field of contestation and resistance is discussed.

2.3.1 Historical terrain: conceptualising woman within broad relations of power

This work was undertaken during a period of political transition, when the national liberation organisations achieved their penultimate goal[31] of taking the country to an electoral process to achieve representative democracy[32], an experience not previously realised in South Africa. By this time, South Africa had endured 47 years of apartheid social engineering by the National Party, a process guided by the Afrikaner cultural wing, the Broederbond. This brand of cultural domination, linked to the imperatives of modernisation discourse and enhanced industrial development, further entrenched social and cultural conditions, already in a shambles following more than a century of British and Dutch colonisation and consequent struggles for hegemony (Price, 1991).

In examining the literature surrounding South African women, it became apparent that their experience and access to power and privilege has been shaped by many sites of complex, diverse and contradictory social relations that link and intersect temporal and spatial boundaries. The course that African women's history has taken from precolonial times to the current transitional moment has been driven by considerable changes in structural and relational realities, directing experiences and outcomes that have been in no way homogenous. Profound dynamics in

---

[31] I would posit that their ultimate goal, based on liberation discourse subsequently captured within the pages of the *Reconstruction and Development Programme* (1994), was social, economic, moral, cultural and political transformation to re-build a society based on principles of human rights and equity.

[32] Representative democracy is a system of governance wherein broad consultation of the electorate guides political actors, who preserve "some measure of autonomy . . . [to] act both in terms of their position in decision systems and as emissaries of interest groups or of movements (Touraine, 1988: 68).

economic, political and social conditions across ethnic and racial
boundaries, rural and urban social spaces, and productive and
reproductive arrangements have had a dramatic impact upon women's
lives, with diffuse repercussions in the forms of dependence, domination,
constrained relations of power and involvement in the terrain of
resistance. Hence, women's experience cannot be captured or described
using reductionary or essentialist approaches. There is no 'essential
woman' in this context.

The work of post colonial theorists has been important in expanding the
analytical lens to the many levels of force relations that have influenced
subject formation and the location of subjugated populations in post
colonial societies. Clearly, colonial power relations have been successful
in displacing indigenous populations within rapidly changing social
landscapes (Said, 1978; Spivak, 1987; Loomba, 1998). These groupings
have been conceptualised by these theorists as the subaltern[33].

Colonialism represents periods of repressive power relations intersected
by the prevalent global narratives of patriarchy and capitalism (Loomba,
1998:2). As subjects of colonial power relations, South African women
have been exposed to a range of these dominating relations. Their
subordinate locations pivot on varied relations between dominant forces
and those operating at local levels. Taking this up, Loomba (1998:13)
makes the case for, on the one hand,

> [needing] to move away from global narratives not because
> they necessarily always swallow up complexity, but because

---

[33]

Beyond examining the location of the colonised within varied power relations, the work of
these theorists urges a shift from conceptualising the subaltern as 'silenced' victims of
colonial subjugation to exploring and understanding their dynamism. This theme will be
taken up in chapter three.

they historically have done so,

while noting the relevance of prevalent, global narratives. In the case of

capitalist power relations she portrays the dynamic as

> . . .drawing various local cultures and economies into its
> vortex. . .[weakening] older boundaries and de-[centring]
> production and consumption. .[and posits that] to ignore
> the economic dimension of the global order is to construct .
> . . a 'shapeless' world.

In South Africa a brand of colonialism evolved in the last fifty years that

drew upon global capitalist and patriarchal relations to forge a variety of

local racial relations. The victory of the National Party in the 1948

elections placed ultimate political control into the hands of a minority

Afrikaner cultural entity within an environment of considerable economic

growth and wealth (Price, 1991). Apartheid policy entrenched an

Afrikaner cultural discourse,[34] instrumental to mechanisms of garnering

control of resources, wealth (Johnstone, 1976; Marks & Atmore, 1980;

Wolpe, 1988), and ideas (Bunting, 1986). Indeed, it delivered instruments

to 'cleanse the Kultur'[35] of ideas that contradicted notions of white

supremacy, that violated the principles of the colour bar[36], and that

actively suppressed resistance and social movements, such as the

liberation initiatives articulated by coalitions such as the African National

Congress (ANC) and the South African Communist Party (SACP).

---

[34] Dunbar Moodie (in Price, 1991:14) asserted that Afrikaner cultural enterprise was
driven by religious doctrine of the Dutch Reform Church, that seemingly designated theirs
as a 'particular' and 'unique' calling to the southern shores of the continent, fortified by
an obsession with maintaining group identity.
[35] From Hitler's *Mein Kampf*, (in Bunting, 1986:296).
[36] Brian Bunting (1986) provides a detailed description of instruments implemented to
control expression, cultural production and ideas through repression and censorship
designed to limit the circulation of anything that might stimulate antagonism or
undermine the authority of the regime.

For the duration of the National Party's tenure, apartheid was integral to the socio-political system as a means of retaining white minority dominance through policies that explicitly and legally extolled racial classification, stratification, and domination as the main tenets of its political and social order. Apartheid, noted by many South African and international scholars as a system of dominance, was sustained by evolving discursive practices and apparatuses of control utilised by its many agents (members or the co-opted) and sites of power. Its brand of official racism confounded international relations[37] while cultivating a dialectic between two forces, based on the imperatives of class and race relations (Johnstone, 1976; Marks & Atmore, 1980; Bozzoli, 1987; Wolpe, 1988).

South Africa's rapid and considerable economic growth (and subsequent decline), and the sustained and extreme forms of rigid social control and racial inequities were two striking features of South Africa during the 1960s. This was problematised by progressive scholarship and examined through Marxist formulations (Johnstone, 1976; Legassick, 1970; Marks & Atmore, 1980, Beinart, Delius & Trapido, 1986; Wolpe, 1988).

Researching in Durban in the 1950s and early 1960s, Leo Kuper (1965) analysed the complex interplay of the race, class and ethnicity matrix in the lives of African professionals and traders. The salience of this work lies in its occupational portraits showing the ambiguities and incongruities central to occupational status experienced within the apartheid context of racial domination, political ideologies and gross and

---

[37] Price (1991:5) notes that within the contemporary global framework, states' coercion of their populations often goes unnoticed by the international community, but the incompatibility of South African white supremacy with the prevailing global discourse exposed the country to harsh international judgement and consequent political and economic recourse.

mounting economic inequalities. Temptations to reduce racial binary constructions of white/bourgeoisie : black/proletariat were dismissed as the many tensions and divisions operating within class relations emerged within the context of shared racial oppression.

Later in the decade, exiled[38] and international scholars shifted the interpretive paradigm from mid 20th century liberal scholarship's concentration on racial conceptions to revisionist historiographical projects.[39] Their work extended conceptual parameters to illustrate the internal dynamic of the state, economy and society, in an attempt to explain how so few could impose themselves on so many to achieve dominance, exploitation, and power (Marks, 1980:2). Among this scholarship, Johnstone (1976), Legassick (1970) and Marks (1980) pointed to the limitations of binary, master-servant constructions resulting from historiographic analysis of frontier relations which privileged the explanatory power of racist attitudes and ideologies. Within this debate, Van den Berghe (in Legassick, 1970:52) suggested there "can be no general theory of race. . . [instead,] race relations must be placed within the total institutional and cultural context of the society studied". This era of scholarship published extensively on the dynamic of racial and class relations, influenced by the expansion of pre-capitalist interests (Marks & Atmore, 1980; Marks & Trapido, 1987; Guy, 1990) and the imperatives of capitalist interests within mining (Johnstone,

---

[38] Many South African scholars elected or were coerced into exile as the repressive machinery of the apartheid regime constrained their capacities to study and work from the 1960s, when liberation organisations were banned. While the circulation of critical thought was curtailed within South Africa until the mid 1970s, radical scholars were invited into English universities, creating academic space for research and broad debate into South African issues (Johnstone, 1976; Bozzoli & Delius, 1990).

[39] Johnstone (1976), Legassick (1970), Marks and Atmore (1980) and Bozzoli and Delius (1990) point primarily to the works of W.M..Macmillan and C.W. de Kiwiet, noted for their contributions to liberal historiography that problematised racial interactions, yet averted 'class' as a conceptual parameter.

1976) and industry (Wolpe, 1988). Binary constructions were shifted from master-servant to those characterised as chief-subject, bourgeoisie-proletariat, or patron-client (Legassick, 1970:68).

New generations of radical intellectuals informed by Marxist, 'new left', and later feminist approaches joined the debates from the late 1970s, exploring the interplay between political/social dynamics and economic forces. Mounting unrest and protest during the 1970s (for example, the Durban strikes of 1973 and the Soweto uprising of 1976) distinguished the workplace and community as sites of resistance, stimulating extensive debate and research in the areas of labour studies, resistance and social movements. Much of this work was built on theoretical constructions of race and class, and explored links between exploitation and oppression within relations of production and reproduction, which were seen as subsidising and inherently sustaining the capitalist economy (Bonner, 1977; Webster, 1978).

During these intense years of oppression and resistance, South African social scientists entered into 'hidden abodes of production' (Webster, 1987). They probed workplaces and community environments, searching the complex interconnections of class and race to elaborate the links and tensions within and between these spaces. At the same time, they elicited non class divisions that contributed to 'consciousness', and in so doing broadened the analytical terrain. Critiques of the explanatory limitations of race and class abounded, broadening analytical criteria to gender and broad relational areas such as domesticity, occupation, culture, ethnicity, and nationalism as important conceptual parameters (Cock, 1980; Bradford, 1987; Webster, 1987; Bozzoli, 1983, 1987; Bozzoli & Delius, 1990; Berger, 1992). These writers refocused analysis on

patriarchal forces that, combined with divisions based on class and race, formed mechanisms perpetuating women's subordination.

2.3.2 South African women: relational 'difference' in the extreme

South African radical, Marxist and feminist scholarship have engaged in critical debates that have enlarged theoretical approaches examining the nature of class, race and gender relations within many sites of oppression, exploitation and resistance. This scholarship has prepared the foundation for exploring the complex intersections within these categories, elaborated in the day to day experiences of women.

The body of literature describing and analysing women's realities, and in particular South African women's realities, is growing,[40] stemming from radical, largely Marxist, historians and social scientists of the 1980s, and incorporating more in the way of post-structural analysis in the 1990s. This work attempts to understand women's experience in and within what Walker (1990) refers to as pre-capitalist Bantu-speaking and settler societies, specifically analysing the evolving impact of patriarchal, colonial and capitalist forces on women and their social relations. Feminist scholars have also specified conceptual categories of race and class (including gender) in the analysis of women's social realities, furthering insights into social inequalities and difference, thereby highlighting the cleavages that intersect and contrast in complex and disparate ways.

---

[40] This in no way intends to contradict Cherryl Walker's (1990) claim that historical records of women's experiences in South Africa have been deficient. Since the 1980s feminists have articulated the 'invisibility' of women in historical accounts, which in many ways served to render women's social role insignificant, passive and without agency.

From the early 1980s some South African feminist authors extended theories to include the dimension of gender within the race and class dichotomy (Walker, 1982; Bozzoli, 1983; Bradford, 1987). Others began to point to the complex relational dimensions at play within these categories (Cock 1980, Marks, 1994). For example, Cock's (1980) insightful work on domestic workers within the 'converging systems of racial and sexual domination' provided illuminating insights into the complexities of race, class and sexual relations. Walker's (1982) research into the formation of a women's national liberation movement in the 1960s opened the conceptual terrain to gender at a time when the concept had not yet been entered into the lexicon of South African conceptual work. Her research contributed to the process of enlarging the image of African women, often depicted as passive, victimised and oppressed, and making visible their strategies and leadership in resisting racial and class oppression. Bozzoli's (1983) Marxist feminist approach to resistance issued a call to an elaborate historiographical exegesis in the domains of patriarchal and class relations within households and between domestic and productive spheres. Shula Marks' (1994) critical inquiry into the nursing profession of South Africa applied the analytical framework of race, class and gender in weaving the complexities and contradictions of hierarchy and domination into the history of nursing in South Africa.

Analysis of the diverse arrangement of power and knowledge that cuts through and across relational categories has consistently pointed to a number of considerations that inform conceptual approaches to understanding and exploring the lives of women in South Africa. Firstly, women's subordination and oppression cannot be reduced to singular categories. By this I mean that the social realities of South African

women, and notably African women, have been intersected by all forms of subjugation in society in the form of asymmetrical gender relations, economic exploitation and racial oppression. Of these, patriarchy has effectively served to subordinate women generally yet also within the parameters of segregationist ideologies, in what Bozzoli (1983) referred to as the 'patchwork of patriarchies'.

Gender relations, across time and space and within all cultural and ethnic groups, have been skewed by patriarchy's uncompromising persistence in constructing women's social role in domestic terms –that of nurturers, care-givers and, in the case of rural African women, producers – compared to men who are seen as decision-makers and providers. In the case of African women the situation continues beyond this dichotomy. Radical historians have posited numerous descriptions of the forms this has taken within precolonial experience,[41] and colonial and capitalist relations (Walker, 1982 ; Bozzoli, 1983; Campbell, 1990; Cock, 1990; Walker, 1990), while displaying the discourses central to validating, and often consolidating, the significant role (and the place) of women in the domestic sphere. For example, Afrikaner women were rallied to 'hearth and home' and to the virtues of Afrikaner nationalism when the discourse of *voelksmoeder* (mother of the nation) was heightened in the wake of the Anglo-Boer War (Cock, 1990; Walker, 1990). With a similar mobilisation of discourse, Inkatha's *ubuntu-botho* syllabus clearly denotes the importance of strong family values and women's subordinate status (Cock, 1990; Hassim, 1991). In many respects, patriarchal power has been buttressed by the role women have played as the reproducers and nurturers of their own oppressive forces.

---

[41] For example, Jeff Guy (1990:34) writes ". . . the history of African women in southern Africa is the history of their oppression"; he asserts the central and valued role of women in pre-capitalist societies in Southern Africa was their fertility.

As Figes (in Cock, 1990:27) wrote, "[patriarchal] power is like the disease of haemophilia. It is transmitted by females but is only manifest in males".

The realities and common discursive spaces that women share across racial and ethnic boundaries have been observed. Writers have explored the spaces shared within motherhood (Campbell, 1990, Cock 1990, Walker, 1990), or in common forms of discrimination most poignantly found in the experiences of violence against women and sexually skewed laws. These commonalities, however, have been obscured by racial ideologies central to colonial discourses, particularly in their propensity for historically intersecting with patriarchy, and by class-based differences.

Capitalist relations of production have divided South African (and global) society into conflicting classes and subjected women to unequal forms of exploitation. The evolving forms and force of colonial relations have augmented this reality most intensely to African women (Cock, 1980, 1990; Walker, 1982, 1991; Bozzoli, 1983, 1987; Berger, 1992).

Further, through social relations denoted by class, race and gender, an arsenal of strategies has underpinned the discrimination women face in many spheres of their experience. Women's access to equity and choice in employment, education, reproduction and marriage has been severely hampered by various forms of control, implicit in legislative practice and within tacit understandings. African women's realities attest to this. Although the number of women entering the labour force has increased substantially since the 1940s (Cock, 1990; Budlender,

Table 2:1: Unemployment Rate by Race and Gender (Budlender (1995), in Budlender, 1996:56)	African	Coloured	Indian	White
Women	50%	28%	24%	9%
Men	34%	20%	13%	5%
Total	41%	23%	17%	6%

1996), African women earn the least and represent the highest category of unemployed[42] (Valodia, 1996). The latter point is illustrated in Table 2.1. Apartheid's policies had a crippling impact on the educational empowerment of Africans, very true for women (Cock, 1990; Budlender, 1996). Similarly, in the area of marriage and reproduction discriminatory practices such as customary law and anti abortion legislation constrain women's choices.[43] Not only has women's subjugation been enforced, but the location of African women as the most economically marginalised signifies vast cleavages between unemployed and employed African women, potentially with the latter realizing their own comparable advantages, notwithstanding the low wages they endure.

As discussed earlier, women's subjective realities and social relations are often multiple and contradictory. A woman's status within the workplace, her domestic reality, her social and community standing are influenced by a diverse range of discourses intersected by notions of gender, race, and class, further influenced by age, marital status, language, cultural beliefs, practices among other categories (Weedon, 1987; Barrett, 1991; Sawicki, 1991; Mama, 1995). Consequently, feminist writers assert that

---

[42]

Informed by a "Labour Market Study" published in 1995, Budlender (1996) notes female unemployment rates to be at 50%, however statistics cited earlier in the chapter suggest the rate is between 40-70% (Marks, 1994:195).
[43] Although these laws have changed the discourses surrounding relations and practice are still, arguably, transitional.

the forms oppression and discrimination of women are varied, deep and complex (Cock, 1980, 1987; Bozzoli, 1983, 1987; Walker, 1992; Webber, 1994). They reflect the dynamism and differentiation of power and power relations.

Overall, women disproportionately include the poorest, most homeless, landless, unemployed and violated in this country. Yet there is no simple congruity in the position of women across space or time, or denoted through gender, class or race relations. Feminist scholars have noted these disjunctures in women's experiences across racial and class relations as significantly confounding women's capacities for political alignment to contest class or gender issues (Bozzoli, 1983; Beall, 1989; Cock, 1990, Walker, 1990 and 1991). Within these parameters, difference unfolds as a site infused by complex, historically-fragmented relations, a site in which disadvantage is inherently situated.

Conceptually, difference acknowledges the diversity of social groups and identities within. The shift towards recognising difference has been taken up by post colonial and post-structural theorists. The former is intent on ending the "exclusions, silences and blindnesses of male WASP cultural homogeneity . . ." (West, 1993:16); while the latter urges the extension of conceptions beyond strict binary parameters, such as white:black, male:female, which have the tendency to restrict insights into multiple systems of oppression.

Theoretically, difference and disadvantage, are necessary concepts for the exploration of women's realities within this research. As Cock and Bernstein (1998) point out, the fusion of these concepts is necessitated politically, bearing in mind the vast and growing inequities experienced

by women and, theoretically, to redress the 'displacement of inequality'[44] as a conceptual tendency within post-structuralist discourses. The field work in this study provides testimony of the need to mobilise these two concepts. Whereas my tendency has been to highlight the vast differences operating within the many levels of the field, material inequality is very clearly a central and blatant reality operating within gender relations.

This brief overview has portrayed women's situation within the diverse sphere of power relations, illustrating the strategies that work to underpin women's subordination to dominant forces and pointing to the assortment of sites and conditions faced by women. A review of the evolution and distribution of power within the specific social and historical context of South Africa to highlight the ways difference and disadvantage have been constructed as a relational process. As Minnow (cited by Cock and Bernstein, 1998:14) writes, approaching difference as a relational process

> allows us to challenge the norm against which some people
> seem different and to see the ways in which institutions
> construct and utilise difference to justify and enforce
> exclusions.

The description of the historical and socio-political situation in South Africa served to illustrate the context within which South African nurses are located. It has pointed to the main power relations of capitalism, patriarchy and racism that have combined to impose a range of diverse and challenging realities. Finally, I have demonstrated the value of shifting the analytical focus from binary constructions such as male : female or black : white. The importance of doing so is based on the illustration of the diverse systems of oppression that form part of

---

[44] Cock and Bernstein acknowledge Anne Phillips (1997) for this point.

women's realities. I have suggested that difference and disadvantage are suitable analytical categories for describing women's and, in particular, nurses' location.

2.4   Resistance, Struggles and Movements

Touraine (1988:26) writes that social relations are always relations of power. At the core of social relations are cultural models that fundamentally govern social practice. When these agencies of social and cultural control are caught within contradictory practices, they become predisposed to social relations[45] and dynamics between forces of domination and forces of resistance and protest (Touraine, 1998: 71). Social movements can emerge which engage in questioning, contesting and altering these cultural models. According to Touraine (1998:26) social movements define themselves both in terms of their "cultural orientations and by the social conflicts in which they are engaged".

Resistance during the era of colonial subjugation characteristically responded to the main contradictions being contested throughout the course of continental African social and political contexts, that is, contradictions inherent to national, race, class, development, and increasingly, gender relations (Hirson, 1979; Walker, 1982; Bozzoli, 1983; Berger, 1992; Nzimande & Sikhosana, 1995). Resistance to colonial, capitalist, industrial and political dictates assumed many forms through the decades. The voices of those held within the trap of cultural and ideological control, to be silenced through physical repression, violence and intimidation, were never totally silenced. Rather, they were heard

---

[45] The term social relations refers to the dynamic of ranging determinations among actors and forces that has consequences for altering the social system and the relations of power.

through strategies pitting social action against the contradictory practices of the social order. In addition, concession to various forms of oppression recurred in scenarios Walker (1990:31) suitably describes as the "dialectic between female resistance to and acquiescence in their subordination", that point to the endorsement of subjugated roles as part of active engagement with their situations. This section takes these themes further.

2.4.1 The South African context

The history of resistance, presenting radical opposition within many sites of work and civil society, has been well documented, with scholarship intent on describing the social contradictions, ironies and disparate circumstances responded to by a variety of jointly coherent yet separate strategies (Mare & Fisher, 1974; Hirson, 1979; Sitas, 1991). Contemporary critical accounts of the coalescence of fragmented initiatives to mass struggle and protest action pointed to the discursive strategies assumed[46] to articulate the larger goal of replacing the regime through Gramscian-style technical strategies of 'people's power'[47] (Nzimande & Sikhosana, 1995). Academics and scholars recognised the growth in coherence of resistance while understanding that social

---

[46] This is exemplified by the United Democratic Front. The UDF was launched on 20 August 1993 by an assembly of over 1000 delegates representing 575 organisations. Its oppositional mandate embraced the "creation of a non-racial, unitary state undiluted by racial or ethnic considerations" aiming "to unite all our people, wherever they may be in the cities and countryside, the factories and mines, schools, colleges, and universities, houses and sports fields, churches, mosques and temples, to fight for our freedom" (quotes from speech by N.G. Patel, in Price, 1991: 177).

[47] Gramsci's revolutionary discourses influenced the South African liberation movement where his concepts of the state, civil society and notions of organic leadership were evident within conceptual formulations and debates regarding the roles of 'organs of civil society' versus ' organs of people's power'. Where the former relates to the nature and character of 'vibrant civil society', specified by a dialectic relationship with the state, the later captures the essence of 'a people united to bring about a national democracy' based on the principles of socialism (Nzimande & Sikhosana, 1995).

movements and their strategies were in no way uniform. The very turbulent nature of the environment predisposed resistors and strategies to ferocious repression and conflict (Sitas; 1991, Hemson, 1996).

South African women assumed important roles in challenging the structures of oppression through popular movements, trade unions and, later, within the mass democratic movement. The nature of women's protest actions and reactions to their protests frequently served to reinforce their gendered location and oppression within particular domains of class and patriarchal relations. Walker (1990 and 1991), Cock (1991) and Berger (1992) point out the way women's protests against violence and segregation policies were frequently framed discursively within their location as women and mothers.[48] These appeals drew many African women into protest action without effectively enticing support across the ideological boundary of gender or race. For example, as women (and mainly African women) joined 'motherhood' protests in opposition to apartheid, Afrikaner mothers and wives,

> . . .made vital contribution [s] to the power of the apartheid state by preserving the illusion of love in an environment of hatred. . . (Koonz, in Cock, 1991:50).

It would be spurious to suggest, however, that forms of resistance were embraced uniformly across racial, class, gender or professional lines, although the nature of inequities, exploitation and oppression is most clearly characterised in these terms. The relations between these forces have been and continue to be complex, influenced by many factors and dynamics operating at a number of relational and subjective levels. They

---

[48] In protesting the issuing of passes to women, the Federation of South African Women frequently framed their opposition to undemocratic process and lack of freedom within their identity as mothers and nurturers (Walker, 1990, 1991; Cock, 1991).

denote, as do the many other forms of protest and struggle, instances when society has 'acted upon itself' in attempts to alter through transformation the cultural models that rule social practices – a process Touraine refers to as 'historicity', (1981, 1988:26). Scholarship and radical literature of this time was in the midst of a descriptive and strategic dialectic, where beliefs of value-freedom were clearly displaced by the 'value-commitment[49] central to the event, aimed at ". . .[mobilizing] *all* in a final action that would crumble the structure" (Sitas, 1991:7). My interest in locating African working women and the agency of women as a social force within these processes has called for further insights. For this reason, I turn now to the broad literature on social movements to elicit conceptual approaches to women in resistance, protest and social movements.

2.4.2 Theoretical approaches to collective action, social protest and social movements

Marxist thought about collective consciousness, subject location and materialism has profoundly influenced current conceptions of social movement activity and questions of agency (Marx & Engels-1872, 1987; McLellan, 1980; Callinicos, 1987; Touraine, 1981, 1988; Smith, 1987; Tarrow, 1994). Marx and Engels initially hypothesised that the contradictions central to the bourgeois-proletariat social dynamic would deepen, and eventually culminate in revolutionary dynamics to overturn and redirect the dominant social arrangement. Explanations of failure to achieve this rested in conceptions of 'false' consciousness. Although the concept of collective 'class' consciousness effectively captured social

---

[49] Mies (1983) develops this notion as 'conscious partiality', an approach that engenders a critical distance within the research relationship, while acknowledging the capacity to relate to the issues at hand and make a constructive contribution.

tensions arising from materialist contradictions, it has been criticised for its inherent essentialism and reductionism – that is, the reduction of consciousness to material conceptions.

Since the 1960s an expanding literature has examined the role of women in collective action, social protest and social movement activity (Friedan, 1963; Millett, 1969; Mohanty, Russo & Torres, 1991; Walker, 1991 & 1992; West & Blumberg, 1990; McDowell & Pringle, 1992; Rowbotham, 1992; Threlfall, 1996). This has coincided with extensive scholarship, from the classical works of Marx and Engels (1987) to the contemporary accounts of resource mobilisation theorists of the 1960s and 1970s (inter alia, Tilly, Olson, Tarrow, Gamson, Zald), and the identity-oriented theorists of the 1980s and later (inter alia, Touraine, Melucci, and more recently Castells). These latter theorists examined the terrains 'generically', that is, not necessarily placing women and gender at the centre of their lens. Their work has been instrumental in delineating parameters central to social action.

Informed by conflict theories, the conceptualisation of social protest, social movements and collective behaviour has moved on. A range of approaches defined the relations central to social movements and considered contexts within which they may or may not occur. Social protest and social movements can both be described as political strategies (West & Blumberg, 1990) aimed at "promoting or resisting change through collective action" (Goldberg, 1989). Yet they differ in the degree of organisation, size, dynamics and duration (Touraine, 1981; Gamzon, Lipsky, Lofland et al. in West & Blumberg, 1990; Rowbotham, 1992, 1996). Social protests and movements are mechanisms used to nudge society along, to alter or forge structures and processes, bringing

the voice of society's constituents to the ears of its structures. In Touraine's (1981:1) terms,

> . . . social life is produced by cultural achievements and social conflicts, and at the heart of society burns the fire of social movements.

Social movements and protest rely on the collective assimilation of social actors committed to the 'cause' under contestation. Collective behaviour has been described as "mobilisation on the basis of a belief which redefines social action" (Smith, 1973:101). A social actor is produced when, based on interpretation of experience, or the meaning appointed to an event, values or mores are honed or redefined and become coherently linked to that of others. This view of collective action posits social actors as predisposed to engagement in social action when they meaningfully alter their beliefs, in Marxian terms, their 'consciousness'.

Prevailing accounts suggest that analysis needs to be shifted from essentialising social class and class consciousness, which root interpretive strategies in the essential feature of history and/or human nature, to the analysis of social relations. Many contemporary scholars believe that the contributions of classical theorists remain central to analytical process, yet need to be adapted to suit the broad relations in the current social, political and economic terrain. Aronowitz (1988:xiii) writes,

> . . .'social class' connotes a purely descriptive, a historical category, bereft of implied actors. In contrast, social relations implies a system of mutual determinations in which action has consequences for changing the relations of power and the shape of the system itself. Thus, class relations [stands as] both a determinate and an indeterminate category. Determinate because it specifies both a system of action and the actor that constitute it; indeterminate insofar as the struggle entails a contest over

who will set the agenda of action itself, who determines the cultural model.

Standpoint feminists also asserted the centrality of class, yet as an analytic feature of patriarchal social relations, what Smith (1987) referred to as 'relations of ruling'. This concept extended classical images of power and domination into the many sites of organisation, control and regulation, asserting that social relations are complex, operate on many levels within diverse locations, are mediated discursively and 'interpenetrate the multiple sites of power' (Smith, 1987:3).

Further, feminist scholars are consistent in asserting gender relations as a central feature in the analysis of social movements (Smith, 1987; Rowbotham, 1992; West & Blumberg, 1995; Threlfall, 1996; Loomba, 1998). The attempt to uncover women's experiences previously 'hidden' from analysis was buttressed by assertions that women face greater challenges to their capacity to stay within the protest arena. South African feminist scholarship suggested that resolving this was politically vital in order to facilitate women's effective involvement in social action, yet argued for theory that addressed the contradictory location of women's situations of resistance and acceptance of dominant forces (Walker C., 1990; Posel, 1992; Walker L., 1993).

Posel argued that power, domination and patriarchy require theoretical tools that enable the exploration of the contradictory nature of urban African gender relations. She suggested the need to establish the difference within and between domestic struggles[50] by elaborating the

---

50

Here she draws on Bozolli's (1983) elaboration of domestic struggles as 'internal', that is those which operate within 'the domestic system' concerning 'labour, income and property relations', and 'external' domestic struggles, which operate between the domestic and capitalist spheres of relations.

existing tensions between challenges to expand power and the consequent challenge to men's positions of authority. Here, she drew on Barrington Moore's work to argue that relations of authority tolerate degrees of resistance in that

> the exercise of authority is not based on coercion alone [but rather] is grounded in some degree of consent on the part of the subject of that authority (1992:13).

Posel suggested there were two different forms of domestic struggles: women's challenges to extend power which does not challenge the position of authority held by men, and women's direct challenges to male authority. Whereas the latter involves some degree of rejection of patriarchal norms, the former struggle occurs within the boundaries of accepted patriarchal norms.

This approach was instructive when trying to understand the historical and contemporary responses to nurses' resistance. Clearly, the 1994-1996 labour unrest and initial mandate by progressive groupings to unify nursing aimed at the resolution of disparities and extension of power of nurses, but in no way presented a challenge to patriarchal relations. Yet the limitation of these frameworks was, not so much in the way that these struggles were interpreted, but notably by the unilateral focus on patriarchal relations of power, that represented but one of the power dynamics prevalent within nurses' experiences.

Although this framework helped to locate this moment within the context of patriarchal relations, it did not take cognisance of the diversity of relations and forms of domination that intersect the lives of these women. The tendency to frame women's resistance within solely patriarchal terms is helpful yet obscures the many other power relations at play and the

variety of forces that constitute women's experiences. Thus, the key to explaining nurses' failure to alter their disparate conditions lies in emphasising the multiplicity and fluidity of women's experience.

2.5 Context, Difference and Historicity: A Summary

This chapter presented a broad literature in order to explore the historical and contextual realities central to the evolution of nursing in South Africa and to nurses as women within a diverse and contested cultural terrain. Throughout, main conceptual considerations that informed this work were isolated and explained. The section on nursing and nurses illustrated how global discourses and practices, specifically the ethics of care, multiple hierarchies and gendered professionalism, intersected with the local manifestations of the apartheid state, with consequent racialisation and interventions that led to disparities, inequalities and subsequent contestation in work and professional environments. It was necessary to describe the historical context of South Africa and to examine the diverse locations of women in this society to understand the way difference and disadvantage operates in the lives of African nurses. These sections were central to placing the respondents within their many complex environments and relations of power, reflecting the historical process and forms of domination that shape their diverse circumstances.

The section on resistance, struggles and movements explained nurses' attempts to improve work and professional realities through their involvement in labour unrest and the unification of professional organisations. I noted feminist observations that women find it challenging to remain in the field of resistance and that their capacity to resist is often curtailed by their compliance to restricting discourses and

practices. For example, I noted how the discourses of care have been constructed to distinguish nursing, while failing to address the structural factors that limit nursing capacity to provide adequate care. I made the point that explanations need to extend beyond theorising patriarchy as the main power relation. Rather, I suggested that forms of dominations are more extensive. Here, the work of contemporary and feminist theorists effectively shifted the analysis of resistance to the broad terrain of social relations, where the recognition of their complexity, diversity and multiplicity has influenced this study and has provided a way of theorising the barriers to successful agency and movement.

In all, these accounts have drawn attention to the many contextual forces that constitute women's realities across time and spaces denoted by occupation and occupational category, race, class, gender, ethnicity, age and religion. The chapter pointed to a number of discourses and practices that permeate a range of social relations, many of which will be taken up through subsequent chapters.

Chapter Three

Exploring Subaltern[51] Realities

3.1   Introduction

Sociological theory aims to move empirical[52] observations into conceptual

fields where patterns, relationships and conditions involving people who

are living, working, engaging and surviving the rigours of social existence

are coherently, albeit partially, framed. Theory systematically outlines

and interrelates concepts, enabling interpretation and understanding of

aspects of social life. In other words, theory guides the course of 'making

sense' of data, (May, 1993; Babbie, 1995). The means of making sense of

data is influenced by the range of ideological, political and social

perspectives, or epistemological positions, at the heart of one's

orientation to research, which Kuhn (1995:40) referred to as paradigms.

Thus, the two – paradigms and theory – are separate yet inextricably

connected. They intertwine in the interpretive process.

---

[51] I've employed this term as it captures, in many ways, the location of nurses within this historical context as dominated, marginalised and the subjects of oppressive ideologies. The term also amplifies the magnitude of the force relations that they face. Use of the term, however, does not in any way suggest that I presume the experiences of nurses to be reduceable to one, shared, essentialised type. Nor does it presume that they cannot and do not resist their objectification.

[52] The term 'empirical' is not to be confused with empiricism. Where empirical refers to "the collection of data on the social world ...to generate the propositions of social science", empiricism is a method of research that embraces the notion that 'facts speak for themselves' and is thus generally forwarded in the absence of a specific theory (May, 1993:6).

This chapter is divided into two main sections with an aim of describing the theoretical, conceptual and paradigmatic ideas that inform this qualitative research. The first section discusses the theoretical approach that guides the interpretation, beginning with a discussion of second wave feminism and post-structuralism. I draw upon the work of the French post-structuralist Michel Foucault, as well as feminist theorists who have elaborated post-structuralist theory. Selected ideas central to Foucault's work, such as power/knowledge and discourse, practices, apparatuses and technologies mobilised to sustain power, and the dynamic of resistance within relations of power, are described. Feminist post-structuralist modes of understanding the construction of subjectivities, fundamental to this analysis, are examined. Post-structural thought has had a particular appeal to feminist and interpretive practice, yet tensions have emerged in relation to notions of agency and the acknowledgement of political commitment (Garvey, 1989; Mohanty, Russo & Torres, 1991; Barrett & Phillips, 1992; McNay, 1992; Ramazanoglu, 1993; Hekman, 1996). The dialectic between theory and empiricism, where theory guides analysis and interpretations and empirical research operates to clarify and edify theory (Armstrong & Armstrong, 1990), is implicit within feminist post-structural responses to Foucault's work. These strategies nudge the conceptual parameters detailed in Michel Foucault's writing by taking up the limitations inherent to his anti-humanist and agency-less standpoints.

The second section outlines concepts that are central to this dissertation and substantiates the contribution of this work to the broader understanding of women as nurses within complex social arrangements. In this section, details of how these theoretical tools contribute to this

interpretive process are presented. The section concludes with an assertion of how this research contributes to the sociological knowledge of nurses during this transitional time.

3.2   Theoretical Approach: Feminist Post-structuralism

3.2.1 Conceptual approaches from second wave feminism

The stream of contemporary feminism that emerged during the second wave of the 1960's Women's Liberation Movement has entered its fourth decade, bringing with it many permutations, adjustments and extensions (Rowbotham, 1996:1). Feminism emerged in the literature as both a political and a theoretical project aimed at constructing knowledge relevant to women's issues. Theoretical approaches rooted in strategies targeting unequal power relations between men and women in society have been developing, informing strategies for change. In this way, feminism can be seen as a movement, as well as a larger project for social transformation.[53]

Second wave feminist theories have been instrumental in explaining gender oppression within the context of patriarchal and other social

---

[53]

A number of political perspectives have evolved within feminism. Briefly, the main theories are:

Liberal Feminism, which opposes discriminatory practices against women and seeks equal opportunities for women in all spheres of life without challenging existing social and political structures;

Radical Feminism, which considers women's biologically-based subordination to men as the main challenge. Radical feminists often assert that recovery of women's femininity and cultural integrity necessitates separating women from men and from patriarchal structures; and,

Socialist Feminism, wherein gender is considered to be socially constructed. Socialist feminists acknowledge the links between various forms of oppression and inequity based on race, gender and class, and seek transformation of the social system (Weedon, 1987; Jaggar, 1988; Rowbotham, 1992).

relations. Contemporary feminist scholars continue to critique and extend this work in search of alternatives that address the explanatory boundaries of the main liberal, radical and socialist perspectives. For example, Weedon (1987) pointed to the limitations of second wave feminist theories arguing that they fail to go beyond structural forms of oppression to consider women's subjective location and the meaning assigned by women to these realities (Weedon, 1987; Scott, 1992). [54]

Post-structuralism, as a theoretical perspective, appealed to feminists seeking to understand the multiplicity of women's subject locations within society and the meaning they give their lives. Within this study, it offered opportunities to explain nurses' constrained location beyond the work or professional environments to the many other sites where relations are enacted and subjectivities are displayed. Scott (1992:253) aptly wrote,

> ... feminism needs a theory that can analyse the workings of patriarchy in all its manifestations – ideological, institutional, organisational, subjective - accounting not only for continuities but also for change over time.... a theory that will let us think in terms of pluralities and diversities rather than of unities and universals...a theory that will break the conceptual hold, at least, of those long traditions of (western) philosophy that have systematically and repeatedly construed the world hierarchically in terms

---

[54]

By applying these theories to the analysis of women's locations within the context of family life, Weedon (Ibid) illustrated how liberal feminists have emphasised the right of women to self-determination while presenting little in the way of a critique of the family; how radical feminists have argued for women's withdrawal from patriarchal families in order to reclaim control of their bodies and femininity; and, how socialist feminists, who have presented family life as a key site of oppression, have argued that broader social relations contributing to women's oppression also need to be taken into account. Thus, while each theory critically examines women's relations within the context of family life, suggesting how forms of oppression may be enacted within this domain, they do little to explain why women take on the role of wife/mother, or why they stay within that role.

of masculine universals and feminine specificities. . . a theory that will enable us to articulate alternative ways of thinking about (and thus acting upon) gender without either simply reversing the old hierarchies or confirming them. . . a theory that will be useful and relevant for political practice.

Within this research post-structuralism, guided by the work of Michel Foucault and by feminists elaborating his work (Barrett, Fraser, Weedon, Sawicki), extends insights into the relationship between subjectivity and meaning. These tools assist in analysing the range of subject locations women occupy, how differences are manifested and understood, and forms of power/powerlessness negotiated within many social relations. This approach aims for an interpretive departure from structural explanations and from the analysis of categories of race and gender into the multiple and diverse contextual sites where complex relations intersect. The following section describes central tenets of post-structuralism and the conceptual parameters drawn from the work of Michel Foucault.

3.2.2 Post-structuralism

Post-structuralism emerged in the 1960s in response to, and to some extent as a rejection of, structuralism. Structuralism, influenced by the linguistic theories of the late 20th century thinker Saussure (1974), posed language as the dominant social determinant, more dominant than the Marxian formulation of economic structure. The structuralist thinker, Claude Levi-Strauss, suggested that all human relations were governed by a series of overarching rules that centred around binary oppositions, like subject : object, body : soul, text : meaning (Sarup, 1993; Fillingham,

1993; Appignanesi & Garratt, 1995). The work of a number of post-structuralist theorists challenged these notions. Roland Barthes (1972) recognised that anything in culture can be decoded. Jacques Lacan (1977) forwarded theories on the social and linguistic construction of the self. Jacques Derrida (1978) was opposed to essentialist notions of the 'certainty of meaning' and advanced deconstruction as a means of peeling away constructed meanings. Finally, Michel Foucault's (1973, 1975, 1980, 1986, 1990) interest in the construction of subjects was theorised through connecting concepts of power, knowledge and discourse.

The work of Michel Foucault influenced the conceptual approaches within this research. It has been informed by a reading of his later works[55], where subjectivity and power were at the centre of his analysis. In particular, I have drawn upon Foucault's conceptualisation of power, knowledge and discourse and the formulation of 'disciplinary power'. Foucault's insights into discourses and practices, which he presented as 'apparatuses' or 'technologies' of power (Foucault, 1975) that permeate the day-to-day experiences, have helped to identify and comprehend the practices that form women's realities and that constrain capacities to resist and alter their locations. His work lends to the analysis of resistance and illustrates how subjects interact with dominant relations of power to either enable and reproduce them or alter and dissolve them (Sawicki, 1991:14).

---

[55]

In particular, Foucault's approaches to power in Discipline and Punish (1975), areas of power and subjectivity from the History of Sexuality Vol 1. (1990) and papers cited in the bibliography (1980 - 1986) focusing on subjectivity, power and knowledge.

3.2.3 Foucault: *how* human beings are made subjects

Michel Foucault's focus on conceptualising power and power relations had its basis in seeking explanations for mechanisms through which subjects are constructed. For Foucault, the questions of subjection and the political struggles associated with 'identities' were central to contemporary social analysis. His conceptualisation of political and social practice is relevant to this study as it is based on explanations that relate to questions of 'being' or 'subjectivity'.

Among his methods was an important shift in problematising questions, wherein he asks 'how' forms of domination and subjection operate. He wrote,

> . . . let us not ask. . . why certain people want to dominate, what they seek, what is their overall strategy. Let us ask, instead, how things work at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours, etc. . . rather than ask ourselves how the sovereign appears to us in his lofty isolation we should try to discover *how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc.* We should try to grasp subjection in its material instance as a constitution of subjects (Foucault, 1980:97, my italics).

Through the examination of subjection, this study aims to bring to light the practices, mechanisms and techniques that sustain, suspend or alter the construction of subjects, illustrating them as integral processes within, what Foucault (1975, 1980, 1986) termed, 'relations of power'. Additionally, although critical scholarship noted a tendency towards deleting the subject in Foucault's work, rather than inferring creativity,

activity or agency as constitutive elements of the subject (Sarup, 1993; Barrett, 1991; McHoul & Grace, 1993), this work aims to consider and employ these ideas as necessary and central to the operation of subjection.

3.2.4 Power, knowledge and discourse in relations of power

For Foucault, power was the ultimate operating principle of social reality. His writing shifted the focus from relations of production to relations of power as a means of explaining the constitution of subjects.

Foucault's work does much to show the dynamism of power in that he demonstrates the technical and strategic flow of power in social relations. Foucault viewed power as omnipresent in both spatial and temporal senses. That is, not only was power a feature of every social relation, it was continually produced and reproduced (Foucault, 1975, 1990). He proposed a view of power as 'capillary', exercised from and within innumerable sites in the interplay of 'mobile social relations'; power as productive rather than strictly prohibitive; power coming from below and intersecting all social sites of production and reproduction through relationships of force; power as exercised with aims and objectives which imbue power relations; and, finally, wherever there is power, resistance is also present (Foucault, 1990: 93-95; Fraser, 1989; Barrett, 1991; McHoul & Grace, 1993). Within this conception of power, Foucault dislodged previous formulations located within a sovereign-subject dichotomy which he termed the juridico-discursive. He argued that these were associated with legal models of power relations characteristic of modernity, or "the core of positivist theories of the law" (Cousins &

Hussain, 1984:232).

Many scholars assert that one of the most radical dimensions of Foucault's work is the claim that power and knowledge exist in close proximity (Dreyfuss & Rabinow, 1986; Cousins & Hussain, 1984, Barrett, 1991). His writings pull the two concepts together in dynamic unity which, he argued, catalyses and alters social relations. Foucault wrote in *Discipline and Punish* (1975:27-8),

> . . . we should admit rather that power produces knowledge
> . . . that power and knowledge directly imply one another;
> that there is no power relation without the correlative
> constitution of a field of knowledge, nor any knowledge that
> does not presuppose and constitute at the same time power
> relations.

In Foucauldian terms, knowledge is closely aligned with 'regimes of truth' and discursively constructed fields of knowledge, constituted through power relations. Foucault (1980:93) wrote,

> . . . we are subjected to the production of truth through
> power and we cannot exercise power except through the
> production of truth.

Regimes of truth,[56] which are distinct in various societies, challenge the status appointed to truth claims and the conditions essential for their construction. In this way, questions are raised concerning the relevance or accuracy of scientific findings and the weight given to them by societies. Barrett (1991:143) argues that Foucault did not dispute truth

---

[56] Many scholars illustrate Foucault's conceptualisation of 'the politics of truth' as a critical departure from Marx's focus on ideology and his concept 'economics of untruth', and Gramsci's "[silence] on the complex matter of the establishment of forms of hegemony" (Smart, in Barrett, 1991:140) as supporting this shift as a critical entry point into the analysis of truth and knowledge claims (Cousins & Hussain, 1984; Dreyfus & Rabinow, 1986; Barrett, 1991)

claims. Rather this focus signified his interest with the operations which secure the effects of truth. In response to a question on society's submission to scientific truths, Foucault (in Barrett, 1991:143) mused,

> ... why, in fact, are we attached to the truth? Why the truth rather than lies? ... rather than myth? ... than illusion? ... How is it that, in our societies, "the truth" has been given this value, thus placing us absolutely under its thrall?

Foucault's concept of discourse, and discursivity in general, is linked to this line of thinking. Whereas post-structuralists employed the notion of discourse to designate words as signs used to denote or signify, Foucault advanced discourses as a means of representing "practices that systematically form the objects of which they speak" (Foucault, in Barrett, 1991:130). He conceptualised discourse in tactical terms, as the vehicle mobilising regimes of truth that constitute social reality and the subjects within. Within this formulation, subjects are constructed through multiple, dispersed and, often, contradictory discourses.

These approaches are suitable for theorising social relations, relations of power and subject formation, all of which are reflected within the day-to-day operation of hospitals. Foucault's technique of explaining the intersecting dynamic of power, knowledge and discourse helps in understanding relations of power that influence subject formation. The range of discourses that constitute social practices provides for insights into the interplay of knowledge and power and the use of legitimising truth claims.

3.2.5 Discursive strategies: technologies and apparatuses of power/knowledge

Foucault's conceptualisation of knowledge, power, discourse and truth provide a framework for understanding apparatuses, technologies and regimes within social relations. Through these strategies Foucault sought answers to how knowledge and power were mobilised discursively to act on society and alter it, and how knowledges and truths secure conformity (Sarup, 1993). These methods are important to this study's concerns about nurses during a moment of social change in South Africa.

Foucault used the term 'apparatus' to denote mechanisms installed discursively and situated contextually as "strategies of relations, of forces supporting and supported by types of knowledge" (Sarup, 1993:65). Society sanctions and employs particular knowledge claims and practices as apparatuses to regulate, control and discipline, and as a means of surveillance. By examining social terrains, Foucault illustrated the discursive constitution of truth claims, the way they are socially sanctioned and their dispersal, reproduction and legitimation through the practices of practitioners, among them doctors, nurses and legislators. Dispersed in this way and through discourses adopted by practitioners, the explanation of social relations is shifted from binary descriptions to those where relations are discursively formed, and multiple in their sites and distribution within social practices.

Through genealogical study Foucault noted the evolution of these apparatuses or technologies around the 17th century, when scientific categories were becoming more specified. Through the apparatuses/technologies of bio-power and disciplinary power the repressive dynamics of social relations, which permeate the culture of late modernity, are explained (Foucault:1975, 1990; Dreyfuss & Rabinow, 1986).

Bio-power is portrayed as two poles of development, linked by a "whole intermediary cluster of relations" (Foucault, 1990:139). The first pole centres on the body with the intent on maximising its integration within

> . . .systems of efficient and economic controls, [through] its
> disciplining, the optimisation of its capabilities, the
> extortion of its forces, the parallel increase of its *usefulness*
> and its *docility*" (Foucault, 1990:139; my italics).

Foucault suggested that disciplinary power was deployed to enforce this process, termed the "anatomo-politics" of the human body. The second pole evolved as a means of regulating and controlling populations through heightened knowledge of 'populations as a species'. Whereas the first pole focused on the local and specific body, the second sought regulation over larger entities, populations. Knowledge was transferred into supervisory controls effected through a series of interventions and regulatory mechanisms which he termed the bio-politics of populations.

These concepts are useful in the study of nurses in that they provide access to the local site of a nurse, as disciplined and developed into a subjected and 'practised' body, what Foucault (1975:138) called 'docile, useful' bodies. Applying the idea to populations of nurses enables an

understanding of how populations of nurses are harnessed, regulated and governed by disciplinary strategies, and thus moulded toward desired practices and outcomes (Sarup, 1993:78).

Within Foucault's formulation, disciplinary technologies are regulatory mechanisms central to bio-power, formed with the aim of achieving the parallel outcome of usefulness (productivity) and docility of individuals and populations. The utility of these technologies has been achieved through the broad, yet often subtle, dissemination of its practices to public and private social sites through two main mechanisms: hierarchical observation and normalising judgement (Smart, 1985:85).

Hierarchical observation depicts the reorganisation of spaces with the installation of disciplinary technologies for the purpose of consistent and functional surveillance. This technology, the disciplinary gaze, merges power and visibility, arranging them hierarchically to achieve conformity of individuals within particular fields.

Normalising judgement is a disciplinary technology exercised over a mass of behaviours and aimed at achieving conformity. Through disciplinary strategies, techniques of punishment and gratification are integrated with practices of training and correction,

> . . . it refers individual actions to a whole...at once a field of comparison, a space of differentiation and the principle of a rule to be followed. It differentiates individuals from one another. . .it measures in quantitative terms and hierarchises in terms of value the abilities, the level, the 'nature' of individuals. It introduces . . .the constraint of a conformity that must be achieved. Lastly, it traces the limit that will define difference in relation to all differences, the

external frontier of the abnormal. (Foucault, 1975:183).

Foucault's formulations provide useful tools for theorising the multiple locations of nurses and the chaotic realities with which they engage. Mobilising these concepts enabled insights into practices that operate to construct, restrict and shape subjectivities of nurses, that are at play within relations of power.

The notion of resistance, as an inherent feature of power relations, is central to Foucault's conceptualisation of power/knowledge and discourse. He wrote

> . . .where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power (Foucault, 1990:95).

Resistance is summarised as multiple in its 'points, knots or focuses' of existence, present everywhere within relations of power, and plural in the form it assumes. Thus, resistance forms the oppositional force within relations of power, driving the transitional dynamic which

> . . .produces cleavages in a society that shift about, fracturing unities and effecting regroupings, furrowing across individuals themselves, cutting them up and remolding them, marking off irreducible regions in them, in their bodies and minds (Foucault, 1990:96).

Resistance exists as a natural characteristic of relations of power. Whereas the institutional integration of power relations often succeeds at enforcing hegemony, or at constructing, restricting and shaping subjectivities, broadly diffused points of resistance often operate to upset, dislodge or challenge as a means of introducing change.

3.2.6 Feminist responses to Foucault's post-structuralism

Foucault's work has been instructive to feminist approaches, presenting critical methods for analysing subjectivity and contextual issues within shifting frameworks of power, knowledge, discourse and resistance. Feminists have been critical of classical theories as "falsely universalising, over generalising and over ambitious models of liberalism, humanism and Marxism" that are connected to inherently masculinist Western cultural discourses (Barrett & Phillips, 1992:1; see also Sawicki, 1991; Barrett, 1991; McNay, 1992). For this reason, analyses were shifted towards anti-essentialist positions. Drawn to Foucault's emphasis on exploring the relational, historical and precarious nature of social reality through the interplay of power, knowledge and discursive practices, feminists mobilised his critical methods to guide research and practice. Whereas the social construction of gender undertaken by feminist theorists traditionally relied upon complex, ambiguous and unstable identities of race, class and gender, Foucault's frameworks shifted analysis to an elaboration and pursuit of multiple and intersecting dynamics (Barrett, 1991: 150).

While Foucault's theoretical commentary is instructive, the political gap he left has been a source of debate among feminists. Foucault's strong anti-humanist stance and the little attention given to agency have been contested by a number of theorists as problematic and paradoxical (Fraser, 1989; Barrett, 1991; Sawicki, 1991). Foucault's anti-humanism was apparent in his intimation of neutrality which predisposed him to criticism, largely for not acknowledging his androcentric location, and to criticism by post-colonial theorists for 'false universalising'. As Said (in

Barrett, 1991:152) bluntly wrote, "his Eurocentricism was almost total".

Anti-humanism imposes methodological limitations, as it essentially subverts the plausibility of political engagement which, in principal, is a central tenet of the feminist project. Feminist theorists like Fraser (1989), Barrett (1991) and Sawicki (1991) suggest that Foucault's anti-humanism, although problematic in its presentation, was reserved for theoretical exegesis, as much of his work relied

> . . .for its own critical force on the reader's familiarity with
> and commitment to the modern ideals of autonomy,
> reciprocity, dignity and human rights (Fraser, 1989:79).

Foucault's critique of modern humanism bears within it the perception of an outright exclusion of subjectivity and agency. As Barrett (1991:153) wrote, "his conception of agency hangs on his theory and vocabulary of power" where the subject does not emerge acting either for or on herself. In Foucault's terms, power, dissipated by discursive strategies through contextual and relational avenues, is the central analytical base for constitution of the subject. In his formulation, subjects may not control their overall direction in history. However, Weedon (1987), Sawicki (1991) and Mama (1995) suggested that subjects remain reflexive and choose among the discourses and practices predisposed to them.

Feminist formulations of subject and subjectivity, drawn from advances in post-structural approaches, emphasise individuality and self-awareness as central tenets of the condition of being 'subject'. Additionally, the constitution of the subject is thought to be influenced by multiple and diverse discourses that effect change and development. Weedon (1987:32-3) located the concept as follows:

> . . . 'subjectivity' ... refer[s] 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 .... Post-structuralism proposes a subjectivity
> which is precarious, contradictory and in process,
> constantly being constituted in discourse each time we
> think or speak.

While feminists value the central Foucauldian claims relating to the

construction of subjectivity, they assert the notion of the subject as

active (Weedon, 1987; Barrett, 1991; McDowell & Pringle, 1992; Mama,

1995). According to Fraser (1989), Foucault can be understood to have

appropriated tools for understanding the 'politics of everyday life', or a

means to strategies that challenge dominant relations of power. As she

wrote (1989:25),

> . . .if power is instantiated in mundane social practices and
> relations, then efforts to dismantle or transform the regime
> must address those practices and relations.

Finally, Foucault's insights on difference within the context of resistance

are most valuable. The question of difference has been the subject of

vigorous debate in feminist forums over time. Difference, as Foucault

suggested, has been the source of fragmentation and disunity, as well as

a creative source of resistance and change (in Sawicki, 1991:18). The

earlier inclination to generalise 'women's experience' as shared across the

cleavages of race, class, age and culture has shifted dramatically, often

painfully, toward emphasis on the differences 'dividing' women,

challenging feminist theory and practice (Barrett, 1991; Sawicki, 1991,

Barrett & Phillips, 1992; Rowbotham, 1992; Mama, 1995). Foucault's

conceptualisation of difference, termed by Sawicki (1991) the 'politics of

difference', underpins the necessity for critical analysis of diversity as a

means of understanding the nature of resistance and for mobilising and

hearing subaltern voices. S.P. Mohanty (in Mohanty, 1991:90) captured
this when he wrote,

> . . .how would it be possible for us to recover our
> commonality, not the humanist myth of our shared human
> attributes which are meant to distinguish us all from
> animals, but, more significantly, the imbrication of our
> various pasts and presents, the ineluctable relationships of
> shared and contested meanings, values, material
> resources? It is necessary to assert our dense
> particularities, our lived and imagined differences. But
> could we afford to leave unexamined the question of how
> our differences are intertwined and indeed hierarchically
> organized? Could we, in other words, really afford to have
> entirely different histories, to see ourselves as living – and
> having lived in entirely heterogeneous and discrete spaces?

While these insights lend themselves to issues surrounding
representation in qualitative research, they also point to the need to
explore and elaborate the category of difference as a central tenet to
resistance and whatever form it assumes within the multiplicity of
experiences, relations and contexts of the every day.

3.3   Conceptualising the Formation of Subjectivities

The notions of subject and subjectivity are central within post-
structuralist theory, signifying a break from humanist tradition's
orientation to abstractions of the 'individual'.[57] Post-structuralism
proposes subjectivity as multiple, precarious, contradictory and
continually in the process of discursive formation (Foucault, 1986;

---

[57] Humanist discourses are varied yet essentialise the individual as 'unique, fixed and
coherent'. Weedon (1987:32-3) cites examples of this in "the unified rational
consciousness of liberal political philosophy, the essence of womanhood at the heart of
much radical-feminist discourse or the true human nature, alienated by capitalism,
which is the focus of humanist Marxism."

Weedon, 1987; Sawicki, 1991; Mama, 1995). This research draws upon this assertion in considering the subject locations of nurses and the discursive constitution and reconstitution of subjectivities within, in what I have termed, subaltern institutional relations.

Subaltern institutional relations refer to the intersections of subordination and subjection that form the realities and experiences of nurses within institutional settings. These are influenced by a number of relational forces, particularly those characterised as patriarchal, capitalist and racialist. They are experienced in diverse ways within the hospital setting, resulting in dynamics that are affected by context, difference and historicity. The notion of subaltern institutional relations draws together the diverse relations within the framework of a complex contextual environment, the multiple subject-locations and the changing socio-political landscape.

So far, the literature framed the broad themes of context, difference and historicity, themes that are employed in the following chapters to capture the diverse realities of the nurses in this study. Discussions of contexts (institutional, professional, historical, private and public) have drawn attention to the relations of power, the practices and discourses that converge through historical and contemporary realities. Notions of difference and historicity capture further conceptual points that concern this study. Importantly, these are not forwarded as distinct and separate concepts. Rather their application will illustrate how they intersect and operate strategically in the construction of subjectivities.

The sites, processes and interrelations of dominant and local power relations reveal the dynamics, technologies and strategies that invoke and alter subjectivities. The construction of nurses' subject location is most acutely affected by the impact and continuous connection of relational forces and the dynamic interaction of resistance within relations of power. A feminist post-structuralist approach must identify the social and institutional contexts where power relations of everyday life reside and intersect to regulate, govern, and reinforce the subjugation of women. Weedon (1987:25) wrote,

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

As described earlier, feminist post-structural, as well as post colonial theorists, point to the necessity for exploring the many levels of power dynamics between the dominant and marginalised, colonisers and colonised relations, which they argue cannot be represented as neat binary oppositions. These relations involve 'complex reciprocity' where the oppressed, whether at the hands of colonialism, patriarchy, capitalism or more localised power relations, do act to "negotiate the cracks of dominant discourses in a variety of ways" (Loomba, 1998:2). The resulting shift may not always issue a form of 'oppositional consciousness', yet the voice brought to the fore as resistance, negotiation, engagement or interaction needs to be identified to visualise possibilities and to de-centre notions of the oppressed as silenced.

In theorising the data, the ongoing construction and deployment of difference is advanced as a practice that influences nurses' locations and capacities to engage with social change. The notion of difference marks the many fields of reality and interactions not caught within the explanatory power of class or patriarchy. It enables the use of multiple categories to describe subjectivities, diverse identities and subject locations (West Blumberg, 1990; Barrett Phillips, 1992, Rowbotham, 1992; Threlfall, 1996).

The value of exploring difference as a site infused by relations and technologies of power bears its relevance in feminist, post-structuralist claims that power uses difference to fragment opposition (Foucault, in Sawicki, 1991:18). Difference can be viewed as a mediating source of fragmentation, as well as a creative source of resistance (Sawicki, 1991). The ways in which women inscribe themselves through the self-appointment of capacity and autonomy is a means of surfacing their voices within dominant relations, while denoting a will to privilege particular discourses.

The examination of difference offers the space for exploring the variance within subject locations and the dynamic epitomised by Sawicki (1991) as the 'politics of difference'. However, feminist thinkers warn that it stands to 'displace' material realities as a central concern of social and political theory if viewed in isolation (Cock & Bernstein, 1998; Fraser, 1998). Class and difference have been dealt with by two political traditions. Marxist approaches considered material conditions within the parameters of class struggles, economic relations and forms of inequality. The more recent focus on difference and identity has responded to

struggles on the cultural/identity terrain (Cock & Bernstein, 1998:2). Inequality and disadvantage present considerable realities for women, in particular black women in South Africa, that tend to be ignored by a singular focus on difference. In this study, these two approaches are set within an analysis of the relations of power and within the historical context in order to strengthen explanatory power.

This research forms its inquiry at the level of historicity, that is, within the framework of social change aimed at altering social relations (Touraine, 1988:11). Where and how nurses are located within the current setting of social change and the distance between themselves and the very capacity to alter cultural, political and social instance is explored through their narratives, as well as by isolating the operative apparatuses and discourses (Aronowitz, 1988).

Historical conditions within society, describing the political and economic spheres and the type of reality underpinning this moment of transition is integral to understanding what has shaped and influenced life and life choices. These considerations are relevant in this research, as it is proposed that the contexts that inform the nurses' realities influence the construction of subjectivities and provide insights to their difference, disadvantage and to their choices for resistance or acquiescence to evolving relations of power.

3.4 Theoretical contribution to knowledge

Applying a feminist post-structural analysis within the framework of difference/distribution, relations of power and historicity, allows for the explanation of subaltern institutional relations, primarily through the explanatory dimensions of power, knowledge and discourse. Mobilising this theoretical approach facilitates insights into the fragmented and ambiguous realities of nurses, the many sites of contention and resistance, the diversity of forces constraining or enabling their movements while bringing their voices forward to be heard.

The literature exploring South Africa's past, women's social location and the area of contestation and social movements brought the particular historical dynamics of South Africa's unique social and political evolution into view. The literature pointed to conceptual formulations of the dynamics of domination, inequality and protest, primarily through central categories of race, class and gender.

This research attempts to go further through the application of a feminist post-structuralist theory, in the following ways. Firstly, this analytical approach extends insights into the lives of nurses to the many subjective fields they navigate. The combined strategy of mobilising the conceptual framework of difference (distribution, relations of power and historicity) and inquiring into the many spheres of women's lives (their actions, feelings, concerns and perceptions) integrates the multiple dimensions of their realities. The aim is to broaden the understanding and perspectives of nurses and nursing.

Secondly, analysis of the relations of power or, in Smith's (1987) formulations 'relations of ruling', extends analysis beyond constructions based on race, class and gender. This is not intended to undermine the relevance of these categories, rather to broaden analysis by exploring and bringing into view the complex forms of relations inherent to the organisation and regulation of society. Smith (1987:3) wrote,

> 'relations of ruling' is a concept that grasps power, organisation, direction, and regulation as more pervasively structured than can be expressed in traditional concepts provided by the discourses of power.

Thirdly, and perhaps most significant, the voices of nurses are brought to the fore in an attempt to broaden and improve the way nurses are perceived by society, in particular black nurses. Their voices have rarely been heard within the lexicon of relations in South Africa. They are voices historically veiled by constraints inherent to their locations within the many hierarchies and relations of their occupation. Their absence points to the androcentric bias that continues to reinforce 'dualistic' notions of nurses and their 'place' within the health care system, that of being passive and in service, thus reinforcing dominant relations of ruling. Hearing their voices, making visible their realities will hopefully contribute to the way social meaning is constructed, and thus, to a knowledge and understanding of these women and the social realities they navigate.

Finally, understanding what nurses are saying about how their world's are contextualised, differentiated, classed, gendered, and contested within the parameters of a hospital regime and a changing social environment is particularly important, given the necessity of redressing

historical inequities, addressing gender imbalances and for the restructuring of health care system. Studying the subaltern institutional relations articulated by black women who are nursing in a disadvantaged public setting constitutes an important contribution for sociology and presents an innovative approach with possibilities for the study of other contexts and institutions.

Chapter Four

From Ethnography to Narratives

4.1   Introduction

Since the 1980s, qualitative research has been recognised as means of bringing a variety of approaches to interpretive practice, calling for researchers to 'situate' themselves within the political, personal and experiential context of field and interpretive methods (Clifford & Marcus, 1986; Haraway, 1989; Denzin & Lincoln, 1994). The way we make sense of ours and others' lives and the methods we use are, according to Denzin (1994:501) 'inextricably intertwined'. Thus, the interpretive process, the way that 'meaning' is discursively formed out of the interaction of research problem, field engagement and 'findings' that constitute the research process, is informed by the interplay of theoretical, personal and political assumptions, perceptions and beliefs.

The theoretical and methodological assumptions developed within the preceding chapters have situated this work primarily within the interpretive terrain of feminist, post-structural thinking. At the same time, the interest to explore and remain receptive to claims that extend beyond these parameters acknowledges an intent to strengthen interpretations and the voices heard through these narratives. The methods described below are informed by theoretical concerns about

interactions: between selves and others, between individual agency and social structure, and within sites infiltrated with various forms of power relations.

The epistemological position asserted is that all knowledge is socially situated, a position which subverts assumptions of 'value-free' social theory (Gouldner, 1971; Harding, 1991; Mama, 1995). The use of a conceptual exegesis rooted in a commitment to social change and the upliftment of women is embraced (Cock, 1980, 1998; Loomba, 1998), particularly as it relates to women whom theorists refer to as occupying 'subaltern' locations (Spivak, 1987; Said, 1993; Loomba, 1998). The objective of articulating the standpoint of women whose experiences have been hidden from history is central to feminist and radical sociological strategies, and is particularly relevant in this social context, where the voices of nurses are rarely heard.

In this chapter, theoretical assumptions are mobilised, illustrating their influence on the methods of inquiry chosen for this ethnographic research. Ethnographic methods are constituted by a range of perspectives that have guided both the field and post field phases. The suitability of ethnography and the choices made in the integration and application of these methods is discussed. Issues of reflexivity, verisimilitude and ethical principles and considerations adopted in this research are explored, as they add rigour to overall assumptions and methods. The chapter then proceeds with an explanation of theoretical and methodological strategies guiding the field experience and data collection techniques. The final stage of moving the field texts to research accounts explores the choices made and the principles guiding the

construction of narrative accounts. Finally, the orientation and approaches to the interpretation of this data are discussed.

4.2   Ethnography in the Postmodern Period

Some theorists claim the world has entered its fourth epoch,[58] the 'postmodern period', signalling a cultural form as well as an era in history (Clifford & Marcus, 1986; Denzin, 1989 in Vidich & Lyman, 1994; Haraway, 1989; Denzin, 1994; Richardson, 1994; Marcus, 1994). Others suggest the notion of 'postmodern' does not necessarily signify a completely new epoch or an absolute rupture with the modern era, nor does it exemplify the need to adopt the concept as a philosophical creed. A fitting approach to notions of the 'postmodern' is that it signals the need for new tools to understand the contemporary world (Hall, 1996; Loomba, 1998).

A central tenet forwarded by some postmodern thinkers is that the moment also marks a shift from an inherent concern about the falsely universalising tendencies of modernity. Richardson (1994:517) captured this when she wrote,

> . . . the core of postmodernism is the *doubt* that any method or theory, discourse or genre, tradition or novelty, has a universal and general claim as the "right" or the privileged form of authoritative knowledge. Postmodernism *suspects* all truth claims of masking and serving particular interests in local, cultural, and political struggles. (Her italics and inverted commas.)

---

[58] The first three epochs are the period of Antiquity, the Middle Ages, and the Modern Age (Denzin, 1989 in Vidich & Lyman, 1994:42).

Postmodernist approaches do not necessarily take the stance of rejecting previously formulated methods of inquiry and understanding. There has been an orientation and receptivity to new methods and an engagement with conventional methods, while subjecting both to critique.

An ethnographic method appropriate for this time is one which Denzin (in Vidich & Lyman, 1994:42) described as

> being dedicated to understanding how this historical moment universalises itself in the lives of interesting individuals.

Ethnographic research methods are widely used by sociology scholars and researchers pursuing an understanding of the contemporary social world, the complex processes which inform social interaction and the meanings and perceptions formed through events, moments and experience. They recognise that social experiences are broadly shared, while response is varied. As Vidich and Lyman (1994) suggested,

> . . . the study of the common condition and the uncovering of the uncommon response become the warp and the woof of the fragile but not threadbare sociological skein of the postmodern era.

By its very nature, ethnography involves a range of suitable and refined methods that can duly facilitate and contribute to rigour at all stages of the research process. Contemporary ethnography has been described in the literature as having a number of features (Glaser & Strauss, 1967; Marcus, 1986; Strauss & Corbin, 1990; Burgess, 1993; Atkinson & Hammersley, 1994; Bryman & Burgess, 1994; Denzin & Lincoln, 1994; Schwandt, 1994, Vidich & Lyman, 1994). Among these are approaches

that focus on exploring complex interactions and meaning within a particular social phenomenon, rather than hypothesis testing. They are approaches that inquire at the 'boundaries' within social arrangements, in this case those related to culture, gender, race, class, profession, hierarchy and organisation. They are approaches that break the research into a number of accounts entailing the dynamic that occurs between researcher, field, data and renditions at all stages (Atkinson & Hamersley, 1994; Clandinin & Connelly, 1994; Marcus, 1986). The ethnographer "makes the familiar strange, and the exotic quotidian" (Marcus, 1986:2).

The suitability of ethnographic methods for pursuing complex interactions is underscored by the importance of exploring moments of lived experiences, inscribed with 'meaning' (Altheide & Johnson, 1994). Dewey (in Clandinin & Connelly, 1994:417) specifies 'interaction' and 'continuity' as central criteria for the exploration of lived experience. While interaction refers to the 'intersection of internal and existential conditions' fundamentally operating at a physical and spatial level, the notion of continuity asserts that every situation brings with it a temporal specificity. This presupposes that events and interactions do not just occur. Rather, they represent the intersection of subjects with contextual and historical influences. It is for this reason that this study draws upon context and history as part of the inquiry.

This research problem has been constructed to investigate lives of nurses and the meaning they give to their lived experiences within the context of a tertiary public hospital during the current socio-political epoch in South Africa. It has called for an ethnographic method focused on the

internal dimension of the feelings, perspectives and dispositions of
nurses, while engaging with the context within which nurses live, work
and socialise, one which has been informed historically.

4.3   The Crisis of 'Representation'

Ethnography as a method of describing the other, denoted by the Greek
prefix 'ethnos' for people, races or cultural groups, can be traced back to
early Greek civilisation (Vidich & Lyman, 1994; Wax in McCormick,
1997). Its evolution brought with it a series of issues and debates that
enable and challenge contemporary research processes. Historically,
sociological inquiry centred around notions of 'other' and sought to
buttress representational issues through foundational mandates driven
primarily by classical theorists. Classical research methodology has been
criticised for sustaining hegemonic arrangements that privileged
dominant social, cultural and political arrangements through exploitative
methods (Mohanty, 1991; Said, 1993; Vidich & Lyman, 1994). In the
area of qualitative research, the notions of objectivity and value-freedom
have required critical examination.

As qualitative and ethnographic methodologies evolved, notably in the
latter quarter of this century, concepts of the 'other' were challenged, in
particular by feminist theorists (Fonow & Cook, 1983; Harding, 1988;
Mohanty, 1991; Fine, 1994; Robinson, 1994), critical and postmodernist
theorists (Denzin, 1994; Haraway, 1989; Lincoln & Denzin, 1994;
Marcus, 1986), and post-colonial theorists (Spivak, 1987; Mohanty,
1991; Hall, 1996). Criticism surrounded the notion of representation
which was considered to be inherently flawed due to the location of

inquiry within the colonising heritage of classical theory and method.

The 'crisis of representation' centres around three fundamental sites: the production of knowledge (who produced it? ..from what space and location? ..for whom? ..driven by what incentives? ..and, with what claims and outcomes?), notions of 'difference' (the social, intellectual, political cleavages between the researcher and researched), and the orientation of researchers to their 'subject' location, or as Robinson (1994) described it 'positionality', in relation to the research process. Theorists have argued that all sites are mediated by power dynamics, installed and enforced by unequal hierarchical arrangements and levels of control (Batth & Reid, 1998; Denzin & Lincoln, 1994; Fine, 1994; Mohanty, 1991; Robinson, 1994).

These debates evolved through different academic, ideological and political terrains both internationally and in South Africa (Horn, 1991; Hassim & Walker, 1992; Robinson, 1994). They have challenged researchers to account for claims, and in some cases dispute the grounds upon which claims are made on the basis of unresolved power differentials in the research process. The methodological implications of representation are manifest during every phase and interaction within the research process. Contemporary researchers are challenged to explore the complex terrain surrounding research relationships and dynamics, and to explore multiple determinants of difference. So doing strengthens the research dynamic and interpretive validity of the study.

4.4   On Objectivity and Value-Freedom

Positivism advanced claims concerning notions of objectivity and value-freedom. These have formed the basis for generating and legitimising scientific laws, culminating in social laws intended for the prediction of social behaviour and events (Acker & Esseveld, 1983; Bailey, 1987; Romm, 1995). The belief that subjective accounts distort the rational process of inquiry is central to the call for objectivity. Value-freedom relates to the attainment of moral neutrality through the representation of the social world that is 'untainted' by the researcher's values, prejudices and interests (Haraway, 1989). These tenets, including issues of 'reliability' and 'generalisability', are central to quantitative approaches concerned with averting bias.

Challenges to positivist notions of objectivity and value-freedom dates back to the work of classical theorists. Weber (in Bailey, 1987:8) reduced the distinction between the natural and social sciences to the difference in the way we relate to the animate and inanimate in our world. The realities of research subjects linked with the realities experienced by social scientists strengthens understanding of the data through what Weber termed *verstehen*, or direct understanding mediated by empathy and concern (Giddens, 1989). Among others, Gouldner (in Romm, 1995a:14) expounded the impossibility of neutrality in social science research. He emphasised the way in which the world and individual reality is 'filtered through a framework of meaning'. Challenges to positivist approaches are underscored by the links drawn between meaning and understanding, emphasising that the way in which the research subject or the researcher constructs reality can never occur in

the absence of the meaning which allows us to make sense of the social world.

Within feminist discourses, the critique of positivist notions of objectivity and value-freedom is further rooted in concepts of 'androcentricity', what Harding (in Jaggar, 1988:375) referred to as 'ontological bias'. These terms relate to the particular construction of inquiry, to rules applied to the process of organising information, observation and experience, historically oriented in and controlled by the dominant beliefs of western culture. Tong (1993:50) explained the origins of androcentric enquiry as rooted in primordial consciousness, the desperate fight for survival resulting in an 'us against them' dualism, which extended into scientific reality of separating the self from the 'other' (Webber, 1994). Hierarchical, dualistic and oppositional forms of inquiry have been perceived by feminists as representing the interests of the historically dominant (Mies, 1983; Harding, 1988; Fonow & Cook, 1991; Tong, 1993). Ontological bias relates to a way of seeing the world, slanted by the dominant, scientific interests, framed by oppositional dualism (Tong, 1993:50). The confrontational paradigm engenders objectification of interactions and operates within a model consisting of strict methodological boundaries which discourage the emergence of the 'self'. Thus, notions of scientific objectivity and value-freedom are inadequate for acknowledging the subjectivities present in all tiers of the research process.

4.5   Interpretive Rigour in Qualitative Ethnographic Research

Qualitative and ethnographic research methods have been tested by exploring claims surrounding knowledge production and mobilising criteria suitable for assessing the quality and rigour of interpretations, aimed at enhancing reliability. Many authors are critical of the tendency to judge claims and interpretations on the basis of their truth and certainty as these concepts are considered to be too restrictive and inflexible for the multiple realities inherent to research situations. According to Olesen (1994:164) postmodernist and feminist researchers concerned with the complexities of more than partial representations of women's lives consider 'truth' a 'destructive illusion'. These debates are concerned with the crisis of legitimation that surround the authority of the text, and with the central measures of truth and validity in textual productions (Lincoln & Denzin, 1994:578).

Schwandt (1994:125) argued that knowledge is "contingent on pluralistic variations of language and symbols and on the variability of reality which is shaped by purpose and intention of human agents." As such, there is no single version of a given situation, but rather many 'world versions' (Goodman, in Schwandt, 1994) that are subject to what are being interpreted and to the insights and methods informing interpretative processes. Thus, knowledge is a discursive practice, arguably rooted within particular world views, ideologies and political orientations. With this in mind, post-structuralists argue that any text needs to be stripped of external claims to authority, and taken in its own terms (Lincoln & Denzin, 1994:579).

Richardson (1994:522), in exploring methods of strengthening inquiry, applies the metaphor of a crystal, which she argued is more suitable to the postmodernist process. Both are multiple in their shapes, dimensions and angles of approach. She wrote,

> ..crystals grow, change, alter, but are not amorphous.. crystallisation without losing structure deconstructs the traditional idea of validity and it provides deepened, complex thoroughly partial understanding of the topic.

Informed by these perspectives, I have elected to draw upon several qualitative strategies to strengthen the rigour and credibility of this research process. Reflexivity, verisimilitude, and ethical principles and considerations are three methods employed at all stages of this process.

4.5.1 Reflexivity

Reflexive approaches in ethnographic research redress notions of 'other' by shifting methodological discourse from claims of scientific neutrality and universal truths to engaging in an understanding of who we are and what we are about when we enquire. Gouldner (1971:489) wrote,

> . . . a reflexive sociology is and would need to be a radical sociology. Radical, because it would recognize that knowledge of the world cannot be advanced apart from the sociologist's knowledge of [her]self and [her] position in the social world, or apart from [her] efforts to change these. Radical, because it seeks to transform . . . A reflexive sociology means that we sociologists must, at the very least, acquire the ingrained habit of viewing our own beliefs as we now view those held by others.

Schwandt (1994:118) asserted that these approaches aim for clarity in comprehending epistemological assumptions, that is, how the social is known and its meaning interpreted.

Reflexive methods involve probing 'positionality' or subject locations on social, political, personal and intellectual levels, to reveal perspectives that influence views, thinking, conduct and interpretation (Gouldner, 1971; Haraway, 1991; Fine, 1994; May, 1993; Bryman & Burgess, 1994; Marcus, 1994; Olesen, 1994, Robinson, 1994). Being actively reflexive stimulates researchers to acknowledge their own narratives as persons writing from a particular location, spatially and temporally, and the influence it has on the research process.

Within postmodernist, post-structuralist and feminist frameworks, reflexivity is considered both a methodological and an ideological process, an essential feature inherent to all discourse. The central question, raised by Haraway (1991), is how to achieve a simultaneous accounting of "radical historical contingency for all knowledge claims and knowing subjects" when the aim is based on a "no-nonsense commitment to faithful accounts of a 'real' world." By situating our experience in what Marcus (1994:568) referred to as the 'politics of location', ethnographic writing realistically attends to what we see and what we attempt to understand, rather than denoting profound truth and knowledge claims. This frees the researcher from the responsibility of writing a single, all-inclusive text (Richardson, 1994:518). Engaging in rigorously reflexive processes throughout the interpretative process allows for the situation of knowledge within a particular location. As Haraway (1991:189) wrote, "only partial perspective promises objective vision."

This approach informed my own insights into the factors and concerns that consciously and subconsciously influenced interaction during the field work and the interpretative process. Throughout the field work I considered the many similarities and cleavages of experience between the nurses involved in this research and my own experience as a nurse in Canada, experiences that were, in some ways, similar. The subordination of women within the medical system to patriarchal relations of power and the focus on discourses of caring operated in familiar ways. The moral ethic that constrains nurses from contesting social and political inequities seems to prevail in nursing. Another common trait was the organisation of tertiary systems along strict hierarchical lines, which function to instill order while disadvantaging subordinates, primarily women, within power relations.

As an expatriate, the political, economic and social history set me apart from the women in this research and sensitised me to the obstacles and strategies that effectively disadvantaged many, primarily as a result of race. Whereas I approached these differences with concern and empathy for the complexities inscribed by this history, I remained aware of how issues of inequality, gender oppression and patriarchal power were shared realities as women and nurses in hospital relations.

Involvement in political projects within nursing in Canada and, since 1994, in South Africa provided exposure to the cleavages and divergent power relations within the profession. In South Africa, initiatives aimed at redressing inequities were supported. However, the participation was challenged by nurses linked to previously dominant groupings. These tensions served to heighten notions of the 'politics of location' while

enhancing reflexive questioning. In particular, they sensitised me to the insecurities of those playing central roles in the reorganisation of power relations within the profession.

An approach was adopted aimed at understanding my positionality while incorporated a reflexive dialogue with the narrators. Providing the narrators with access to information about me and my orientation to the research created a space where they could assess my intentions. Responses were varied. While initial encounters signaled inquisitiveness or a sense of uncertainty, this approach provided an opportunity for the nurses to reflect on their experiences. It also aided in building awareness to my position as an 'outsider', not only as a researcher but as a woman with a different contextual and historical perspective.

4.5.2 Verisimilitude

Verisimilitude is a textual concept promoted by ethnographers as a means of assessing the coherence, plausibility and correspondence of the analysis to what readers recognise and consider authentic (Adler & Adler, 1994; Altheide & Johnson, 1994; Lincoln & Denzin, 1994). Conceptually, verisimilitude pertains to the relationship between the textual presentation of 'reality', which is multiple and diverse, and the opinions, understanding and perspectives of the interpretive communities. As such, verisimilitude has no bearing on singular claims to truth, but is rooted in the epistemological and methodological imperatives of this research which aims for multi-voiced, diversely-situated interpretation.

The criterion of verisimilitude can always be challenged, as textual representations of reality are generally the site of political struggles over the real and its meanings (Lincoln & Denzin, 1994:580). Within this research, this criterion is mobilised to enhance ongoing scrutiny of representations by continuously drawing the connection between a broader framework of meaning, interpretation and this written account.

To ensure verisimilitude I elected to draw on a range of sources and perspectives during the different stages of research. I felt that this would enhance the development of the interpretation and lead to a clear description of these realities while testing the interpretation of the narratives. The divergent approaches found within the few historical works focusing on the evolution of the profession, ranging from Charlotte Searle's (1965) invested account and Grace Mashaba's (1995) representative account, to Shula Marks' (1994) critical scrutiny of the origins and contradictory practices central to the evolution of nursing in this country, were most helpful in this process.

Findings from the national survey of nurses[59] offered important insights and affirmed many of my findings, while pointing to areas for further examination. Member checks were undertaken (Sandelowski, 1993), which involved discussing the interpretations with the narrators. This helped to clarify and bring the nurses' interpretations to the narrative accounts. In addition, a regular forum of scholars and academics,

---

[59] This research was conducted by an interdisciplinary research team at the University of Natal (Durban) involving myself and other sociologists, an historian, the Trade Union Research Project (TURP) and, initially, a nurse from the Industrial Health Unit. This quantitative survey was conducted in 1997-1998 and explored many terrains of nurses' experiences including their social and domestic lives, their workplace experiences, their professional affiliation and positionality vis-à-vis resistance.

involving historians, sociologists, nurses and a medical doctor, engaged in discussions of the narratives, offering questions and comments that added tenacity to the interpretive process.

4.5.3 Ethical principles and considerations

This research was influenced by ethical principles and considerations that guided interactions with participants and the information they shared. In entering the field and the research relationship, ethnographic researchers invite participants to share their stories. The result is the development of narratives that are based on what has been told, heard, interpreted and shaped to include the researcher's voice (Olesen, 1994). This demands utmost attention to understanding not only what we bring to the research, but also the responsibility that we show to the participant at all stages of the research process.

Feminist principles, promoted by many postmodernist ethnographers, advocate transparent research methods that build trusting and respectful relationships. A commitment to search for narrators' understandings and interpretations of contexts, experiences and events in a collaborative and accountable way is at the center of these methods. The contextualised-consequentialist model exemplifies these ideals and was employed during the different stages of this research. This model is guided by four ethical principles – mutual respect, non-coerciveness, non-manipulation and the support of democratic values and institutions, as well as the belief that every research act implies moral and ethical decisions that are contextual (Denzin & Lincoln, 1994:20). It is my belief that continuous reflection and application of these principles during the

research process strengthen the dynamic between those participating, while ensuring accountability and respect for the participants at every stage.

Ethical considerations involved:

- ensuring that nurses were clearly informed about the research before they agreed to participate;
- guarding the identity of narrators, both within the tertiary research site and in the textual account; and
- ongoing reflexivity during the writing phase to ensure non-harmful representation of the information.

During the initial contact with nurses scheduled for interviews, a detailed account of the research and the methods of recording, transcribing and interpreting the data was provided. Ethical principles were discussed with the nurses, in particular methods for safeguarding their confidentiality and their right to terminate their involvement at any stage of the interview. These rights were revisited at the end of the first interview and reinforced at the commencement of subsequent interviews.

Interviews were tape-recorded with the consent of the participants. The tape recorder was turned off when nurses requested, which occasionally occurred when they felt they were sharing sensitive and potentially compromising information. The tape recorder was also turned off and interviews interrupted whenever intruders entered the interview space.

Ethical methods for ensuring anonymity of the participants and of fictionalising research texts were employed (Clandinin & Connelly, 1994: 422). The tapes were labeled with the date and time of the interview and were transcribed by myself, except for five interviews which were

transcribed by a hired typist. To ensure that the identity of the participants remained confidential, transcriptions were coded numerically and labeled in this way. Original transcriptions and all interview material were kept in my possession.

Representing the voices of these nurses in a way that would not obscure the stories they told was a central issue. My first concern was with the narrators. As some of the events that appear potentially enable the identification of individuals, strategies were used to minimise the possibility of linking the narrations with the participants. Names were altered and identities safeguarded by modifying features of events that might disclose identifying information. Additionally, some scenarios were not described in full. Rather essential details were captured in the narrative section, while identifying features were omitted or obscured.

During this research process, a number of techniques were employed to strengthen the interpretive claims. Reflexivity contributed a 'politics of location' situating my own political, personal, intellectual and cultural framework within all stages and interactions. The process of verisimilitude assisted with ensuring the interpretation resonates with the nurses and in other communities. Ethical principles and considerations guided interactions in the field, and were informed by tenets of the sociological discipline and those of my own political and ideological orientation.

4.6   Entering the Field: Research Design

An ethnographic research design was adopted, aimed at observing, hearing and interpreting how the narrators describe, explain and interpret their diverse locations as women in relationships and within the structures of their homes, communities and work environments during the early post apartheid moment in South Africa. This section will describe approaches to the field work, including choice of a research site, negotiating access to the field and to the narrators, developing research relationships and methods used in the documenting, managing and analysis of data.

4.6.1 The research site: temporal and spatial context

The primary site for the field work was King Edward VIII Hospital (KEH) in Durban, the second largest hospital in sub-Saharan Africa. As a subsequent chapter focuses on a historical and contextual overview of this setting, only selected comments are provided here in order to explain the choice of a research site.

KEH is a public sector institution, since 1993[60] under the jurisdiction of the provincial Ministry of Health in the province of KwaZulu-Natal. It operates as a central referral acute care facility for this region, catering

---

[60] Prior to the political transition process of the early 1990s King Edward VIII hospital was in the magisterial region of Natal and fell under the jurisdiction of the state-run Natal Provincial Administration. Restructuring of physical boundaries and consolidation of formerly fragmented areas, which fell under the former Provincial Department of National Health and Population Development (NHPD) and the KwaZulu administration, under one provincial structure is recent and centralises administrative functions and responsibilities.

primarily for the health care requirements of black and indigent patients. The hospital is governed by an internal hierarchical structure headed by the Chief Medical Superintendent, a medical doctor, who oversees major decisions affecting all staff, including nursing. Whereas the medical staff is racially representative, the majority of nurses at all levels of the hierarchy and service staff (general workers, porters, maintenance) are black and from South Africa, although ethnically diverse. Positions in nursing administration, management and the tutorial roles were dominated by white nurses under the apartheid regime and remained such until the late 1980s when government policies of separate development and improved access to professional training augmented career opportunities for black nurses. The current hierarchical make-up of KEH is a relatively recent development.

The racial inequities of the apartheid era resulted in significant disadvantages for public sector facilities catering for marginalised racial groups. Disparities in health care facilities, in the way of limited availability of hospital beds, resources and staff, fueled and sustained levels of discontent. Periodic labour unrest attempted to surface the discontent and concerns of health care staff, as was evident in the wide-scale strike action in the health sector during 1994 and 1995. The impact of these strikes was of interest to me during this research process.

KEH was considered to be a desirable research site during this socio-political moment for a number of reasons, among them the size and composition of the nursing staff, the complex nature of professional and work relations, and the implications of the historically disadvantaged

location for the lives of nurses which introduced and sustained contradictions to the medical and the nursing ethos. An additional and most intriguing characteristic was the involvement of KEH nursing staff in the 1994-1995 strikes, in which resistance was mounted to the many chronic concerns. As such, KEH presented a single site offering a number of sub-sites within its parameters.

4.6.2 Negotiating access

The process of gaining access to the hospital commenced in June 1995. Acquiring the interest, feedback and approval from the Department of Nursing was a first priority. I was aware of the demanding nature of their work place responsibilities, the tensions of the post strike period and the impact research by an 'outside' researcher might have on staff relations. Because I was interested in engaging in a research process that would be of some value to nurses and which would be considered relevant and non-threatening, it was imperative that the gatekeepers of the nursing department approved the focus and aims of the study.

Contact was initially made with a senior nursing administrator who expressed interest in the nature of the research and was willing to facilitate participation of the nursing staff. The proposal was subsequently presented to the Senior Matron who approved submission of the 'Request to Conduct Research' to the Medical Superintendent who issued overall approval (Appendix 1), applying no written limitations to time or sites, leaving this to the discretion of the nursing hierarchy.

I believe that the interest expressed in the research by the nursing leadership influenced approval of the research project. These nurses, university graduates and postgraduate students, were themselves interested in the potential value of research to nursing and offered their insights into the topic and approaches. Divergent ideological and political positions were observable within this grouping, yet most had some stake in the transitional process within nursing and were thus interested in these research questions. Clearly, all of these nurses played central administrative and management roles during the labour unrest, and were in the process of 'making sense' of the way forward.

A meeting was held with the most senior nursing administrators to engage in further discussion about the research and research strategies, to seek support related to locating and involving nurses and to discuss the parameters of their and the nursing staff's involvement in the research. It was agreed that I would attend monthly staff meetings held separately for nurses of all categories, where I would explain the nature and method of research, respond to questions and solicit interest in participation.

Three meetings were attended: one each for management, professional and staff nurses. During the meetings, the research was described, the ethical considerations were outlined and a brief biographical account situating my interests in the research was presented. The aim of these sessions was to raise awareness, interest and voluntary participation. Following the presentation, discussion ensued concerning matters related to confidentiality, duration and place of interviews. I had hoped to leave

the meetings with lists from which participants could be randomly selected. Although a great deal of interest was expressed, few professional and staff nurses signed the circulated form. When asked about the poor response, several nurses cited their concern with indicating their interest in the presence of supervisors and peers. This was an indicator of the tensions present in this hospital, perhaps exacerbated by the recent labour unrest. Alternative mechanisms were pursued.

In subsequent discussions with a nursing administrator it was agreed that the research would focus on one of the four hospital areas, to be facilitated by the chief professional nurse (CPN) responsible for this area. The CPN was very receptive, yet was already juggling immense managerial responsibilities and issues. Once she was oriented to the research, the selection criteria and the interview requirements (time, space, privacy, confidentiality), the interview process commenced. Her role in the research process was refined to facilitate entry to areas in the hospital and identify nurses who would be willing to engage in the interview process. I refer to her as the 'manager-facilitator'.

4.6.3 Field methods

Field work was undertaken from early 1996 until mid 1998. Two main strategies were utilised for the collection of data: participant observation and semi-structured interviews.

4.6.4 Participant observation

Participant observation was incorporated as a means of observing and gaining insights into the clinical settings where nurses of all categories work. During the course of the research considerable time was spent observing the dynamics and interactions within the hospital environment and its many settings. The form of participant observation employed is known as participant-as-observer (Babbie, 1995), so named as during these periods there was no actual engagement on my part with the day-to-day routines, events and scenarios.

Participant-as-observer field work assumed three main forms. Firstly, considerable time was spent in conjunction with scheduled interviews taking note of the movements and interactions. Secondly, I frequently strolled through areas to capture a sense or glimpse of activity levels, tone, moods and dynamics between personnel and clients. These settings were approached without declaring my presence, objectives, or affiliations, allowing for unobtrusive observation. Minimal notes were taken during these times. Rather the impressions and interpretations were recorded once the settings were left, so as not to draw attention. Thirdly, on several occasions during the field work, on-duty matrons were accompanied on rounds of the hospital. At these times I was introduced as a researcher and engaged more actively in discussion with on-site nursing staff. I was informed about aspects of their day-to-day experiences, for example, issues related to patient care (numbers, acuity and staff-patient ratios), issues related to working conditions (resources, hours of work, staffing), and general issues that arose during the course of the conversation

(relations with doctors, professional/labour organisations). These visits provided insights into the realities of the workplace.

4.6.5 Interviews

Two forms of interviews were undertaken. During the course of the field work interviews were held with a number of key informants from different settings. Among these were interviews with senior nurse administrators, a medical superintendent, staff from the staffing office, the allocation area, and the finance department. Their voices are not quoted within these pages, yet the information they shared helped to construct an understanding of the hospital's history, evolution and day-to-day process.

The majority of the data was gained through a series of semi-structured interviews conducted with 26 nurses of four specific categories: nurse managers, professional, staff and student nurses. These interviews were undertaken over the course of one or two sessions, lasting from 60 to 90 minutes. The interviews were tape-recorded, with simultaneous note-taking.

4.6.6 Involvement in the research and a profile of the narrators

The sampling technique was non-probabilistic to assure representation across a range of nursing categories, thus ensuring access to a number of voices in a stratified sample. The initial strategy can best be described as purposive sampling (Babbie, 1995; Bailey, 1987), as the criteria for participation in the interview process needed to be established and shared

with the manager- facilitator. These criteria were kept to a minimum: female nurses from both professional or subprofessional categories who were willing to engage in the study. Initial contact was made by the manager-facilitator. She provided me with names, locations and times of the first interviews.

As nurses were interviewed and the findings reviewed it became evident that there were specific areas that I wanted to rigorously pursue. In particular, I wanted to strengthen insights into nurses' involvement in the unification of nursing organisations and their responses to and roles during the labour unrest. At this stage theoretical sampling was combined with purposive strategies. According to Glaser and Strauss (1967; Burgess, 1993; Babbie 1995; Schwartz & Jacobs, 1979), theoretical sampling does not aim for representativeness, rather it seeks to follow-up on the conceptions developed during interviews, thus allowing for the development of queries, identification of gaps in information and areas that need to be pursued. In this case, the manager-facilitator was asked whether she knew of a nurse that had specific involvements in areas such as the labour unrest, the unification process and so on.

One of the criteria was to involve nurses from a range of categories, such as various levels of responsibility, location in the nursing hierarchy, age, level of training and education. Twenty-six nurses participated in the interviews. The two specific nursing categories, termed professional and subprofessional, were represented equally. Of the twelve nurses from the professional categories four were senior managers with a mean age of 56; four were middle managers overseeing clinical sites, with a mean age of

55; and four were professional nurses with direct patient care responsibilities, with a mean age of 37. Of the eight subprofessional nurses, all of whom were involved in direct patient care responsibilities, four were enrolled, with a mean age of 34; four were enrolled nursing assistants, with a mean age of 36. Four student nurses at the second, third, and fourth year levels of their four-year, professional nurse training programme, with a mean age of 24, were involved.

The number of nurses involved in the study was not predetermined, although I initially aimed for a representative sample of around twenty nurses. I remained receptive to increasing the sample size until I was certain that the experiences and positionality of nurses were broadly accounted for. In other words, my confidence of the data's authenticity grew as the narratives increasingly resonated of similar themes, insights and concerns.

All of the nurses interviewed were black women trained within a hospital diploma programme, mostly at KEH. Twenty-one of these nurses worked solely within this institutional environment. For all except three of these nurses, who worked elsewhere for more than two years, KEH had been their primary employer throughout their adult life. Six of the senior nurses, three managers, two SPNs and one PN had pursued postgraduate studies to obtain a nursing degree, having first registered through a hospital diploma programme. This group was dominated by the older, more senior professional nurses, while few of the younger PNs had pursued this route.

At the outset of this study, seventeen nurses were active and voluntary[61] members of the South African Nurses Association.[62] This included all nurses of the professional category and five from the subprofessional category, but no students[63]. Thirteen nurses were affiliated to labour organisations. Union affiliation was evenly spread through all categories with the exception of managers, none of whom were affiliated to labour organisations. While affiliation to organisations was common, active participation was not. Only one matron and one professional nurse played active roles in the professional association or in a labour organisation, respectively. By 1998, affiliation to professional and union bodies was varied. Nurses working in hospital environments required indemnity insurance, yet there were a range of competing bodies making this available to them, amongst these DENOSA, NEHAWU and SADNU featured most prominently at KEH.

4.6.7 Establishing and maintaining the research relationship

Increasingly in ethnographic research, the relationship developed in the field is acknowledged for its influence in shaping the nature of the field text and ultimately the story which is being told (Clandinin & Connelly, 1994:419). Postmodernist and feminist researchers have engaged in debate about unequal power relationships in research situations (Olesen, 1994; Haraway, 1991; Harding, 1987; Fine, 1994; Fonow & Cook, 1983;

---

[61] Membership in the professional body, SANA, was mandatory until 1992.

[62] SANA officially dissolved in October 1996 to join the unification process that resulted in DENOSA. However, it still existed at the time of the field work.

[63] Although all of the fourth year students joined SANA when they entered nursing, none of them renewed their memberships in 1994 and 1995.

Personal Narratives Group, 1994), and view the formulation and incorporation of reflexive strategies as vital to engendering ethical and politically informed interactions where trust is built.

In particular, cross-cultural research dynamics have received the attention of a number of feminist authors who stress non-hierarchical relations as unrealistic and untenable (Dyck, et al, 1997; McDowell & Pringle, 1992; Mohanty, 1991; Robinson, 1994). Entering the post-colonial field I was aware of the power relations existing in the interactions across subject locations that marked the importance of acknowledging the multiple subjectivities of the researcher and of the narrators. Probing my "positionality", as suggested by Robinson (1994:7) to understand and acknowledge the implications for all stages of the field and post-field process, was a useful method for attending to the effects of power-relations. By entering the field with these perspectives I aimed to develop relationships that would be honest, transparent, receptive and respectful of the narrators' interests. Efforts were made to identify and displace my own perceptions of textually constructed identities that might distort the interactions. It was hoped that this would produce an understanding of the multiple locations of the narrators, while acknowledging my own presence in the construction of the interpretation.

I entered the field aware that activity levels and job responsibilities might preclude nurses' availability for the interview. Clinical area supervisors were approached and authorization received from them to proceed. Once I introduced myself to the nurse, we found a space designated by the narrator, where the interview would occur. Generally, this strategy

worked well as the narrators were most familiar with their surroundings. Occasionally intrusions or interruptions resulted in delays; however, this was unusual as most narrators secured relatively private spaces.

The dynamic between the manager-facilitator and nurses in setting up the interviews was not observed. It was quickly apparent that the narrators who had not been in attendance at the staff meetings I attended had little clarity of the details of the research. When I initially met nurses in their work settings, I occasionally perceived tension, suspicion or concern about the reasons they were 'targeted' for involvement. Some had simply been told that a researcher from the university would see them at a designated time. Thus, the initial phase of our time together was spent clarifying the research process, its origins and methods, my involvement and orientation to this research and to them, the ethical principles that formed part of the process, as well as biographical details. I was careful to create space at this juncture for clarification of what had been said and for further questions about the research and their role. For some, an interest was expressed in how the research might contribute to exposing and resolving their issues. It was important to displace distrust and instill the understanding that they could choose whether or not to participate in interviews. Once nurses indicated their interest in participating the interview progressed, involving not only my own agenda, but also an agenda that included the narrators' interests (Personal Narratives Group, 1994:202-3).

Agreement to participate was an indicator that narrators had their own reasons and agendas for involvement. It was important to be sensitive to the narrators' interests in participating in the interviews, and to issues of voice, that which was heard and not heard.

One aim of the ethnographic interview process was to develop an environment, in the field and in subsequent stages, in which the narrators could speak for themselves, based on researcher-narrator participation in 'mutually developing the data' (Olesen, 1994:164). A semi-structured interview guided respondents through their life stories. The interview focused on memories of childhood experiences, their choice to enter and remain in nursing, experiences related to training and clinical nursing, their choice and perspectives regarding organisational affiliation, and their views of the transition of nursing in South Africa. The research was intent upon retrieving social, political and personal perspectives of the micro and macro dimensions of their realities, thereby understanding the contexts within which they live their lives.

A conversational approach to the interviews was introduced, which created a space wherein the narrators could question, correct, and engage in a two-way dynamic. This approach varied for the 26 interviews yet at times resulted in robust dialogue. The interviews flowed smoothly with narrators engaging actively in the process, in all but two of the interviews. In one case, the nurse showed considerable interest in being included in the research process, yet did not elaborate in her responses. In the other case, the nurse consented to proceed with the interview, but quickly seemed to become disinterested and fairly non-communicative.

For some of the respondents, their stories met obstacles where their accounts were interrupted by the emotion of a particular memory or time that held their attention, and mine, and which resonated through the remaining narrative.

All of the interviews were conducted in English, the second language for these nurses. The respondents came from primarily Zulu and Xhosa backgrounds. The language spoken in their homes was a combination of their first and second languages. The language of post-secondary and tertiary instruction for all these nurses has been English. The primary language used amongst nursing, managerial and medical staff is English, as is the language of their clinical records. Most communication with patients, on the other hand, is in the patient's first language. Thus, all of these nurses were proficient in speaking and understanding the English language. There were, however, differences in intonation, accents, nuances and concepts used in communication. Repetition and clarification were occasionally necessary.

Feminist, and in particular feminist-action researchers, promote extensive participant involvement in interpretive stages of the research (Batth & Reid, 1998; Olesen, 1994). Therefore, I thought it might be of value to explore methods of engaging with the nurses after the interview stage. The pressures, tensions and the hierarchical dynamics at and within all levels of the nursing department in the early post strike period were complex and changing rapidly. It became clear that the environment and relationships were too fragile for extending the research relationship beyond the interview process.

4.7   From field texts to research texts

Field texts included written records of observations, reflections, tape
recordings of the interviews, and notes made away from the field. It
became very evident to me early in the field process that the range of
experiences and reflections that would be captured in the narrators'
voices and my own observations would be extensive and would require a
comprehensive data management process. This section records the
chronology of working with field texts, the process of 'making sense' of
what was learned and the organisation of data into accessible research
texts.

4.7.1 Observations, voices and reflections

Records of the field experience (field texts) contained my observations, the
voices captured in notes, and the tape recordings of interviews. Personal
reflections were recorded away from the field. Reconstructing these into
research texts involved the verification, clarification and isolation of
information that would inform theoretical sampling.

Once I left the field, I was careful to review the records made of
observations and interviews. Field notes of perceptions, queries and
interests consisted of point-form notes taken during interviews.
Contextual information was later added in order to recall the
environment. General perceptions and questions that arose were
recorded.

The transcription process served to recapture the field experience, reminding me of the context, voices, silences and tones of the narrative environment. As I listened and re-listened to the narrators' voices, I made side notes of impressions and emerging questions. For those interviews transcribed by the typist, I reviewed the tapes to verify the records and made notes along the way. Refamiliarising myself with the voices on the tapes was a valuable way of reinforcing my interest in developing an interpretive process that would capture the nurses' voices, bringing the multiple interpretations and tones to the fore while de-centering my own voice from the text. The power their voices held captured the texture of the occupational, environmental and cultural experiences.

4.7.2 Developing the research text

The field texts were voluminous, necessitating a coherent data management technique to, as Denzin (1994:501) writes, 'experience the experience'. Grounded theory methods were instructive and were drawn upon to work with the data during the initial stages of analysis. Grounded theorists approach the analytic process by looking for 'the main stories being told' (Hughes, 1994; Strauss & Corbin, 1990; Glaser & Strauss, 1967). Approaching the narrative accounts in this way created space for the voices, scenarios, experiences and interpretations. Additionally, 'theoretical sensitivity' was incorporated as a means of recalling the spatial and temporal realities. This enabled an analysis of the subtleties in the data, rather than an acceptance of a linear interpretation.

Guided by these two strategies I reorganised the field texts into a series of notes: observational and theoretical. The transcript and notes for each narrator were reread, searching for the main stories, which were recorded as observation notes. The events experienced through watching, listening, feeling and interpreting were pulled together, eliciting themes, concepts and dimensions for each interview. Following this I recorded theoretical notes, where I self-consciously attempted to exact meaning from the emerging texts in the observation notes (Schatzman & Strauss, in Hughes, 1994:45). The theoretical notes allowed for expanding the individual contexts in the narratives and encouraged ways of connecting and interconnecting the experiences within a broader narrative framework.

Throughout this early analytical phase a number of social, occupational and personal categories emerged, like gender, class, race, professional category and hierarchical location. These were visible in a number of public and private sites (Marks, 1987, 1994; Rispel & Schneider, 1989; Rispel, 1990; Myburgh, 1990; Webber, 1994). I constructed spatial and temporal sites that guided the development of the narratives within which the interplay of analytical strategies could continue working. There were six spatial sites:

- 'choice' to enter nursing
- experiences through the training programme
- home lives
- community lives
- professional accounts, and
- descriptions of the workplace;

and two temporal sites:

- the transitional process in professional nursing organisations
- the 1990's labour unrest at King Edward VIII Hospital.

The narrations were reread to extract concepts and data that fell within these sites. This information was organised into 'site-tables' which I developed to retrieve and order the data for analysis. The site-tables were created with a series of columns that evolved as follows: the left column held the code number of the nurse, next I wrote the data relevant to the site, this was followed by several columns where categories were noted. The conceptual properties and the singular or plural phenomenons that seemed to arise from the data were cited. The observation and theoretical notes were used as cross-references through this process.

Site-tables were subsequently summarised on main tables illustrating the categories, concepts, themes arising from the data; prevailing relationships, tensions, contradictions; and summary notes citing noteworthy points. These were used in conjunction with the site-tables which provided a visual display of the narrators' statements at each site. This approach aided in noting the origins, prevalence and frequency of particular accounts.

The systematic organisation of the data through these methods facilitated the translation of data from the field, into the volumes of transcriptions that emerged, and the subsequent retrieval of information arranged into research texts. This process strengthened my confidence that the research texts reflected the stories being told.

4.8   Interpretive Realism: From Research Texts to Interpretive Accounts

Moving the research text through the analytical phase to the interpretive account called for the development of a writing style that would effectively capture the narratives, while incorporating ethical and interpretive theoretical tools. Donna Haraway (1989:8) captured the essence of postmodernist ethnographic accounts when she wrote:

> I think there is an aesthetic and an ethic built into thinking of the scientific practice of storytelling, an aesthetic and ethic different from capitulation to "progress" and belief in knowledge as passive reflection of the "way things are," and also different from the ironic scepticism and fascination with power so common in the social studies of science. The aesthetic and ethic latent in the examination of storytelling might be pleasure and responsibility in the weaving of tales. Stories are means to ways of living.

The image of an aesthetic acknowledges levels of emotion and the intellect rooted within ethnographic research. It engenders the notion of reciprocity in approaching social inquiry, full appreciation of the opportunity to engage and participate within a domain that is outside the usual, everyday moment, while responding to the ethic. The ethic underscores the responsibility inherent to methodological integrity. It relates not only to the 'means' with which the story is told but also to the fundamental objectives that guide involvement in the research process, in this case contributing knowledge and enhancing social change.

Developing a narrative form that retains the voices of the original narrators resulted in the choice of interpretive realism, a writing style that includes the self-understanding and personal interpretation of the author into the life situations of the individuals studied, thereby acknowledging the interplay of the author's and narrators' voices (Denzin, 1994:507). This writing style aimed to place the voices of nurses in the foreground.

The nurses' accounts were powerful and reflected their movement through a number of personal, private and public spaces. The scenarios they disclosed pointed to the many constraints they share with women and nurses in South Africa. They are personal, they are familiar and global, and thus they are political. I elected to present the analysis in three separate chapters, through which theoretical explanations are advanced.

The first (chapter five) describes the research site, a complex and historically significant setting. This chapter is a culmination of the literature, field notes and the interviews held with key informants.

The next two chapters present the voices of nurses in two different formats, best described as diachronic (chapter six) and synchronic (chapter seven). The diachronic format involves chronological accounts of the narrators' lives, describing the unfolding of different phenomena over time, and framing events within specific temporal and spatial moments (Personal Narratives Group, 1994). Four narratives are presented that illustrate personal and historical realities along with the choices, complexities and dynamics that constitute the lives and experiences of the

four nurses.

These four narratives were chosen as they presented diverse perspectives that seemed to capture the overall range of experiences, insights and meanings forwarded during the course of research. They stand alone as the experiences of these individual protagonists, yet their multiple and complex features dissect and cut across the experiences evident within the lives and perceptions of others. They represent the range of tensions, relations and tones of interactions intersecting the day-to-day realities of nurses.

The synchronic approach sets aside the temporal and spatial aspects of the chronologies and pulls in the voices of all the narrators to present an analysis organised by conceptual categories. The various experiences, perspectives and expectations of all the narratives are noted to illustrate the discourses and practices, the contradictions, and complexities of nurses' experiences. Writing the narratives in this way emphasises the interconnections of time, space and context with the many perspectives and experiences that emerged in the narrative accounts.

4.9   Conclusion: The Interpretive Approach

This chapter presented a detailed description of the methodological considerations guiding this study. Ethnographic research methods were discussed with consideration given to recent debates related to this approach. Principles and approaches engaged to enhance overall rigour, specifically reflexivity, verissimilitude and ethical considerations, were

outlined. The chapter then went on to describe field methods, the processes used to manage and to translate the data from field texts to research texts.

Ethnographers writing during the postmodern era portray interpretation as the moment when multiple meanings are sifted from the field experiences and written as text. Meaning, wrote Denzin (1994:504),

> is not in a text, nor does interpretation precede experience, or its representation. Meaning, interpretation and representation are deeply intertwined in one another.

This explanation is in keeping with this approach where meaning is considered to be discursively constituted, and therefore not neutral. The approach suggests that one way to understand and interpret is to examine what is being said (Garvey, 1989:461) from the multiple texts and sites emerging through the study.

There is no single approach to the analysis of discourse. Rather a number of methods and theories exist that are applied in a variety of ways. According to Garvey (1989) discourse analysis involves the careful reading of texts with a view to distinguishing discursive patterns of meaning, contradiction and inconsistencies. It operates from the assumption that discourses are not static, fixed or orderly, but rather fragmented, inconsistent and contradictory.

The interpretive process involved a complete review of the interviews, with frequent cross-referencing of the transcripts, site-graphs and summaries. In this exercise, a series of conceptual notes were developed that were

linked to relevant textual material. The approach focused on the discourses and practices inherent to relations of power and on notions of difference in subject location and distribution. It highlighted varying contexts and historicity pertaining to diverse social realities, tensions and inconsistencies experienced by the narrators. The notes were arranged in thematic piles, then placed schematically on a large surface where I was able to draw the links, relationships, tensions. The exercise allowed me to visualise the interplay of relations of power, the many discourses and practices at play, the location and intersection of contradictions, the forms of resistance, and responses to transitional dynamics. During this process, I was able to take into account the intersections of my own reflexivivity with the data.

Approaching the texts and narrations in this way yielded consideration of the many subject positions nurses negotiate and the multiple discourses and practices that mediate, intersect and challenge their subject positions. This process of sifting and intertwining multiple meanings from the textual, narrative and reflexive representations provided some assurance that the overall interpretation (chapter eight) is a faithful representation of the nurses' accounts.

Chapter Five

King Edward VIII Hospital

5.1   "It's a Unique Hospital."[64]

It was early August 1995 when I first encountered the corridors of King Edward VIII Hospital. As I made my way from Sydney Road to the entrance, I wound through a number of people milling about the street waiting for transportation, bartering with fruit vendors, negotiating entrance to the grounds with the security guard. Scattered on the small patch of grass in front of the gates were women with infants, the elderly and infirm, most dressed in layers to insulate themselves from the cold wind, some lying sleeping, most waiting as diesel buses roar past.

The view from the front doors overlooks an industrial area by the busy roadway. To the sides additional buildings, 'add-ons' over the years, dot the eleven-acre landscape. It is a low piece of land, and nurses complained that in summer there is little breeze to relieve the air of the humid industrial stench that builds in the heat. Patients were wandering the grounds in institutional garb, some carried intravenous bags connected to a limb, casted others hobbled on crutches or moved about in wheelchairs.

Once on the inside, other scenes unfolded that told stories about the interface of order and chaos in daily interactions and routines. Three main stories became instantly clear, and were subsequently reinforced on return visits. Firstly, the accumulation of overuse and abuse of this space was

---

[64] This narrative has been compiled from field notes taken over the course of four years of field work at KEH.

apparent in every dull corridor, where refuse was collecting, trolleys were abandoned, and scavenger rats ruffled through garbage, darting out from time to time in front of my path when footsteps startled them. The many blocks are connected by an endless maze of brick corridors, open to the internal workings of the hospital – spaces with huge engines and turbines sit adjacently to laboratories and clinics. It took me many visits before I confidently found my way through the labyrinth to various destinations.

Secondly, many of the occupants – the workers, nurses, patients – assumed a presence as worn as the space itself, an apparent resignation to the endless nature of their waiting or the demands on their time. Corridors leading to the Out-Patient Departments were continuously jammed with patients who appeared to have reconciled themselves to a long wait. Within the departments, trolleys filled the corridors, holding patients whose state of health, dress and awareness were as varied as their appearance. In 1997 more than one million made their way to these departments, well over 3,400 per day.[65]

The doctors? They were rarely visible, encountered only through an occasional glimpse into an examining room as the door swung open, or viewed stereotypically striding through the corridors, white lab coats with dangling stethoscopes, flapping in their own breeze. A discussion about doctors was rarely initiated by any of the nurses I met or interviewed during the course of fieldwork at KEH. It was only upon questioning about working relationships that nurses responded with anecdotes, yet during the course of my field work doctors seemed somewhat peripheral to the organisational experiences nurses related, and appeared only in the distance as separate, non-linked entities.

---

[65] According to King Edward VIII Hospital records for 1997, 1,257,457 patients sought treatment through the OPD, an average of 104,788 per month, and 3,445 per day. The busiest months were from May to November when the monthly numbers ranged from 105,124 (November) to 125,319 (July).

Third was the palpable thread of sanity drawn through the chaos – something that kept all this together; technologies, strategies, habits that sustained the patterns and discourses appeasing expectations. Whether it was the repeated scene of nurses cutting pictures from magazines to decorate the covers of manuals, or the flow of communication witnessed from the enrolled nursing assistant to the patient, or the matron to the professional nurse, or perhaps the occasional moment when the sight of a patient being moved within the corridors of the OPD was witnessed by all. These served as reminders of the endless movement through these halls.

The wards were another experience. They were stark, in desperate need of paint and an occasional picture or curtain to brighten the walls. The beds, narrow and old, formed a monotonous pattern lining the walls. Old trolleys were wheeled from bed to bed, carrying drugs and procedure trays for the patients. Some, not all, had bedside curtains that offered privacy during examination or other personal moments. Patients filled all the beds, all clad or semi-clad in light hospital gowns and fewer blankets than were needed to ward off the chill.

In August 1998 I returned to the hospital. It had been nearly nine months since the interviews were completed, and other commitments precluded making my way back before then. In that short time a great deal had taken place. Firstly, the hospital occupation had fallen from over-utilisation of the 2,000 beds to less than 1,913 beds;[66] the total number of patients admitted the previous year had fallen from an annual figure of close to 110,000 throughout the 1980s to just over 72,000. Of these, 98% were from an indigent population and consequently not paying for their hospitalisation.[67] The hospital was statistically benefiting from the relaxation of racial restrictions on tertiary facilities. Black patients were being distributed more widely

---

[66] Figures made available by the Medical Superintendent, August 1998.
[67] Based on statistics provided by Senior Administrative Officer for Financial Services, August 1998.

throughout Durban's hospitals. The corridors and passageways linking the many buildings appeared less cluttered, predisposing small patches of mown lawn to ready vision. It was a sunny day and there was a sense of cleanliness and order prevailed as I made my way to the OPD, where little had changed. Sitting, stretchered, standing bodies filled every available space. They seemed stationary as uniformed nurses wound their way purposefully in and around. The OPD offers many specialty services and thus draws patients from other medical facilities as well as the high-density residential areas. Statistics during the visit showed that the OPD experienced about 6,000 site contacts during a 24-hour period.[68]

Later on the same day I returned to conduct rounds with a matron on duty. She explained that a substantially tightened budget formed part of the explanation for the bed closure. This, she told me, had also rippled through all tiers of hospital staffing: fewer hours for doctors, no overtime or 'moonlighting' nurses, fewer support staff, and no replacement for absenteeism.

She was on the phone when I arrived. I was told that an elevator, not working since the afternoon, was still awaiting repair. The elevator linked the main floor of the hospital with the operating room, the intensive care unit and a resuscitation-holding unit. It was a vital elevator for the transportation of trauma patients from the emergency unit to the operating room, yet it hadn't been possible to entice an engineer from home to repair it. . . remnants of apartheid?!

I was initially deposited in the emergency department where some time was spent with the nursing staff. As I arrived a nurse answered a phone call from an employer inquiring about the whereabouts of her injured gardener. The ambulance attendants told the employer that 'the nurses

---

[68] Based on interview with Assistant Director of Nursing Services, August 1998. This figure represents the total of all clinic visits in one 24 hour period, including the multiple sites used by each patient.

were slow' and the gardener would wait for three hours in the unit before being seen. One nurse was dispatched to locate the patient and returned to inform the insistent caller that the employee was not in the department. When she got off the phone, she appeared demoralised and defensive.

There were few patients as the ambulances had been alerted to the dysfunctional elevator and would attempt to reroute traumas and casualties. Busy days in Emergency consist of the treatment of up to 300 acutely ill people brought in mainly by ambulance, given 'life numbers' (aptly named to designate patients are alive!) and registered by nurses in the 'red book'.[69] A six-bed trauma unit stands ready for the resuscitation of critically ill patients, while less urgent patients are seen in smaller curtained cubicles. During the day ambulatory patients are sent to another area of the hospital called the 'sorting station' and are assigned treatment areas from there. At night everyone enters through the casualty unit.

The nurses talked about the lack of security. They treat a high percentage of people who are victims of violent crimes, and feel vulnerable. Last year one of the nurses was shot and killed in the unit by an angry boyfriend who arrived to settle their argument. They told me that they have learned to 'keep quiet' when patients become aggressive. They speak of the range of cases they see: the traumas, the high level of HIV/AIDS related cases, the violated women, the abandoned babies. As we spoke, the level of activity suddenly rose sharply. I watched the nurses move into high gear, and as I prepared to leave, was told by an exasperated nurse that the gardener had just been wheeled in by the ambulance attendants.

We then made our way to the medical out patients' department (MOPD). Six nurses (two RNs, two ENs, two ENAs) were on duty to manage the anticipated ±90 patients

---

[69] Nurses log the treatment, outcome and allocation of all patients seen in this unit; thus it forms the main register for inquiries made.

that generally seek care during the evening and night. They were staffed with two doctors for the next hour, after which one would go home (funds!). Many of the patients would spend the night in the unit, as no transitional beds and little treatment was available until the morning.

We moved onto the female and male transitional ward, where admitted patients awaited hospital beds. Each ward was fully occupied with 25 patients, four of whom were of high acuity, requiring intensive monitoring. The remaining 21 were ill, in need of attention. Each of these wards was staffed with one registered nurse and two enrolled nurses, a 1:8 ratio. The matron told me this ratio was extremely high and unreasonable given the level of acuity of these patients, yet funds were limited! Nurses who called in sick were not replaced, as 'it might encourage the practice'. She told of one ward where there were 30 patients and one nurse that evening. Poignantly, she commented, "What can I say to that nurse when I see that she is not managing? All I can say, is thank you for coming to work". Her cool and demure response to this grossly untenable situation was staggering to me, yet she had clearly resigned herself to these realities.

The matron spoke of the escalating demotivation amongst nurses over the past year. Budgetary cutbacks, staff shortages, heavy workloads remained unresolved frustrations. There was no talk of strike action or labour unrest, but nurses were evidently frustrated with the relentless conditions. The matron claimed that nurses took more sick leave, exacerbating the shortages, and that generally there was little sense of relief in sight. She herself was planning to take early retirement, as had some of her colleagues.

5.2 Introduction

Describing a complex organisation, such as King Edward VIII Hospital, with its history and distinctive character is relevant to understanding the narratives that follow in the next chapter. The literature on the hospital is scant[70] as it has not been a key site of critical research. Thus, this chapter pulls textual material together to paint the broad strokes in this motif. The finer details are filled-in based on my experiences[71] within the spaces of this hospital.

The aim of this chapter is to describe King Edward VIII Hospital and to present a contextual and relational description of the research site that adequately frames the images and textures of the corridors, while considering the disciplinary discourses that influence the social dynamics. The narrative at the beginning of this chapter presented experiences and observations of the spaces and movements during the period of field work. It introduces the environment and presents some of the striking sensations that impacted on my perceptions of what one

---

[70] KEH has not been a major site of study. Only one dissertation was found (an architectural dissertation by McCaffery, 1978), describing expansion of out-patient facilities for the hospital. Short journal articles, primarily marking the 50th anniversary, provided a historical if somewhat romanticised approach to describing the evolution of the Hospital. Several archival pieces were found citing agreements between the Hospital and the University of Natal's Medical School and recommendations for expansion of the out-patient facilities in 1956. King Edward VIII itself has not maintained an accessible archive, as funds have not permitted for a public relations facility. However, deep within the drawers of the Medical School Librarian's filing cabinet, press clippings and various records chronicled some of the Hospital's moments, particularly as they related to its relationship to the University Medical School. References to working relationships are cited in a number of history and sociological texts, for example in L. Kuper (1965) and Marks (1994).

[71] During the field work several days were spent as participant observer with senior administrators and chief professional nurses in the main administrative areas and with nurses within clinical areas. Much of this data is drawn from those interviews and interactions.

senior nurse called "a very unique hospital". From here a post-
structural perspective on organisations has been framed within which a
historical and contextual overview of KEH has been situated. The next
section describes the nurses, their professional categories and the
institutional hierarchies within which they work, drawing upon
Foucault's (1975) notion of 'docile-useful bodies'. The process and site of
'allocation' are then described as the prime discursive apparatus at work
to survey, monitor and manage the flow of communications, patients
and nurses within the monolith. I conclude by pointing to some of the
contradictions and cleavages in these discourses, areas that will be
taken up more fully in subsequent chapters.

5.3   Hospitals as 'Pure Communities' / 'Disciplined Societies'
5.3.1 Post-structuralist approaches to hospital organisation

Hospitals as we know them today are the product of modernity,
specifically the era of industrial capitalism that introduced factory-based
systems of production within which scientific principles of organisation
were generated and refined. Organisational theory from the late 19th and
early 20th centuries prescribed many of the guiding discourses. Theories
found in Taylorism (scientific rationality), Fordism (Taylorist rationality
with assembly-line production), and Weberian thought (rationality and
bureaucratic management) presented a rich modernist discourse with
which to explain the organisation of institutional environments like
hospitals (Fox, 1993). As Fox (1993:48) writes, hospitals exemplify many
of the modernist features of bureaucratic, hierarchical, detached and
indifferent images of organisation. The parallels between factory and

hospital work have been drawn[72] to emphasise the degrees of stratification and divisions of labour that displace many of the discourses central to conceptions of hospitals as unitary (for example, discourses of caring and professional discourses).

The organisation of institutional environments and the relations within have been the centre of considerable post-structural scrutiny. In *The Birth of the Clinic* (1973) and *Discipline and Punish* (1975), Michel Foucault presents compelling descriptions of the historical evolution of spaces to 'disciplinary institutions' through the 17th and 18th centuries. The process of establishing the complex dynamics of the 'panopticon[73]' through which power and knowledge are arranged, ordered, driven, contested, resisted and reformed are introduced when he wrote:

> . . . two ways of exercising power over men, of controlling
> their relations, of separating out their dangerous mixtures.
> . .The first is that of a pure community, the second that of
> a disciplined society. . . [where] hierarchy, surveillance,
> observation, writing [intersect with] . . . the functioning of
> an extensive power that bears in a distinct way over all
> individual bodies (1975:198).

Disciplinary institutions involve the merger of pure community, as the theoretical model of the perfect discipline, with the instillation of disciplinary practices. This merger provides a functional mechanism that works to enhance the exercise of power "by making it lighter, more rapid,

---

[72] Rispel and Schneider (1989) and Rispel (1990) draw on the work of D. Wagner when discussing the proletarianisation of nursing.

[73] Bentham's Panopticon is an architectural figure designed to maximize surveillance. His principles inverted pre-modern images of incarceration (based on enclosing, depriving light and secluding) by heightening internal visibility, while maintain enclosure, to instill a sense of perpetual surveillance.

more effective" (Foucault, 1995:205) which in tertiary settings is needed in order to manage, direct and control systems. Hospitals personify this composite of strategies that are needed to maximize and assure expedient operation.

Tertiary settings bring into play a system of practices that enable their operation, while sanctioning local power. Clinical environments, socially inscribed as pristine spaces of specialisation, expertise and care, house a precarious arrangement of social dynamics, perhaps as instrumental in privileging and preserving spaces for the medical practitioners as in establishing the right to health for the clients. Fox (1993:49) maintained this point when he wrote,

> . . . all organisations are mythologies constituted
> discursively to serve particular interests of power, and
> contested by other interests of power.

KEH is a prime example, as an organisation shaped by a unique historicity that evolved and intersected its day-to-day operations, and by the many dynamisms and discourses that influence its contextual realities.

5.3.2 The origins and evolution of King Edward VIII Hospital

Within the context of apartheid South Africa, 20th century hospital environments were imprinted with contradictions resulting from social policies of separate development, unequal distribution and their consequences. As a major tertiary facility for black patients in Durban,

King Edward VIII Hospital bears the results from years of implementation of apartheid policies and the waves of struggles and resistance borne of these contradictions. It is an entity, monolithic by design but fragmented by a dissonant historicity.

Built in 1936 on a lip of land bordering one of Durban's oldest industrial sites, King Edward VIII Hospital was established to respond to an acute shortage of hospital beds for the massive influx of the African and Indian indigent to Durban (Dyer et al., 1986). The original site comprised two separate buildings of general wards referred to as 'N' for Native and 'I' for Indian, divided by a variety of clinics, theatres, administrative buildings, and a maternity ward set amongst the maintenance buildings. From the outset, King Edward VIII was beset by a lack of resources and equipment for patient care. Second-hand diagnostic and therapeutic equipment was borrowed from Addington Hospital, while nurses constructed patients' mattresses out of grass from the grounds and used kitchen trolleys to transport equipment (Dyer et al., 1986).

Ongoing deterioration of economic and social conditions in rural areas and the expansion of industrialisation in the 1930s and 1940s fed the continuous growth of Durban's population, one whose health had been compromised by manifestations of socioeconomic inequality and poverty visible in the clientele of the hospital. The first medical superintendent of King Edward VIII, R.E. Stevenson, wrote,

> . . .an enormous amount of our work arises from
> preventable causes - hospital and public health work are
> most intimately connected; the health of the non-European
> is deplorable and this is mainly because of poverty and the
> inadequacy of public health measures; nearly all native

patients are grossly under-nourished and infested with intestinal parasites; the incidence of TB and venereal disease is fantastic (quoted in Dyer et al., 1986).

Throughout 60 years of operation, KEH was constrained by a shortage of beds and nursing staff, insufficient equipment and facilities for the care of patients. The Race Relations Survey (1994:48) compares funding of Groot Schuur Hospital, the Cape Town Hospital where Chris Barnard performed the world's first heart transplant, and KEH showing the gross disparities manifested through apartheid policies. KEH operated on half the budgetary allocation, 33% more beds and 132% fewer staff than Groot Schuur. In addition, since the hospital expanded to its 2,000 bed capacity, records showed a continuous over-occupancy, resulting in an average of 150 patients cared for on floor mattresses or, in the case of children, in the double-occupancy of beds, which became a root cause for cross-infection (Moosa, 1986).

By its 50th anniversary, KEH's doctors turned to the daily newspapers to draw attention to inequities. These doctors were frustrated by the failure of the medical superintendents to take their grievances seriously. The grievances concerned the chronic shortage of beds that resulted in over-crowding, cross-infections, higher mortality rates for children with gastroenteritis than in less developed countries[74], in addition to the shortage of personnel, equipment and facilities. Further exacerbating the frustration of health care staff were the reported surplus of facilities in hospitals reserved for white patients through apartheid legislation.[75]

---

[74] "Appalling Death Rate among Hospital's Gastroenteritis Babies" *Sunday Tribune*, 31 August 1986.
[75] "Medical Dis-Services" in Sunday Tribune, 31 August 1986.

Since then, a number of events have altered the day-to-day realities. The strict segregationist policies repealed in the early 1990s and the redistribution of healthcare funds to develop a district health care system have had a number of consequences for the distribution of patients and the evolution of available care.

The hospital currently comprises 52 wards, each housing up to 60 admitted patients. Every ward is designated according to medical specialty, acuity and stage of transition through the system. These wards constitute two of the three patient-care 'areas'. Area One is assigned to pediatrics, gynecology and obstetrics, reproduction and maternal-child interests. Area Two houses all other in-house areas: surgical, medical and psychiatric systems and subsystems, which include a number of speciality areas such as opthamology, orthopaedics, urology, the intensive care unit, and the out-patient's department. Area Three is designated for theaters – the operating theaters, the casualty ward.

KEH has been the site of nurse and medical training since its early years. The College of Nursing produced mainly African professional nurses and nursing auxiliaries, while the University of Natal Medical School has been active since 1950 as the first training facility in Natal for 'non-European' doctors. Like other educational and employment facilities in South Africa, the early segregationist policies legitimised by the National Party, like the Separate University Education Act of 1957, affected relational patterns and dynamics, as well as resulting in

unequal salaries for all 'non-European' health care personnel.[76]

From the hospital's opening in 1936, the nursing hierarchy was organised racially with all supervisory and leadership positions occupied by white nurses (from matrons to senior ward sisters) and tutors who presided over the work of the racially mixed nursing staff.[77] Implementation of apartheid policies of separate development and a chronic shortage of nursing staff increasingly served to alter these arrangements. Gradual promotion of black nurses to supervisory and tutor positions occurred initially in the College of Nursing from 1964, when the first black nursing students from the Department of Nursing at the University of Natal (Durban) graduated with Diplomas of Nursing Education. By 1972 tutors and white nurses in senior positions were encouraged to transfer to white facilities, a process facilitated by a high vacancy rate. This cleared the way for the advancement of senior black nurses, who increasingly worked their way up the promotional ladder from the ward level (as SPNs) to matrons' positions (CPNs). White nurses and matrons, who were reluctant to leave their positions, were seconded to Addington Hospital from as early as 1972.[78] By 1989, the nursing leadership was entirely in the hands of black nurses. With the departures of Mrs. Lowe in 1989, Principle of the College of Nurses at KEH, and Mrs. Van Reenan in 1993, the Chief Matron, the racial composition of the hospital leadership was completely transformed.

---

[76] Editorial extract from *The Lancet*, 11 May 1957; "Separate University Educational Bill" in *Natal Mercury*, 8 April 1957.

[77] This information has been compiled from a series of interviews with the Senior Nursing Administrators at KEH, the senior staff and one of the early tutors from the KEH College of Nursing, and from records from the recruitment office.

[78] Interview with Mrs. E.T. Khumalo (5.10.98), who worked as a tutor at KEH from 1971.

5.4   Knowledge and Power in the Organisation of Bodies

In *Discipline and Punish* (1975:231) Foucault succinctly captured the dynamism that exemplifies developing relations within institutional environments and the consequent organisation of bodies when he wrote,

> . . .throughout the social body, procedures were being elaborated for distributing individuals, fixing them in space, classifying them, extracting from them the maximum in time and forces, training their bodies, coding their continuous behaviour, maintaining them in perfect visibility, forming around them an apparatus of observation, registration and recording, constituting on them a body of knowledge that is accumulated and centralised. The general form of an apparatus intended to render individuals docile and useful, by means of precise work upon their bodies. . .

Human relations within hospital environments differ from most institutional settings in that they are guided by an overwhelming moral discourse central to universalist ethics of care that perpetuate notions of efficiency, accountability and quality assurance. The apparatuses Foucault referred to are underpinned in hospital settings by discourses of performance, qualifications and goodness. Bodies are not only rendered docile and useful, they are constituted to project uniformity of purpose and high moral standards in performance.

5.4.1 Training bodies and designating 'space'

As the mainstay of healthcare systems globally, the nursing profession epitomises these parameters by maintaining itself as a highly regulated occupation. Nursing practice is inscribed with an ethos and etiquette that governs interactions with all tiers of health care relations. It is promoted as a discipline, with its own body of knowledge and strategies of power. Thus, it is built on a unitary discourse of purpose. Yet, its constitution is based on discontinuous practices which fragment and categorise, with strict specification of tasks upheld by the regulatory body, SANC, in terms of a discourse called 'the scope of practice' .[79]

Three categories of nurses work within the corridors of KEH. Enrolled nursing (assistants) auxiliaries, enrolled nurses and registered (professional) nurses.[80] The three groups differ according to the length of training, the level of remuneration, and the terms of reference, based on the scope of practice. KEH trains nursing auxiliaries in accordance with its staffing requirements. In 1998, 65 pupil nurses with a minimum of ten years of primary and secondary schooling were screened by recruitment officers, who reported directly to the Assistant Deputy Director of Nursing. Once accepted, one year of training was undertaken on site with tutorial instruction provided by the linked training facility, the College of Nurses. Pupil nurses sign a one year contract with the

---

[79] Scope of practice is designated by SANC for each nursing category specifying the acts and procedures that they are permitted to perform either independently or under the supervision of a registered nurse.
[80] The terminology used in designating nurses has changed throughout the years, thus the names in brackets are historical terms that are still found within the hospital's discourses.

hospital, during which time they are paid. The scope of practice restricts ENAs to designated tasks under the direct supervision of registered nurses. They are distinguished within the work environment from other nurses by a black, round badge worn on their uniforms.

Enrolled (staff) nurses are not trained at KEH, yet comprise more than half of the nurses who care directly for patients at the institution. ENs undergo two years of preparation which accords them some autonomy and authority to supervise and direct ENAs in the performance of duties. The scope of practice stipulates that direction and supervision of their duties are overseen by RNs. They wear white epaulettes upon which the SANC badge is pinned. Bridging courses that enable upgrading of qualifications to that of an RN were introduced by SANC with the initial intention of phasing out this category. According to Van der Merwe (1996:12), the exploitation of ENs' cheap labour informed SANC's decision to rationalise the divisions within nursing. KEH offers the bridging course to a limited number of ENs annually.

Registered nurses are trained following twelve years of primary and secondary education for a minimum of four years, earning either a diploma through a college programme or a degree following university level training. The College of Nurses at KEH recruits up to 80 students annually for their four year programme, which includes the basic general nursing programme with specialised mandatory components, including midwifery, psychiatric and community nursing. Student nurses sign a four year contract and are paid during the course of their college programme. They wear coloured buttons that designate their status as

students in the RN programme and that, according to colour, indicate the year of training. During their training period they are directly supervised by tutors or, on site, by RNs. As RN's they wear maroon epaulettes with a SANC badge and coloured bars that indicate the specialised qualifications they have achieved (navy for psychiatry, green for midwifery and yellow for community health nursing). Once basic general training is complete, RNs have many more opportunities for career mobility, unlike colleagues of other categories.

5.4.2 Distributing, classifying and extracting

Foucault applied the concept of disciplinary power to relational dynamics as a means of illustrating the disjunctures in uniformity used to organise and discipline bodies. The value of disciplinary technologies is based on their efficiency as a means of separating, analysing and differentiating, thus binding

> . . . in such a way as to multiply and use them. . .the
> success of disciplinary power derives no doubt from the use
> of simple instruments; hierarchical observation,
> normalising judgement and their combination. . . (Foucault,
> 1975:170).

As a disciplined and disciplinary profession, nursing is marked by varied autonomies, authorities and dynamics of power within its hierarchy and in its relation to other professions. Table 5.1 illustrates the prescribed order of positions within the nursing hierarchy at KEH. RNs have the most autonomy and varied authority depending on their location within the hierarchical structure. They occupy all of the senior supervisory posts, and thus have access to greater promotional

opportunities than nurses of other categories.

Table 5.1 KEH Nursing Staff by category and year		
CATEGORY (1998 actual and, in brackets, designated posts now frozen)	1995	1998
Deputy Director of Nursing (Chief Nursing Service Manager)	1	1
Assistant Directors (Senior Nursing Service Manager and Nursing Service Managers)	1 6	5 (7)
Chief Professional Nurses	29	34
Senior Professional Nurses	93	86 (88)
Professional Nurses	720	519 (559)
Senior Enrolled Nurses	38	26 (38)
Enrolled Nurses	681	564 (687)
Senior Nursing Assistants	11	(2)
Nursing Assistants	520	264 (337)

Based on data from Administrative Services KEH, 1995 and 1998

The deputy director of nursing is tasked with overseeing nursing services for the hospital and reports directly to the Chief Medical Superintendent. She represents nursing on the many committees that govern and plan the running of the hospital, and represents hospital mandates to her team of nurse administrators. She is directly followed in the hierarchy by a team of five assistant directors whose portfolios are administrative in caliber and site. Until recently the hierarchy was a little steeper, with one nursing service manager directly responsible for nursing affairs (recruitment, allocation, disciplinary processes) and more than six nursing service managers who oversaw patient areas and senior administrative areas. Although that level of the hierarchy has been

leveled discursively, all but two of the original nurses retain similar roles. Thus, of these five administrators the one overseeing the field of nursing has retained her portfolio, three assistant directors still have direct jurisdiction over the three patient-care 'areas' and one oversees administrative aspects related to 'patient welfare'.

A field of regional matrons report directly to the three area directors. These are chief professional nurses who survey particular spaces, and who directly oversee day-to-day operations, patient and staff welfare. The regional matrons act as informational conduits between the directors and the nurses in charge of each ward.

The charge nurses are senior professional nurses who supervise the operation of wards. These nurses delegate functions to their staff, oversee performance, liaise with doctors and supervisors and preside over the care of patients. Professional or registered nurses, enrolled nurses and enrolled nursing assistants form the team of nurses who assume specific elements of care provided to each patient, with the professional nurse designated overall responsibility, according to the scope of practice required. For example, the staff in the Intensive Care Unit consists primarily of professional nurses as many interventions require specialized training and technical skills. Within a general ward, patients may be administered to by each of these categories for different interventions. For example, the PN might hang the prescribed intravenous drug, the EN might record the blood pressure and pulse and

give an injection, while the ENA would perform the bed bath and feed the patient. The 'scope of practice' discursively arranges, divides and orders skills and tasks.

The professional or subprofessional category dictates, in theory, the scope of practice and procedures they are licensed to undertake or supervise, while the strict hierarchical arrangements mark their station, their level of decision making rights and their command or subordination to others within their spatial environments. The discourses that underpin notions of hierarchy, scope of practice, and ethical conduct prevail yet, in reality, there are many inconsistencies and cracks in the veneer that confound this 'order'. Chronic and marked shortages of staff and operational funds, dysfunctional communications at all levels and within all spheres, and low morale are apparent, both within the historical documents and subsequently during personal encounters and interviews.

5.5 The Discourse of Allocation

Foucault uses the example of panopticism in describing the gaze as a means of centralising power to survey, monitor and control. The gaze fundamentally operates to induce a 'state of conscious and permanent visibility that assures the automatic functioning of power' (Foucault, 1975: 201) and the 'government of bodies' (Turner, 1992:21). It operates through incessant recording, through the registering of detail.

Within KEH this is most clearly found within an apparatus aptly named 'allocation'. Allocation is a site and a process. It is the first physical site encountered as one passes through the front doors of the administrative wing. It forms the hub, the communications centre, adjoined by three less visible sub-sites. Before extending and linking into the teatment areas of the hospital, several long corridors reach into key administrative networks from this hub, specifically the chief and deputy medical superintendents, the nursing directors and recruitment offices, and the administrative offices of the finance department.

Allocation and its sub-sites are pivotal to communication between the administrators, the hospital and the community. The central hub is staffed 24 hours a day. Three nurses are on duty during the day and two nurses at night. Central to communications are movements of bodies. The nurses on duty survey transfers of patients from KEH to other institutions. They monitor movements from beds, maintaining continuous information on bed-availability. They monitor movements of patients and note those that cause concern (lost and found patients, dead and acutely or unusually ill patients). Finally, they survey the movements of nurses (assigning casual staff, recording sick leave, locating staff and relaying communication to other hospitals). Twice a day the allocation staff process written reports from the regional matrons to nursing directors. At their disposal are forms for every task, registers that record a number of contingencies related to the scope of their communications, and files that hold details of staff, service and

maintenance information. Everything, from staffing lists to reports, are recorded and updated by hand. Centralised computer systems have not infiltrated these spaces.

The nursing allocation office adjoins this hub. It is staffed by three PNs who oversee the designation of nursing staff to wards on a monthly basis. They also assign vacation and study leave to nurses. These nurses are also the keepers of registers. Hand-written lists of nursing complements, numerical rolls, night rolls, change lists, establishment, allocation and sick lists are recorded and fed into different areas of the system. This area links directly to the central hub and to the recruitment office down the corridor. The recruitment office is dominated by a large board covering an entire wall. On this board the name of every nurse is printed on a small block and listed according to designated area of work, category and rank. In theory, as changes are made the blocks are shuffled. In practice, according to the clerks, the system is challenged by ruptures in the flow of communications. The two clerks in this area also manage files and registers. Applications, resignations and recruitment criteria are all attended to without the aid of computers.

5.6   Cracks in the Veneer

This short description provides some insight into the origins and the evolution of KEH. The procedures undertaken for the distribution of nurses as individuals, of their management and their surveillance have

been described to provide an illustration of how nurses are constituted with specific discourses that reflect prescribed bodies of knowledge.

Yet the veneer of this 'pure community', the disciplined society and the discourses and apparatuses central to operations, conceals the underlying disorganisation, mis-organisation and chaos that is exemplified throughout the historicity and present day reality of the hospital. It conceals the anti-humanism born of years of unresolved and contradictory practices evident in the acute shortages of nursing staff, the indifference that has replaced youthful optimism and pride, and the subtle forms of resistance that are reflected by a 20% rate of absenteeism, disjunctures in accountability, communication and adherence to the scope of practice. As one senior supervisor told me, "KEH is unique. We are so huge. We have our own problems".

Chapter Six

Constituent Knowledges

6.1   Introduction

In these next two chapters I undertake an analysis of the many voices heard in the field in an attempt to understand the narrators: their origins as young women, the lives they lead as nurses and women, and some of the scenarios they navigate in the course of their day-to-day experiences. This chapter proceeds with the narratives of four of the women interviewed. The accounts were told by Cynthia Nyuswa,[81] Grace Chiliza, Agnes Molepo and Jabu Ngcobo. These are women whose work as nurses has spanned from 10 to 36 years. Most of their working lives have been spent within the corridors of King Edward VIII Hospital. Two trained at KEH more than 30 years ago in the early years of apartheid. They have witnessed and endured the inequities dispensed by various apartheid administrations, the resulting transition and adjustments incurred through recent strategies to deracialise the nursing hierarchy.

---

[81]

These names are fictional, chosen to conceal the identity of the narrators. Any resemblance to actual people bearing these names is completely coincidental. Further, the quotations cited have been written as they were heard.

The work of the Personal Narratives Group (1989) was influential in developing the narratives. I drew upon their description of a diachronic method, considering it to be a suitable approach to guide the chronological development of these accounts. Flowing in this way the narratives portrayed individual contexts, highlighting the nurses' involvement in a range of scenarios and processes linked to conditions within public, and to some extent, private spheres, structural relations and organisational affiliation. They appear, bearing in mind that these examples must not be

> understood as inflexible categories to which individuals can be reduced. The more we consider context, the more we realise that while the general constructs of race, class and gender are essential, they are not rigidly determinant, (Personal Narratives Group, 1989:19).

This chapter points to the social and experiential realities that influence the subject locations women and nurses occupy, hence the title *Constituent Knowledges*. It is based on the premise that the social contexts experienced throughout the lives of these women and nurses have done much to shape them, their behaviours and responses to the day-to-day.

It begins to examine the range of power relations that provide the points of reference influencing their subject locations as women and as nurses. These narratives depict the lives of nurses and women who are grappling with a range of issues, as both active and passive agents on public, private and collective spheres. The chronologies provide insights into the different levels and intersecting nature of concerns and interests, and provide some clarity into where and how nurses submit to the interests

of other relations, where and how their own interests and needs are articulated and served within the lexicon of relations.

During the course of the field work it became very apparent that a mechanism was required to present some of these unique and compelling narratives, albeit in a partial way. This not only provides evidence of the specific social and historical locations, it illustrates the experiences that resonated, that is, the day-to-day contexts they elected to highlight, and the perceptions of their locations within a number of relational fields. Their narratives do much to illuminate, what Marks (1987) referred to as, the South African condition. Making their lives visible in this way assists to strengthen the voices of nurses in South Africa, who have been hidden from history as a result of their social location within patriarchal and colonial relations (Marks, 1987). Amplifying their voices confronts their enduring isolation within the nexus of subaltern institutional relations.

6.2   *He perceived me not as a nurse, but as a woman!*

Cynthia Nyuswa was a pre-retirement matron who came from the senior ranks of the nursing hierarchy of KEH. Mrs. Nyuswa was the branch leader for SANA and, as such, the intermediary between the professional organisation and the nurses. This interview was valuable as it provided insights into her overall experience, and provided reasons for her affiliation to SANA, her experiences within SANA and views on the unification process.

Mrs. Nyuswa's initial responses during the interview process seemed to be constrained. Mrs. Nyuswa, whose exterior veneer was hardened and proud, initially projected a tone of distrust and unease, yet this dissolved and she responded extensively to the process. Reflecting on her life and experiences seemed to offer cathartic value, an opportunity to reaffirm herself at a time when her achievements had been undermined by the chaos within the health care system and nursing. So although the interview started with a rather rigid exchange of preliminary information, she quickly assumed control of her narrative. By the end, her distrust had evolved to a deep rage, poignant in its sadness and sense of defeat.

Mrs. Nuyswa was born in a township [82] outside Durban. The land had been sold to the community by a white farmer and was divided by the Nkosi[83], allocating plots to families. Her father, a self-employed bricklayer and carpenter, was a religious leader in the community. She indicated that anyone visiting the community had to gain permission from her father to do so. This responsibility conferred him significant status as the primary contact for 'outsiders' within their community, while informing him of social trends that, according to Mrs. Nyuswa, guided parental decisions.

> The priest would visit monthly for community service. He would spend time with my father. He knew our family. The priest advised my father to educate the children. He would

---

[82]

Townships are residential areas appointed to specific racial categories through apartheid policies. Their construction was largely intended to provide a labour force to service industry and trade. In this case, the respondent is likely referring to a rural settlement, land that would have been owned by a tribe prior to the 1913 Land Act, which delegalised sales of land to blacks .

[83] The social organisation of the rural settlement would have been under a chieftainship, an Nkosi, who practiced overall author.

insist on an education.

Educating the children was a main priority that was reinforced for all children.

> As children we would go from house to house selling. The money we earned was saved for food and for our education. When the eldest child was educated as a teacher, he taught the younger ones, until another older one became a teacher, then she took over. We were all educated by these two until we were all completed with our junior certificate.

She reflected a sense of security and pride when talking about her childhood. The priority placed upon their education as a means of improving their life chances must have imparted a sense of coherence and direction that would inform future strategies, as elements of these emerged when she reflected on raising her own children.

Mrs. Nyuswa and her seven siblings acquired post-secondary school diplomas, except for one whom she referred to as an 'ordinary woman'. She did not make reference to preferential treatment along gendered lines when it came to the children's responsibilities in raising funds for education or in teaching the younger siblings. Chores the girls were called upon to do to sustain the domestic productive functions were not mentioned in her testimony.

Patriarchal roles were clearly established in her social environment and inscribed within perceptions of her home. She described her mother as the housekeeper and barely spoke of her. She clearly admired her father whom she frequently mentioned through descriptions of his roles as the moral educator, the community leader, and the conduit to the outside

world. The mother, like her unaccomplished sister, was embodied by a discourse that stratified and located them as 'ordinary women'.

Mrs. Nyuswa entered nursing almost by default.

> My sister had done nursing and, therefore, I was familiar with it. When I applied, though, I didn't know precisely what qualification it was for.

She did not claim an interest in a particular field or occupation, nor did she recount a sense of disappointment in being limited to one of the two career options available to girls of her era, nursing and teaching. Rather, her entry into nursing seemed to mark the successful outcome of the patriarchal discourses and practices issued by her father's, and the priest's, ordinances to educate the children.

Mrs. Nyuswa was accepted to study for a professional nursing diploma at the KEH College of Nursing. She fulfilled requirements for the diploma in four years, at which point she married. In her recollections of her early adult life she reflected on the realities of violence within her new urban community.

> I didn't know Durban. I stayed with my cousin in Umkhumbane (Cato Manor). It was the nastiest place. . .the streets weren't safe.

She described the area and the people as 'nasty', but did not make reference to the socio-political realities of the time that predisposed this settlement to destabilising dynamics.

She described her husband as a labourer, someone who belittled her and refused her the recognition awarded to women who had achieved nursing qualifications in the 1950's and 1960's. As a professional nurse, Mrs.

Nyuswa believed that she should have status, authority,[84] and upliftment from the grinding roles ascribed to women in their day-to-day lives. Her husband's occupation assigned less status than her own, which introduced ongoing tensions between her sense of self as a professional and his social standing as a labourer. She stated that their relationship became untenable. She complained that his behaviour constrained her sense of development and coherence, resulting in what seemed to be an acrimonious divorce and, thereafter, embittered relations. Her marriage eventually failed.

> I was married when I qualified and had three children prior to taking study leave to do my midwifery. . .My husband ridiculed me. He perceived me not as a nurse, but as a woman. . . Once I was divorced, I was able to develop myself.

Her marriage resulted in a clash between two discourses, those of gendered roles: where the dominant marital relations of ruling were patriarchal, buttressed by social practices reinforcing women's subservience to men in domestic and social arrangements;[85] and professional discourses: that designated status, recognition and autonomy. In her response to the tensions between the two subject locations as woman and as professional, Mrs Nyuswa chose to emphasise the latter discourses and practices, rejecting the stereotypical role as a subservient woman.

---

[84] As discussed earlier, and illustrated through the work of Shula Marks (1993, 1994) and Hilda Kuper (1965), gaining professional status through nursing appointed women, in particular native African women, status and privilege that untrained women could not access.

[85] These tensions are effectively described by Hilda Kuper (1965).

Upon leaving the marriage, she spoke of her determination to survive the challenges of single parenting. She aimed to introduce more coherence into her life and into the lives of her children. Within a year she acquired the subsidy necessary to purchase a home. She involved the children in discussions concerning domestic and financial planning and she was their role model in setting educational goals.

> I used to do things in a progressive manner. My own children viewed me as a responsible person. I would plan each year with the children. On payday I would sit the children around the table with the money and the bills. I would show them how much money it took to pay each of the bills. Then I would show them how much money we had left for food. They could see where the money goes.

Once divorced, Mrs. Nyuswa aimed to improve her professional opportunities. She described various certificates and the nursing degree she acquired, and the ensuing career mobility. She set and achieved a number of career goals and raised her children to be responsible, accountable and educated. However, she confessed,

> the problem with educating my own kids was that it interfered with my own studies.

Mrs. Nyuswa challenged many of the social discourses ascribed to gendered roles. She projected self-sufficiency to her family and community and reflected upon her community's responses to her success as a single parent.

> [My neighbours] viewed me as highly responsible . . .a woman in a big house, educating all the children. It impressed the neighbours. They were surprised that I was doing such big things when I was just a single parent. They ended up fearing me. . . Some women saw me [as a leader]. They would come and record their problems.

Although she seemed to feel that she was an anomaly, she valued the recognition and status she earned within her community. She reflected on the ultimate sense of affirmation and victory for having survived the challenges of single parenting and felt vindicated when asked to hire a suit for her ex-husband to wear to their daughter's wedding.

Mrs. Nyuswa worked in various positions and ranks at KEH throughout her career. In the mid 1970s, she became involved in branch meetings of SANA and, in the early 1990s, was appointed Chair of the local branch by the hospital's Chief Matron. In many respects, her affiliation to SANA and her leadership role complemented her need for professional recognition on public and private levels, and placed her in overall positions of authority in the work environment and within the professional sphere.

Her tenure as Branch Chair of SANA occurred in the 1990s when the organisation was confronted by the social and political winds of change. In 1995, SANA was resisting unification with the newly formed DENOSA and losing some of its stature as the national nursing association. With the political shift towards democratically held elections, SANA's short-lived determination to remain autonomous was generally perceived to be reinforcing the oppression of black nurses, for which the Association came under considerable scrutiny. It was also the period when nurses' expectations for relief from the chronically under resourced conditions of labour peaked and exploded into labour disputes, which resulted in the temporary closure of KEH. As a result, Mrs. Nyuswa found herself increasingly drawn into a position that her predecessors had not

previously confronted. The status generally accorded to SANA leaders was eroded by heightened tensions between black nurses and SANA.

The social chaos and, in particular, the inequities within the health care system and nursing, finally pushed the contradictions that Mrs. Nyuswa had tried to ignore to the forefront. The institutional and organisational facilities, once a source of pride and status, were effectively disrupted by nurses protesting about the persistent disparities within them. As a woman with a tremendous focus on succeeding and surviving, she approached the final years of her career thoroughly demoralised, frustrated and bitter towards the players and structures that once sustained a sense of pride and achievement. She concluded the interview in an intensely defeated tone.

> It's hard to be a representative for SANA, this SANA which
> is dropping nurses. . .I feel like retiring. I don't think I'd be
> saying this if there was no labour unrest. . . It will take
> years to understand what democracy is.

6.3 *If you are a professional, you are something. You have got epaulettes. You are better than others.*

Grace Chiliza is a middle-aged single parent, with residual disabilities from a childhood illness that caused pain and significant limping. Despite these and other obstacles in her life, she persevered in her chosen career, nursing. Mrs. Chiliza embraced the opportunity to share her life story, in particular to provide a descriptive account of her experiences and work-based relationships.

Mrs. Chiliza worked the majority of her nursing career at KEH. As a senior staff nurse, she was in the upper ranks of the enrolled nurse category yet subordinate to professional nurses, thus typified as subprofessional. Mrs. Chiliza's life history illustrated the ideals and life chances that predisposed her to nursing. The reality she constructed of her training and of the institutional work environment offered valuable insights into a work force and profession confronted by startling contradictions and divisions.

Mrs. Chiliza was born in rural KwaZulu-Natal. Her father died when she was twelve years old, and by customary law[86] ownership of the family homestead went to the eldest son of the first marriage.

> When my father was there, it was a well-off family. My father was having cows, goats, he was also working and he built a beautiful house with stone, you know those old houses built with stones. So when he died my stepbrother took over. He sold all the things and he sold the cows, he sold even the house. . . and he chased my own mother away from that house.

Mrs. Chiliza's childhood memories were marked by a dramatic shift from being in a comfortable and secure family setting to a situation of financial constraints and loss of home and shelter. Her mother found refuge with relatives and, despite having never worked, managed to finance the children's education by selling second-hand clothes.

---

[86] Customary law was introduced in the 19th century by colonial administrators, and legitimised the subordination of women to the authority of patriarchal family members. Conversely, the relationships of the colonisers came under the legal umbrella of a European-based system. According to Kaganas and Murray (1994:17) customary law . . . necessitated the translation of flexible customary practices into a rigid set of rules which could be applied by the colonial authorities and which, over the years, have been subject to interpretation and evolution at the hands of the courts. Under customary law husbands virtually controlled all aspects of material and legal rights, controlling women's lives within highly unequal domestic relationships.

My mother was selling clothes to support us, buying
second-hand clothes from the Europeans, from house to
house. She educated me until I was doing standard six.
And then after that I was helped by my cousins in order to
get education.

Despite this, Mrs. Chiliza reflected proudly on her childhood as secure and

happy. Her mother featured as a strong role-model in her life, a woman who

managed to reintroduce coherence following the loss of her father, home

and security.

During this period Mrs. Chiliza contracted a disabling disease which

required lengthy hospital stays, exposing her to hospital settings and care

providers. Her exposure to nurses during these years was recalled in

positive terms. She introduced images about the profession and aspects of

caring that she found appealing.

During those days there were European nurses, oh they were
so nice. They have got love, they had love. . .I was so
interested to come and learn to nurse my own people.
Because I saw the nurses nursing me, so I wanted to nurse
other people. . .When I was a child I wanted to be a nurse, but
people used to discourage me, some other people used to
discourage me, no they won't take you because you are
crippled. The sister who encouraged me said, you are a born
nurse, she used to tell me, you are a born nurse.

Hampered by her physical disability, Mrs. Chiliza returned home upon

finishing school, to be employed as a domestic worker for R6 per month.

For a young woman of the 1960s there were few options, due to her physical

disability, racial category and economic disadvantages. Employment as a

housekeeper was demeaning and did not offer Mrs. Chiliza the development

outlet she sought. A nurse, who had cared for her during her hospital stay,

encouraged her to seek nurses' training and, with the support of her family

doctor, she made her way into a hospital setting for training as an enrolled

nurse.

The training experience introduced her to a new world where she was surprised by the harsh, structural dynamics.

> When I was trained it was tough. What can I say, the way we were treated. . .by the seniors. You can feel that you are a junior nurse. . .an African nurse. You can feel it, sometimes you cry. They ill treat you. They ill treat you. Sometimes the sister in charge won't like you. I had one sister in charge, an African sister, who used to hate me. I nearly packed my things and went back home. . .She made me work harder. She used to allocate me in the sluice room. You know the sluice room? I used to work there for the week without seeing patients. She will tell me, oh that cripple nurse.

She characterized the behaviour of the senior nurses to subordinates as harsh and contradictory to previous conceptions of nursing as a caring vocation. Once trained, she worked briefly at the mission hospital before moving to King Edward VIII. Her decision to move was based on financial realities and an interest in broadening her experience.

> I left the [mission hospital] because the money was too little. Then I came here to King Edward. We had to work hard. The money was so little, but it was better than [the mission hospital]. ...and then I wanted to have more experience in nursing, so that's why I decided to leave there. When I came here, I learnt many things.

Again, divisions were reinforced through discourses that emphasised categories and ranks. Nurses of higher ranks benefited from privileges, for example, assignments in preferred wards and better access to the dining room with reserved seating arrangements. Although Mrs. Chiliza often personalized the harsh and abusive dynamics as a reaction to her disability or linked it to racialised practices, she offered an elaboration of the hierarchical code of behaviour that was part of the institutional reality for many nurses.

> They told us that if you are a senior nurse you must show that
> you are a senior nurse to the juniors. But we never did that
> when we were senior nurses. . . The African nurses were tough
> to us. It was like that, it was so bad during our time. . . They
> told us if the senior is coming to enter the door you have to
> stand and open the door for the senior nurse. Even when you
> are queuing for food, we have to allow her to come forward, in
> front of you. . . There was a table for the senior nurses in the
> dining room and there was a table for the junior nurses. There
> were no European nurses. European nurses used to have
> their own dining room, the matron and the principal matron
> and the tutors.

As an enrolled nurse, Mrs. Chiliza was made to feel less worthy by

colleagues from the professional nursing category. Professional nurses

frequently made demeaning comments, undermining her intelligence and

sense of pride.

> Some of the people they are proud that they are educated. We
> [staff nurses] are not educated. We were trained in the
> mission hospitals. As the other sister told me, what are you,
> you think you're a sister, you are not a sister.

Throughout the majority of this interview, Mrs. Chiliza focussed on issues

central to hierarchical relations as it affected her own location, but most

profoundly in the relations between enrolled and professional nurses. She

described the divisions between these two categories as one would describe

the racial divisions enforced by apartheid, as a very destructive reality.

> There is a lot of tension between the professional nurses and
> the staff nurses. There is. They have got their segregation that
> they are sisters. You feel it. You can feel it. Sometimes you
> feel like resigning. Sometimes they will tell you that they are
> better than you. They are professional nurses, what are you? .
> . . As I am telling you that if everybody can be a sister, there
> would be no segregation.

The result of segregated work relationships undermined a sense of recognition for her contribution at work. She sounded demoralized and without options for constructively influencing the relations of power inherent in the overall institutional reality.

> I consider myself as a worker. If you are a professional you always carry that you are professional, you have got epaulettes, you are something, you are better than others. You don't do some of the work. The dirty work is not for you. You will call the staff nurse to do it. She will call me to clean the patient who has messed herself or himself. The staff nurse must go there.

Further to this, she observed the projection of hostilities by nurses to patients in a way that she described as both cruel and humiliating. This resonated at another level upon which perceptions of power and domination worked within hierarchies.

> Some were good to patients. Some were not good to patients. I mean they used to shout at the patients. Shout at a child of four years. "Why are you messing the bed?", you know! Some people are very harsh and cruel towards the patients.

When asked to explain this behaviour, she stated that the majority of women who entered the profession had little choice. Nursing provided a salary and housing during the course of training. Thus, it was often chosen for economic reasons rather than as a vocation by women who had no other option.

> I have been nursing for quite a long time, I can see the people that have got nursing in the heart. . .sympathy, love, you know. Some, they just took this profession because, during our times there were no other professions, it was only teaching and nursing. I'm talking about the old nurses. There was nothing like being a clerk. There are so many courses now, there are so many courses.

For many disillusioned nurses the reality of day-to-day responsibilities limited options for change. Mrs. Chiliza was a single parent who carried the financial burden of supporting her own and an extended family. Time away from the institutional environment was overwhelmingly consumed by the rigours of domestic responsibilities. As her own salary was often insufficient to meet the requirements of daily living, Mrs. Chiliza, like many other nurses, attempted to compensate by working additional shifts, a practice referred to as 'moonlighting'.

> I have got three children and I was supporting my sister's children and my brother's children. There is no husband; the first man I met he left me. He was a policeman and then he was transferred to Zululand where he met another lady. So he got married to that lady. So he left me like that. . .Sometimes I moonlight, but before that I used to buy groceries for R200, and then all the money that I am getting just goes away. I don't bank. I've got no banking. I cannot save. I cannot save at all. As long as they are family, I will support them.

This testimony, indicating the enduring strains as sole provider, was observed in the UND survey (Sitas, et al, 1998) which showed that a high percentage of nurses are single parents, and often the only wage earners within extended family settings.

Mrs. Chiliza expressed concern for the safety of nurses, stating that she felt nurses were increasingly exposed to violent incidents.

> Nurses are not safe now. To be a nurse, we are not safe. I mean the people are wild now even here in the hospital, they can quarrel with a patient and the patient can attack you anywhere outside the hospital or even inside the hospital. It's not a safe profession. I'm telling you.

Like many nurses, Mrs. Chiliza was threatened by the strikes and the impact they had on her public and private life. Within the institution, nurses like herself were forced out of hiding places to join the labour action during

the strikes. Coercion by strike leaders was threatening to her on both public and private levels. Furthermore, as the primary breadwinner, Mrs. Chiliza feared the labour unrest would compromise her position and impair her ability to work and earn a salary. Additionally, the closure of many wards and the social and political response to nurses during the strike, particularly through the media, dealt a harsh blow to the values central to the nursing ethos.

> As I am telling you that our dignity was low that time when they striked. It was not there. The newspaper coverage was bad because everybody was complaining that we are leaving the patients and the patients are dying, that was very bad because we are here for the patients. They look down at this profession now. Our dignity has been lost forever. I don't think nothing can be done. Yah, because you can hear people saying that, "what are nurses, because they can do what, they are educated but they can do what uneducated people can also do, they are just like other people".

Mrs. Chiliza's story introduced issues related to the subordination of nurses within strict and complex hierarchical relations. Hierarchical practices offered a range of sites where relational and structural dynamics occurred and integrated into the day-to-day system of caring. For Mrs. Chiliza, this constituted a significant variance to the ethos of caring central to her own notions of the vocation.

As an enrolled nurse within institutional and organisational spaces, Mrs. Chiliza had few career alternatives and little resolution to the workplace tension. Her sense of safety and security was impaired as she felt vulnerable to the hierarchical dynamics and to the chaos that escalated in the workplace during the period of labour unrest. Significantly, financial constraints and her domestic responsibilities presented little opportunity to

seek alternatives. As a final insult, the labour unrest disrupted the sense of dignity she had earned in her public life and the pride that she held for the profession.

6.4 *They used to say from the grapevine, I am a challenger. They would not mistake me.*

Agnes Molepo, a senior nurse working as a front-line manager, embraced the interview process as an opportunity to tell her story. She was direct and her contributions resonated with charm and composure under a formidable veneer of control. As with many of the narrators, her story showed a dynamism that seemed to be central to her determination to be successful within a chaotic world, as well as the poignancy that comes from feeling the lingering presence of defeat.

As it was in Mrs. Nyuswa's childhood, Mrs. Molepo was taught at home by siblings until she was old enough for secondary school. Then she continued her schooling while boarding with members of her extended family.

> I started schooling in a rural area where I come from. We used to have our classes under a tree in our home where my sister used to teach us and later on, when I reached standard two, I was taken over by my aunt. She was a nurse married to the principal of the school. There I stayed until I was doing standard four. When I was taken over by a cousin of mine, who was married to a doctor. I had to live with the family. I stayed there until I was in standard seven and then they had to go away to do their internship. Then I had to go to a boarding school.

Mrs. Molepo made reference to family members whose status as nurses, principals, doctors and interns earned them the distinction of being professionals. This seemed to make her feel proud. Her focus on achievements that set her apart from her peers in secondary school was

recalled in the same way.

> What is remarkable about my stay as a student there [is that] I
> was a prefect. I used to play a piano. For our final exams, I
> was actually the person they gave a piece and I played that on
> the piano. I used to come up number one. In sports, I was
> involved in field events: discus, shot-put, tug of war. I was very
> tiny, but I had the know-how in throwing a spear. I am very
> good in throwing that.

She trained as a teacher while at boarding school but submitted an

application for nursing during this period.

> And while I was there, I applied for nursing with a friend of
> mine and then I forgot about it, [while] I went into teaching. I
> completed and taught. When I was still there, a note came from
> this hospital stating "are you still interested in nursing?" Oh! I
> couldn't believe, I'm going to leave teaching, because I was
> earning so little. Little did I realise that in the coming year I
> was going to earn even less.

Although aware of her limited occupational options, Mrs. Molepo indicated

that neither nursing nor teaching were professions she aspired to or which

she felt a 'calling' for.

During the course of the interview, Mrs. Molepo did not frame her experience

in the larger social context that influenced nurses' realities. Rather, her

focus was on her own achievements within nursing and the obstacles that

she faced in the process of developing her nursing credentials. Interestingly,

the comment noted above regarding poor salaries in nursing was the only

time she referred to a chronic issue for nurses.

> I went straight into training sessions when I came to King
> Edward and I found it super. I got all my practicals . . . From
> there I went on. It was nice. I was good in my practicals until I
> completed my studies. And you know in the apartheid era we
> were not allowed to complete our course and immediately go
> into midwifery. We had to go and suffer a little bit. I don't know
> what was the aim for that. So I worked in Zululand for about

three months. Fortunately I was in the teaching department
and I produced seven honours and PTS nurses with the staff
nurses I was teaching. Then I came back to King Edward to try
my luck with midwifery.

Apartheid was not represented or analysed within the context of nursing or

racial differentiation, rather it presented as an anomaly that she

acknowledged and circumvented while setting career goals.

Mrs. Molepo's ongoing reference to discourses of personal recognition and

achievement was important to note. She entered her career as a black

woman in a space and time when her race and gender were two of the most

suppressed (and oppressed) categories. She worked within a patriarchal,

bureaucratic environment where the subservient role of women was, for the

most part, an unchallenged reality. Yet she represented herself as someone

who moved forward with considerable determination and autonomy in her

field and with recognition from colleagues.

> While I was there, we had ladies who were teaching what we
> call Clinical Care Administration as a diploma. They came to
> the labour ward. They were teaching some students there and I
> went to them and started asking questions and then she said,
> "why aren't you [in a more senior position] because you are so
> good". I said, "But you know the chain of command. How long
> [will it be before] I am going to reach that? Maybe somebody
> has not seen the potential in me. Once they see the potential,
> I'll be offered to do that".

The nature of hierarchical relations emerged as she recalled the challenges

to mobility within the institutional environment. Whereas recognition was

provided by the matrons, other forces were at work to obstruct the options

she pursued. Her resolve to overcome these forces was illustrated in the way

she constructed a number of these scenarios.

I was sent to the general side. They took me on in the pediatric
ward. Oh, it was nice. The matron used to come in there and
say, "oh, I don't even have a problem of going right in, I know
things are running well here". And, after some time, a post was
advertised for someone to do a pediatrics [course]. I applied.
I'm trying to tell you of the suffering that I've gone through
here. I applied and my name was up because I had the
potential. Because of somebody else who said something, I was
removed and somebody else's name was put in. And you know,
what the grapevine is. It leaked that my name was removed.
Then I was removed from pediatrics over to the surgical block.
I enjoyed myself here, because I understood the leadership
roles.

She described the hospital setting as a neutral site where forms of identity

did not cause tensions or interfere with working relations. In a country

where racial, cultural and ethnic identities were the source of considerable

violence, it was a striking point to make.

Here we meet under one banner. We look at patients and
nothing else. As nurses, although we have those cultural
backgrounds behind us, we look at a patient as a unique
individual who have come to us without a background.

About 20 years into her career Mrs. Molepo started moving up the career

ladder to more senior positions. Her marriage,[87] described as highly abusive,

had come to an end rather traumatically. It was difficult to understand

whether the stressors within her marital relationship related to a clash

between Mrs. Molepo's status as a professional nurse and with that of her

gender within a patriarchal home environment. While it became apparent

that her marriage had not been an easy or a happy experience for her, its

termination was met with investing in her own development. She made the

decision to 'improve herself'.

---

[87] She described details of her marriage outside the interview environment once trust had
formed in our rapport. She, however, did not seem to intend to include this as part of our
formal discussions, thus the details will not be elaborated upon here.

Then I looked at myself and said I am not old. I don't have a
standard ten. Then teacher-training was equivalent to matric. I
said, let me improve myself. I started studying for standard
ten. The funny part of it was I recruited a friend at the bus-
stop. I said, we are going to do a matric. She said, "no, no, no".
I said yes. We are. The registration stops tomorrow. Can we go
there? We went and they said, "how many subjects are you
going to take?" And she looked at me and said, "six of them". I
said, six of them. The principle was nice. He agreed to six while
others were cut down to two or three. To our surprise I [passed]
with three C's and a D in Afrikaans and an E in my mother
tongue, but otherwise it was too good. We could not believe
these lovely marks. I said, friend, lets go on. We enrolled for
BK, which I completed in 1987, because we had to do it in
tidbits. . .I had done a diploma in Industrial Relations as well,
which I completed last year. I just wrote the exam. I did
Human Resources Management as an extra. Now I am just
loafing around!

With time, Mrs. Molepo succeeded in achieving a senior management post

which oversaw one of the three patient-care areas of this institution.

It was a challenging professional life, if you want to put it that
way. I was expected to go wherever there was conflict; I was
going to be picked. "In the middle of the month you're going to
move here, going to move there." I had to go there in another
department and everything would become calm. They used to
say from the grapevine. I am a challenger. They would not
mistake me. But now, they've ultimately given me the most
horrible department. I'll be confronted by problems where I will
use my psychology. I've not got problems. I let people know
what I want because I don't want it from them. It's the patient
that is demanding. I am not in charge of the people who are
working. I am in charge of patient care. I am supervising
patient care and I made it clear, if only I could chop off their
hands and look after their hands, I'll be the happiest woman.

Mrs. Molepo portrayed the professional nurses subordinate to her critically

and did not acknowledge the difficult conditions confronting them in their

work environments. There was little evidence of consultative practices or a

discourse which embraced and promoted teamwork. Rather, she framed her

supervisory function in authoritarian terms. This in itself provided a

poignant disjuncture that had grown between her and other professional

nurses. Although she made regular reference to her own need for recognition, her behaviour with subordinate professional nurses suggested that she rejected their issues and did not acknowledge their contributions.

Although her earlier experiences illustrated a degree of animosity towards those responsible for obstructing her growth, once she gained seniority she assumed the characteristics central to hierarchical disciplinary technologies, affirming a sense of personal power.

> One of the people who was my role model said, "I was watching you all the time, when these things were happening, you were never discouraged, you were never destroyed. Instead you became more powerful and showed off your way"; and I am now showing them.

Her references to the way that she had been exploited and the "suffering I've gone through" were marked by a deep resentment for the institutional players that had obstructed her potential. Recently, Mrs. Molepo invested tremendous energy in holding a ceremony that marked the contributions of the cleaning staff and the most subordinate of her staff. The ceremony provided her with a forum to demonstrate her own achievements to those who she felt had been and were now unsupportive. It seemed to signal her success in overcoming their attempts to stifle her potential.

> Then last month we had a ceremony, [acknowledging] people that are working under my jurisdiction. It came up tops. It came about when I was looking at my life, at how I suffered with nobody looking at me when I actually had the potential. I had become angry with myself for not having challenged those issues. Here and there I was afraid of the politics because I couldn't challenge some of the issues and could see what was exploiting me. Something was being compromised as far as I'm concerned. What made me think that there was ...anger, that was in me.
>
> Now, I wanted the people in this hospital to realise how much they are exploiting me and I was not going to sit down and exploit other people. I was going to recognise how people are

participating. . . It was super. I dressed in a traditional way. There were speeches. I invited everybody who is everybody to come and see. The chief matron superintendent, the chief matron and her deputy and everybody in charge of the cleaners and what have you. It went on quite well.

So from that I've taught many people that you don't sit on other people. When you go up the ranks you must do so by lifting other people to better ranks. That was the only way I could see that I am not sitting on your potential, I recognise you.

Her ceremony did not acknowledge the contributions and performance of the professional nursing staff. Rather, it seemed to be a demonstration of power and control.

This is how I'm looking at it. Now I'm trying to send a message, that the way I am participating, in anger, I am the happiest woman. Anger is producing an intelligent woman with vision.

Mrs. Molepo's chronic anger was the culmination of years of frustration within a powerful system of hierarchical relations, which often left her feeling powerless. She reflected on the discipline of her era as a practice that "will die a natural death". The new breed of nursing students were considered to be less disposed to accepting the rigours of disciplinary discourses.

As we are growing up and going out, the replacement at the bottom they are the fighters, because they talk. Like if you negotiate for a thing that doesn't work you go again and negotiate, no results, you go back for a third time and negotiate. When you fight, this is how they put it. That was the nunnery type. It will be phased out and we will be left with the challengers.

Like many nurses, Mrs. Molepo was profoundly isolated within her work environment. The professional association, to which she had remained affiliated throughout her career, was noted for the services which she had not accessed.

> I am still a member of SANA at the moment. To tell you the
> truth, I've never probed into what SANA is doing. But one of
> their functions I cherish the most is when you are being sued
> by a patient. The indemnity with the lawyer and the promise
> that you get some money when you are old is another thing.
> But otherwise I haven't seen the effectiveness of SANA per se.
> It's just now and then. And one incident, when a nurse gave a
> patient wrong blood, then SANA fought for this somebody and
> paid the bills. They got a lawyer for her. Besides that I just pay,
> pay, pay. I don't know. Not as an individual. I haven't been a
> naughty person to know.

Mrs. Molepo responded critically to the role of SANA in supporting apartheid

practices, yet she had little choice but to remain a member. She considered

the failure of SANA in 1995 to unite on the behalf of nurses to be

inappropriate, particularly as nurses were not given the opportunity to 'own'

their professional organisation. She related that nurses were not consulted

nor included in decision-making processes. Rather, they were ordained to be

members, which they accepted passively, true to their indoctrination. Thus,

Mrs. Molepo was not actively involved in matters pertaining to the

professional organisation, but did express impatience with SANA's failure to

unite the nurses of South Africa.

> When SANA disqualified black nurses in 1984 that was really
> nasty. It told me that it was the apartheid system that was
> working. You see, if you unite, you'll never fall. But if you are
> divided up, you are going to fall. SANA should have been made
> to transform into what we wanted. We are not united. We
> should have looked at what we don't like and pressurise
> instead of now fighting.

Her lack of involvement in the unification process was illustrated by her

assessment of DENOSA as an organisation with a particular ethnic identity.

In a country where political incentive and behaviour had so often been

associated with racial and ethnic categories, it was not surprising that this

became a source of concern for this nurse.

We don't understand this DENOSA. They are there to earn money or serve in the interest of the nurses. The people at the top seem to be from Natal. Are we duplicating the same SANA? People don't know which organisation to pay their fees to. There is a problem with the way DENOSA is composed, the way it was formed. There are too many from Kwa Zulu, too many Zulu. I must stay with SANA, as I must keep the old broom as it knows all the corners. The new one may break the next day. As they say, better the devil you know than the one you don't.

Mrs. Molepo had been intensely focussed on succeeding in her career, and did so within the bounds of this institutional and hierarchical setting throughout her adult life. The characterisation of herself as a 'challenger' initially seemed to have an impact on nurses at a local level. However, years of mounting systemic tensions, chronic issues and frustration among nurses seemed to diffuse her potential to have an impact. More recently, she alienated herself from the professional nurses she supervised through her choice to neglect their needs for recognition, a frustration she herself raised regularly in recalling her own experience as a professional nurse.

6.5   *All our frustrations, we just swallow them .. at the end of the day we strike.*

Jabu Ngcobo is a professional nurse who, at the time of these interviews, had worked in nursing for ten years. In many ways she represented someone who had survived one of the most difficult realities of poverty. She was a woman who managed to uplift herself from a destitute background, yet now found herself within an institutional environment that she considered to be full of obstructive and destructive elements. She characterized these elements as obstacles to the rights of patients and care-providers to workplaces conducive to good quality care.

Miss Ngcobo's childhood was similar to many of this generation who were thrown into the cauldron of political policy mixed with social, cultural and economic upheaval.

> My home town is at Ositromp[88] Township. It's a location. You know that we've been grouped together and put in locations. I'm not sure of the exact year but close to 60-something, but I'm not sure when. I was born there. It was peaceful but it was frustrating because we were living in shelters. They just put us into a tiled one-room house. Irrespective of whether we had six or ten people we had to share that room and then build another room next to it. So that was the most frustrating part of it all. There was no privacy at all.

In the early 1970s, Miss Ngcobo's father was killed in a car accident. The loss of income and overall family support resulted in a further decline in the family's meagre lifestyle. As the eldest girl, she earned additional responsibilities for the daily upkeep of the house and her siblings, while her mother, despite little education, found full-time employment within the health care system.

> My mother struggled, she wasn't working, so at that time she had to go and seek a job. She was only having standard six, so fortunately for her she managed to get a job in a provincial hospital as a nursing assistant. I grew up in a very difficult situation because at that time it was impossible to have six children and then no husband. The salaries were poor and all sorts of things. I was the one who suffered most because I was the second one. The first one was my brother and I was the second one of my parents. So I was the only one who had to see that my younger sisters and brothers had food and everything. I had to make a point of them going to school. I have to take them somewhere else. So those were the difficult part of my life.

---

[88] Name altered to protect the identity of the respondent.

Despite the social and economic challenges in her day-to-day life, this woman expressed insight into her capacity to alter her life chances to escape poverty. She aptly assessed the frustrations in her domestic reality: loss of space, lack of privacy, declined income, and focussed on strategies for upliftment.

> Anyway, I got my education and I got my standard 10. The very first thing that went through my mind was that after such a difficult life, let me get my education so that in the end, I'll be something, because I can see that people who are educated, they live a better life. So I always told myself, I won't be a maid or something, I must get my education and be something. So I had that motivation in my life. At least if I am educated, I'll be able to help my mother and my brothers and us. So I obtained my exemption in my matriculation.

As for many women in the 1970s, career options were limited due to her racial and economic location. For someone of Miss Ngcobo's background there was considerable pressure to earn a salary as soon as possible in order to contribute to the sustenance of the family. Interestingly, she developed enthusiasm for her second career choice, through the influence projected by the image.

> The two things I had in my mind: I said if I wasn't a nurse, I'll be a social worker or, my last resort, I can be a teacher. It was so difficult for me to be a social worker because I had to go to university. My mother wouldn't have money to send me there so I said the next thing to be is a nurse. Anyway I liked nursing because at that time I even envied the nurses having white uniforms, so fortunately I completed my matric and I was called here at King Edward to start my training.

For many of the women interviewed, the image of nurses in their white uniforms and blue capes represented a discourse of its own, pointing to subject locations of women who had earned status, and recognition and who were in control of their lives and the situation of others. The image was a strong one, signifying power and authority. For Miss Ngcobo the pristine

image of nurses and nursing was abruptly tainted upon entering training.

> Unfortunately for me on my first day when I was a student
> nurse in the ward, I had to take over for the night duty. When
> I go into the ward, the nurse just gave me the valuables. She
> said "we've got a dead lady here...a corpse. Here are the
> valuables...the rings". She just gave it to me like that and went
> away. She didn't even explain to me, I was so shocked standing
> there, holding these valuables in my hand. I was just so
> frustrated.

Her initiation to nursing, a visit to the morgue on the first day, offered her
the first lesson in hierarchical relations and the authoritarian practices of
institutional relations.

> I can say the frustrating thing I observed in nursing is this
> thing of seniority and that when we are new nurses we are all
> being ill-treated. You know all the duty things we have to do
> when we are a junior. In nursing there was a thing of having to
> revenge, saying that when I am senior I will do the same things
> to my junior. For nursing, the ill-treatment was very high
> because the way you are being trained and the working
> situation, you say that "I'm not going to do this when I'm
> senior, my junior will do it". Whereas when you are a junior,
> it's the bad thing to do such a thing. So that was the thing I
> hated in nursing.

In this and the previous excerpt Miss Ngcobo described a terrain where the
relations of power were clearly demarcated by hierarchical discourses. She
expressed disdain for the hierarchical discourses she related. However, she
adopted them, thereby reproducing the nursing hierarchical relations she
criticized.

To this point in the interview, she had described the realities of disciplinary
practices operating to subordinate and regulate her as a nurse. She
displayed her intent to reproduce this with junior nurses and clearly
demonstrated its effect in relations with patients. She expressed some
frustration with the resistance in encounters with patients yet she did not

lose focus on the well-being of patients and the realities of the socioeconomic constraints they face. She indicated her growing awareness of how institutional relations were implicit in reinforcing socioeconomic and racial disparities.

> If we have shortages here at King Edward, we just admit and people end up having to sleep on the floor, on floor beds, under the beds. Only to find that even the foods that they are eating, it's not satisfactory. We end up frustrated, not having enough linen to give these people to wear. You know you dehumanise people, and depersonalise them, because an old man for example from his own home, he is still respected at home. When he comes to the hospital we give him shorts and that's the only attire we give him, and a short shirt that can't even cover his stomach or whatever.

Her sense that the hospital is a site of dehumanising and depersonalising discourses fuelled her frustration. She was frequently confronted by the patients' frustrations with the disparities, and felt responsible for the lack of resources necessary to maintain pride and dignity, and often for their essential care.

> That's depersonalisation and that accumulates in that person. It accumulates and that causes friction now between you and that man because here in the hospital they don't respect people. So all those things you are being confronted with, like the staff shortage, and you are trying to do your best but there are barriers between you and this person and there are things that you can't go beyond to help this person. At the end, you yourself, when you are working hard, people never appreciate it. All our frustrations, we just swallow them.

Unlike the other nurses, Miss Ngcobo made direct reference to the impact of apartheid on the health care system, specifically on questions of access, resources and provision. With poignancy, she painted a portrait of a patient stranded within the hospital setting.

There were so many things structured during the apartheid government that affect black people in so many ways. Here, the patients come from afar. There is no food for the patient for the whole day or even three days. Because we have to report them from here to the X-rays, from X-rays to ultra sound, from ultra sound to ..., then the whole day the patient has to go right around. And the worst part of it is that the patients are here the whole night, whereas our dispensary is closed at 17:30. So from 16:00 hours they are sick overnight, they can't get transport to Kwa - Mashu or anywhere. So they have to sleep here overnight. And when the patients are sleeping over, there's no place for them to sleep. They have to sleep on the floors or on the benches without blankets. We can't do anything. What is sad is the patient says, "We have to go to the hospital to get treatment and when you get to the hospital, we can't get any treatment. We have to wait for the following day for the dispensary to open. All those things are hurting us to watch. Too bad to ask. People are suffering and they can't go anywhere to get help and they don't even know where to go.

Compounding these challenges and pressures was the isolation that she felt as a bedside nurse dealing with disparities and contradictions in her patient-care environments. Miss Ngcobo illustrated this rather graphically when displaying her frustrations with the nursing supervisors, who were portrayed as demanding, unhelpful, and unreasonable in the priorities they set.

And when the matron comes in, she never sees the good things you do. She always looks for mistakes, you're always being accused. You'd phone and say "Matron we are having a problem! We have three nurses who are off sick". She says "where do I get those nurses from?" So you have to work for [those] three nurses. Say you are in a ward with only 14 beds and there are say 44 patients, you are working under stress. You do your work, working very hard and sometimes you might make a mistake, and forget to write a report; she'd say "What are you doing here? Will you do what is important, just leave that one and carry on!" You don't have no time to come back . So I'm being accused . . .

She emphasised the sense of isolation she felt and the heightened frustrations from working within a system which quietly sanctioned ethical contradictions, such as over crowding of patients and under resourcing their care.

> This frustration goes on and on. We don't ever have somebody specifically for nurses where we have to go there and sit there and say "I've got this problem". Or a social worker specifically for nurses to deal with nurses' problems. So I have to bear my frustration. Do a good job, work hard, nobody praises you, but at the end, you are accused, "why are you not doing this? But you can see I have done this."; "Write it down!" All those things makes people frustrated and angry and there's when you complain, nobody attends to your complaint, because they've always said that nurses can't go on strike.

Mrs. Ngcobo illustrated how nurses were stranded and without support within the hospital environment. Her claim reflected the opinion that there were limited options for support from the professional organisations that represent nurses outside the institutional hierarchy. SANA was criticised for its political legacy, while DENOSA was understood to be influenced by a particular stratum of nurses. Neither was considered to be fully representative of nurses.

> SANA was compulsory. If SANA accommodated everybody, maybe it would be something else, rather it operated as an authoritative body. DENOSA started with nurses who were concerned. But, the structuring of DENOSA was wrong. It only catered for lecturers, for the elite, women who are no more feeling the pinch. There is a certain stigma to it. We need to have 'nurses' up there.

As a professional, she considered the contradictions she faced as damaging and humiliating for patients and patient care. Thus, her choice to strike was viewed as a mechanism for increasing the visibility of the issues, given constraints within the system to hear them.

The strike helped a lot. There are things that have been there long. Nurses don't [usually] get to stand. They know we're not supposed to do so. As nurses, it takes a long time for decisions to be made. Management are there in the position, there to make the hospital work, to ensure the hospital is working well. They do stuff to make us feel pinched, to make us feel subservient. They are practising their powers.

From a very young age, this nurse dealt with tremendous disparities that she seemed to be intent to overcome. From her point of entry into nursing, the hospital environment and the hierarchical nursing relations introduced dynamics that were somewhat intimidating to Miss Ngcobo, but which she eventually found ways to adapt. As a young and determined nurse she displayed energy and expressed aspirations to redress issues that presented obstacles to her ethos of care. Her choice to participate in strike action was rooted in her support for raising the profile of the disparities and contradictions within hospital care. Unlike the other narrators in this small sample, Miss Ngcobo felt that the strike had been worthwhile and although they did not succeed in disrupting the dominant hierarchical relations, they had succeeded in giving visibility to their issues.

6.6   Summary: Constituent Knowledges

This chapter presented the narratives of four nurses illustrating the complex relations navigated in their personal, occupational, institutional and organisational environments. These accounts displayed the diverse backgrounds and experiences that preceded entry to nursing and went on to show a range of encounters and dynamics central to their public and private

locations. These testimonies depict the range of power relations influencing many aspects of their lives and interactions. It brings their voices forward to present evidence of the impact racialised and patriarchal backgrounds had on questions of political, economic and social choice, yet shows how the evolving temporal and different spatial terrains nuance choice and perceptions of local environments in these different experiences.

Chapter Seven

Nurses in Institutional Relations:

Practices, Experiences and the Personal

7.1   Introduction

Analysing the failure of nurses to effectively redress chronic disparities in their work place realities at this moment of political transition in South Africa will be taken up by exploring the diverse relations, multiple discourses and practices, forms of domination and modes of resistance or defiance that intersects their lives. This chapter draws upon the voices of all the narrators to continue this process. In essence, three main points emerge. Firstly, multiple, separate and often contradictory experiences and practices inform the circumstances of nurses. These are rooted in the socio-political, institutional and domestic contexts of their lives in South Africa. Secondly, nurses engage in subtle practices to resist the unsatisfactory conditions and contradictions within their institutional and personal realities. Thirdly, despite strategic attempts to redress disparities through labour unrest and the unification of nursing organisations, threads of resistance and subtle forms of defiance in the workplace rarely connected with these two transitional processes. For the most part, nurses retracted, often fearfully, into ethical and moral discourses.

The chapter brings the conceptual framework of context, difference and historicity to the fore in an analysis of respondents' perspectives and experiences within their public and private settings. I start with a discussion of the nurses' lives prior to entering nursing college, which situates the respondents within the historical and socio-political context of South Africa. I argue that their experiences are influenced by various power relations, specifically racial, patriarchal and capitalist relations of power. The next three sections focus on nurses within the institutional setting through an examination of attitudes to care, hierarchies and notions of the profession. I have asserted earlier that these three areas form central themes within subaltern institutional relations of nurses lives and help to reveal ways nurses are both propelled and restrained within fragmented and isolated existences. I introduce comments related to their private lives, as a means of displaying broader considerations that form and drive subject positions.

The final sections examine testimonies related to the inconsistencies in the discourses and practices of their working and personal lives. These provide insights into their attitudes towards resistance. Narrative accounts of the work environment and workplace relationships illustrate the tensions, disparities and frustrations that provide evidence of the attempts by nurses to reconcile their own locations, particularly by adopting resistive practices.

Lastly, discussions regarding the labour unrest and the transition of nursing organisations reflect multiple and inconsistent perceptions and reactions that clearly confounded possibilities for nurses to address their

chronic issues coherently. These sections work together to illustrate the multiple and diverse subjectivities that emerged within this grouping. Evidence emerges of how these nurses contend with and negotiate the difficult and often deflating institutional environment, and how they acquiesce in ways that reinforce the reproduction of constraining power relations.

7.2   The Grounds for Nursing

Nurses were asked to describe their childhoods by focussing on their families, their home lives, relationships and meaningful experiences, particularly those that influenced their decisions to enter nursing. The narrative accounts provided distinct, varied and powerful testimonies. The discourses and the practices they reflected upon fully affirmed their overall locations within highly patriarchal, racialised and capitalist relations of power, although these labels were not applied by them. The narratives described perceptions of nursing and of nurses, and the conditions that pre-empted entry into training programmes. These were termed 'constitutive practices' as they encompassed the range of perceptions, experiences and conditions held by each woman as she headed towards a nursing career.

Origins offer important explanations to how current moments are lived and understood. They offer insights into areas that build an individual's perspectives and expectations, influence the direction life has taken, as well as the outcomes. All of these women were born and raised in areas that were politically prescribed by the evolving policies of apartheid,

where patriarchal systems of control played a strong role. For some,[89] their rural farm holdings were designated by tribal authorities with the primary social relationships played out through patriarchal arrangements and practices. For those living in townships[90], forms of racial policy and control were integral to where they lived.[91] For a few,[92] the memories and consequences of relocation at the hands of apartheid's removals policies[93] were recounted.

All of these women were raised in a country where gendered roles were buttressed by customary law, privileging men to ownership and control of property. Fathers, present during childhood and in roles as the primary earners, were portrayed as authority figures who set the household rules, as well as the moral tone of their childhoods.[94] Cast in the position of decision-makers and role models, fathers who were present in the home were referenced far more than mothers, whose domestic and moral contributions were rarely highlighted. References to mothers were essentially reduced to income generating descriptions, in which they were depicted as "[having] no paying job" (3 2/5), "worked in the home" (2 23/10, 8 1/12), a "housewife",[95] or "never worked" (5 6/9).

---

[89] This included the following: 8 1/9, 8 1/12, 6 12/95, 3 2/5. Narrators are coded according to category and date of first interview, this information being given in parentheses.

[90] Peri-urban areas assigned to accommodate groups of people by race.

[91] This included 2 8/7, 2 23/10, 2 28/7, 2 31/7, 4 3/4, 3 6/9, 6 2/2, 6 12/12, 7 21/5.

[92] Narrators who chose to relate experiences of apartheid relocation policies included 3 2/5, 6 2/2, 7 21/5.

[93] Platzky and Walker (1985:141-2) list 18 major laws that dealt with black land rights and relocation, from the Black Land Act of 1913 to the Laws on Co-operation and Development Amendment Act of 1982. These laws guided and, in the eyes of the National Party, legitimised the designation and frequent relocation of living spaces for the black population. Coercion and co-optation strategies often played a part in achieving the co-operation of chiefs and tribal officials..

[94] For example in 2 23/10, 3 6/9, 3 5/9, 6 12/2, 3 2/5, 7 6/12 and 8 1/12.

[95] This from a number of narrators including 3 5/6, 6 12/12, 6 12/2, 7 21/5, 7 11/95.

Thus, for many, their mother's participation, involvement and concern for their daughter's upbringing did not feature as a strong part of the narratives, and were generally superseded by the roles their fathers played.

During the course of the interviews, many women did not clearly identify with their gendered roles or that of their mothers, nor did they critique the disproportionate power and control that men or patriarchal systems played in their early years.

Where fathers were absent or in situations where fathers played negligible roles (impaired by alcoholism or withdrawn from financial support), the mothers not only featured but were profiled for urging their daughters to achieve financial autonomy. They instigated and supported their daughters' pursuits of career.

> It was a difficult situation. Our father wasn't supporting us. It was our mother which was struggling, even though he was working, he wasn't supporting us . . . because he was a drunkard. It was very, very difficult, but my mother tried to pick us up. . . My mother used to tell me I must learn something, so in the future I won't get problems, because I wouldn't have someone to support me. I must be myself. (4 6/9)

For most of these women their day-to-day realities were compromised economically. Many spoke about existence on the edge of poverty, which was often linked to the loss of one or both parents, with consequent financial responsibility for large or extended families.[96] Only two women

---

[96] These factors were evident in a number of narrations, including 2 8/7, 2 31/7, 5 6/9, 6 2/2, 6 12/2, 7 6/12, 7 11/95, 7 13/12, 8 ½, 3 6/9, 3 2/5.

claimed to come from backgrounds of financial security, consolidated in a solid family experience.

Many references were made to hardships and struggle as a consequence of racial policies. Whereas very few women commented on the political directions of the country, their jobs or their gendered location, many had vivid memories of how political forces affected their lives. For example, land policies defined where they were raised and where they could live. In several of the testimonies, 'forced removals'[97] introduced instability yet were endured. Others faced the havoc of losing space and security as people were relocated into their reserves. Memories of social instability within peri-urban areas were frequently recounted, yet often not linked to racial inequalities or political control.[98]

> Families moved into the area so we had smaller plots to farm. People were too close. Our animals were lost, sold and vanished. Mother was told that people would be moved in. People came and spoke with mother and other neighbours. Many people were allotted land. Those who people thought were witches were not allowed to stay. (3 2/5)

> My brother was stabbed to death at home. . . Well, as I say, there was a lot of unrest [in Cato Manor]. How can I call it in English. . . people were misbehaving. They were killing each other. The police were working very hard and they were really doing their work. . . There was a lot of misunderstanding and hatred between people of the community and the police. . . Cato Manor was corrupt, you

---

[97] Relocation, removals and resettlement were all terms used to describe the National Party process of reclaiming land. Forced removals was often the term applied to illustrate the coercive nature of these acts that characterised the apartheid system (Platsky & Walker, 1985).
[98] Reference frequently made to levels of violence within communities: 8 ½, 8 1/9, 7 21/5, 7 1/8, 6 2/2, 4 3/4, 2 28/7.

see. People kill tsotsis, gangsters and pick-pocketers. . . We were removed by law. All the people moved to either KwaMashu and Umlazi and I think we are happy because we improved our lives and living conditions. In Cato Manor there was one big room and we'd separate with big curtains. (7 21/5)

I was born in KwaMashu. We stayed there until 1987. . . It was affected by riots. During the nights we used to stay with my cousins. . .They would come and get all the men to come out. You would have to belong to certain political organisations and if you didn't your life was in danger. About four houses from my house they burnt the house because the man in that house belonged to Inkatha. It was an ANC area. The police used to come and they would throw tear gas at us and rubber bullets. And then I had to move from the school in that location. (2 28/7)

It was evident from the narratives that racial policies assumed a variety of forms and left a range of consequences, including those that influenced choices to enter nursing. For the majority of the respondents, entry to nursing was a consequence prescribed by interconnections of gendered, racial and economic constraints, not the result of a 'calling'. For only two of the nurses interviewed[99] nursing was the chosen field they grew up wanting to pursue. Both these women were raised in farm settings where life and production were hard and precarious, even though their fathers were employed in trades, supplementing the farming income.

---

[99] From 7 6/12 and 5 6/9.

For five of the respondents, the inclination and motivation for 'caring' was related to exposure they had to chronic illness and death as children.[100] Although claims were made that they did not have a strong desire to be care-givers, it was a role often assigned to them as young girls.

> My grandmother was always sick, I think she had cancer. We didn't know it was cancer. She had a lump growing in between her breasts and every time she had an operation it would grow bigger. I think she died of that. I used to take care of her because I was the youngest daughter, until she died. (3 5/9)

For many girls, nursing was considered the right thing to do as it responded to what Gilligan (in Bowden, 1997:6) identified as a characteristic 'voice of care', a caring perspective informed by a strong sense of morality and concern that translated into taking responsibility in interpersonal relationships. As this woman expressed:

> When I was young, I used to look at my parents, and my parents then, they were old. Even now they are still old, but when I was a child I used to look at my parents and they were like granny and grandpa in today's world. . . And I always thought, when I grow up I want to nurse my father and Mum. I don't want them to suffer. Whenever I came to the hospital with those long queues, people having to sit on the benches for long hours, not being attended, I said no. . .So I thought, maybe if I may become a nurse I may make a difference to the public. Maybe I'll be a nurse who will be kind; to be a nurse that is willing to help to go overboard to help the community. (2 23/10)

---

[100] Narratives of 2 23/10, 3 5/9, 6 12/12, 6 2/2 and 8 ½, referred specifically to illness or loss in their own families as a motivating factor for nursing, while a number of others reflected on notions of caring in generally altruistic terms: 3 2/5, 4 6/9, 5 6/9, and 7 6/12 as suitable explanations for entering the trade.

For most of the respondents, entry into nursing was a decision made by default, as they acknowledged that their options were limited to either nursing or teaching. A number of obstacles presented for those whose aspirations were set on different careers. For example, the perspective of this woman's school official determined her career options, despite her own goals.

> No, my career was an accident. My dream as a child was to
> be a dentist. This came just as an accident because I didn't
> get the university entrance, or whatever. I disappointed my
> father by not going to university. He had really been let
> down. . .[My father] had already found out from the
> principal. . .and, the principal told him in no uncertain
> terms that I would not produce the material. So that was
> the thing. . . So that's what I did. I applied for nursing and
> came here. My older sister was already a nurse by that
> point. My idea was health related. I didn't want to be a
> teacher or anything. Those were the two options. I had
> never thought of [nursing] before. There was no calling. (7
> 1/8)

Most made reference to financial insecurity as the factor that led them to nursing.[101] This, coupled with the practical reality of receiving a salary while training, influenced their choice of nursing rather than teaching.

> My father had been ill, so we had no funds [for studies].
> Living was hard. Nursing education was free. I was earning
> a salary and was able to support myself and my parents. (7
> 11/95)

The younger generation of nurses, aged between 23 and 30, acknowledged greater choice in career options. Yet, almost unanimously, their decisions to enter nursing were based on monetary realities. They came from impoverished or financially constrained family environments,

---

[101] Financial circumstances influencing the choice of a nursing career featured in the narratives of many nurses : 2 8/7, 2 31/7, 2 28/7, 3 2/5, 3 5/9, 3 6/9, 4 3/4, 4 6/9, 3 6/9, 5 6/9, 6 2/2, 7 21/5. 7 11/95.

where a primary reason for entering nursing was to achieve a career while being paid.

> I definitely wanted to be a lawyer from standard four or five. My uncle was a lawyer here in Durban. I can say he was my inspiration. He was a general lawyer, practising in town. My family supported me. [They] tried their best to educate me. . .I was actually very good in law for the two years I studied. My parents wanted me to continue with my studies. They said that you needed to be educated. My dad wanted me to be educated, independent and to have opportunities that he didn't have. . .My father died. My father was the most encouraging about ongoing education. . . My mother wasn't coping very well financially. I had to make a sacrifice. . . I tried to apply for loans. I couldn't succeed. The place where you can study and not pay is only nursing. So it was nursing or being a police, and I didn't want to be a police. (2 28/7)

Most of these women were compelled to send their salary home to support their families.

> When we grew up it was unfortunate, as you know, that we didn't have a mother and [my father] was fighting to support us. . . We learned from that, okay, we don't have to depend on somebody else, we have to strive for our own good, to get something that belongs to you. . . My first choice was social work, but we didn't have the money. I found that in nursing, every month you used to get paid something. So we have to support home, we have to do some things with that money, as compared to social work, who don't get anything. (2 31/7)

Notwithstanding their reasons for entering nursing, the symbolic appeal of the profession and reference to nursing and nurses in iconicised terms recurred regularly during interviews with women of all ages and professional categories. These references frequently consisted of terms that suggested control, certainty, confidence and a sense of direction.

This was most poignant in the following narrative from a woman whose family lived in impoverished farming conditions following the death of her father. Thereafter she and her family experienced apartheid's policies of forced removals, resulting in the loss of land to a number of relocated families.

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

Nurses were admired for their pristine appearance, but also as women who represented financial control and opportunities:

> What I admired of nurses was the uniform, the cleanliness. I used to tell myself that if I was a nurse, I would have my own monies. . . Anyway I was dreaming of having all of the things that I saw other people who were doing nursing having. There was a sister who was living close to my auntie's place and she had a car. Till now I have no car and I don't think I will have a car. (3 5/9)

Mirrored in other women's comments is the notion that the image nurses project is intertwined with notions of altruism and caring, linked to financial autonomy.

> I just wanted to serve the community and care for sick people. The only other option was teaching, but standing up before the children, talking a lot, is something I hate. By that time I thought nurses were getting lots of money. . . Seeing my mother in a white uniform and a cap. I would say, one day I will be a nurse. I was impressed by my mother's uniform. (4 6/9)

The narrators' origins, within a historical and socio-political context influenced by the nexus of racial, patriarchal and capitalist relations of power, were instrumental to their eventual career choices. The circumstances that unfolded as segregationist policies and practices

permeated their rural, peri-urban and urban realities generated varied experiences and perceptions of difference and disadvantage. The relations of power instrumental to *constituting* subject locations in connection to gender, class and race underpinned many of the explanations around why these women entered nursing. Being a woman, being African, being poor worked separately and together in influencing their entry into the profession, while informing their aspirations within the profession. For some, the hopes of escaping poverty and improving their life chances within a 'dignified' profession featured. For others, their gender and racial location precluded other choices. For still others, the salaried training programme was the only way of combining their pursuit of qualifications with their financial obligations. In many cases, these three facts intertwined to influence their choice.

7.3   The Practice and Experience of Nursing

This section of the analysis explores the narrative accounts from the point of leaving home to take up mandatory occupancy in the nurses' residence for training, to their experiences as practitioners within the corridors of this monolithic space. The period of nursing training and practical experience spans 39 years, from 1960 until 1999. This time was circumscribed by the social and political era of apartheid, when racialised policies and programmes of separate development and maldistribution reached their greatest intensity. It involved the uprisings of the 1970s and the dynamic resistance of the 1980s, to the period of political transition marked by the

release of Nelson Mandela and the unbanning of liberation organisations in 1991.

This section considers the main discourses and practices reaching nurses within training environments and in clinical settings. The narratives, depicting nurses' caring practices and their experiences within hierarchies and professional sites, point to the impact of socioeconomic and political disparities on clinical environments and to the chronic disparities experienced by nurses.

7.3.1 Motifs of care

The accounts nurses provided of the 'care' administered in their roles as healthcare providers, their capacities to 'care', the perceptions of how they were viewed and treated as 'care-providers' contributed important evidence of the disjunctures between the discourses and practices inherent to their work. As noted in chapter two, 'care' is a prime operative discourse mobilised throughout nursing. It served to distinguish nurses from other members of the health care team. The interviews in chapter six gave some indication of the pride, commitment and determination nurses brought to their roles and responsibilities as care-providers, a finding that echoed throughout the exchanges with all the respondents.

Perspectives on caring, drawn from excerpts of professional and subprofessional nurses working at the bedside, generally embodied a sense

of morality and genuine concern for their responsibilities.

> Caring is looking after someone wholeheartedly, not just because you are going to be rewarded, but because you have feelings for someone, and because you want to care for someone. It has to be from deep down in your heart. (6 12/2)

> Caring to me as a nurse, it's like when you have peace in your heart, you are able to make peace with other people. And if you are a nurse, and you are happy, definitely you have that inside for putting yourself in somebody's shoes when he's having a problem. . . you have to put yourself in his or her shoes and treat her like that. (6 2/2)

> When a patient is sick there are a lot of things they cannot do for themselves, which you need to do. Which means you must always be near her, and listen to what she's saying, so that you will always be able to fulfill her needs. (5 2/6)

Nurses are guided by regulatory mechanisms aimed at ensuring good practice. One example of this is the nursing process, a method of planning, organising, implementing and evaluating care to patients. It can also be viewed as a discourse reflective of the 'justice voice' of care (Gilligan, 1982), as this nurse noted.

> If you really follow the nursing process, you care for the patient according to the patients' problems. It's individualised. Like, you look at myself and say, I have one, two, three, four problems. You plan your nursing care according to my problems which I have got. . . if you plan, you have to put it down. [Let's say] Mrs. X has so and so problems, maybe she is sweating. The only way is to plan and write it down. After writing it down you go and do the nursing interventions, and once you have the results, you go and write it down. After writing it down you go and do the nursing interventions, and once you have the results, you go and write it down. . . For you legally, you are covered because it's written that you've

done it. (6 12/2)

Their testimonies ultimately indicated caring as a practice constituted in the relations of response. Whereas the nurses' primary focus was upon patients' requirements for care, the expectations of doctors for nursing assistance and the hierarchical location within the nursing ranks influenced nurses' responses. Most testimonies highlighted the constraints and barriers that impacted upon capacities to care, as well as noting how their practices evolved with time.

> It's not like before. We are working very hard. Sometimes we don't get what we should be getting. . . there are those things which make us uncomfortable when we work: hard-working conditions, shortages, no compensation . . . (6 12/12)

> As a nurse [caring] is difficult to achieve, because of the circumstances surrounding our working conditions. Firstly, because of the shortage of nurses; you know, if you want to provide that very care, the proper care, it is so difficult, because we are so short. You have to look after so many patients. So it's difficult to achieve. You just give the care you can at that particular moment, but you don't give the proper care which you were taught to give. We were taught that you are supposed to do things: one, two, three. The caring we do, when it comes to practice in the clinical situation, is something different. There is a shortage of staff, a shortage of equipment, so you cannot do things that you were taught. You have to improvise. You have to prioritise, you have to do what you can do and leave out the rest. (6 12/2)

The dysjunctures between what was meant to be done, the way of doing it and individual / collective capacities to fulfil responsibilities heightened vulnerability. Interestingly, these circumstances induced resistive, self-

protective practices, as noted in the next excerpt:

> So what we do mostly, you look at Mrs. X and her problem at
> that particular time, and you just don't plan on the paper. You
> just look at the problem and you solve the problem. You have
> no time to write on paper. After two or three minutes, you just
> go and check what the outcome is. But if anything goes wrong,
> as long as it is not written on paper, you didn't do it. . . so you
> don't want to get in trouble. So you write it down, and
> sometimes you don't even do it. You get my point! (6 12/2)

Although the notion of caring was projected as central to nursing, many

practitioners did not feel acknowledged for this contribution. Rather, a

sense of isolation within the workplace was reflected in their interactions

with other healthcare practitioners. Although there were exceptions noted,

when asked whether doctors viewed nurses as caring, nurses' comments

held these sentiments:

> Yes, I think so. Some of them. Others are always saying a lot
> of things. Like saying you are not working, you are not doing
> this. Because, problems we have, definitely, because we are
> short staffed. Because if there is one problem they just take it
> as though we are not serious. (5 2/6)

> Hey, they don't treat us well. They are rude. They expect
> wonders from us. It's very bad. They don't treat us as people
> who are professionals. As I have these white epaulettes, I am
> proud of them, but they do not treat us as people who are
> professionals. They just look down upon us and say whatever
> things they like. Even if a doctor talks with you, you can feel
> that, 'hey, this one is very high'. . .I once quarrelled with a
> consultant. He wanted KY jelly and KY jelly was out of stock. I
> told him it was out of stock. He quarrelled with me. . .
> sometimes they don't believe us if you tell them that we don't
> have any equipment. They just take it that we don't want to

look for it. (5 2/6)

> Most of them don't take us as their colleagues. The training
> might not be the same, but if we can compare, we can take the
> consultants [as] equivalent to the senior sisters, the registrars
> with the professional nurses, interns with the other categories
> of nurses because they are also entering and they can't do
> what / what. When the interns come for practicals we do
> guide them and most of the time they are with us. But when
> they go up the hierarchies becoming registrars or senior
> interns, some of them look down upon nurses as if they can't
> do anything. They don't take that we must work together . . .
> rather, they shout at us. When you explain to them that it
> doesn't go like that, we must work together, we are just a
> working team; not that somebody is a boss, or somebody is
> inferior. Here at work because we are fighting for one goal, we
> must work together. (6 1/7)

Nurses found themselves in the awkward, and disheartening, position of

being berated and denigrated by doctors when unable to respond to their

expectations or needs. Doctors seemingly focussed on the immediate

context without acknowledging the wider issues that served to constrain

nurses in their work environment. As noted elsewhere in these narratives,

this position was frequently reinforced by unsupportive matrons.

> The doctors become very furious. They don't understand that
> we can't carry out the orders because we don' t have the
> supplies. Sometimes they want to see the matron. The matron
> will come back to the sister in charge and confront her,
> although she knows that we have a shortage of the nurses or
> supplies. (6 12/12)

> If there is an order given by the doctor, like he might say, give
> lasix to the patient and I say, okay I'll give it. When I'm trying
> to take it, someone calls me, "do this", "or that", or "this was

not done". So you end up forgetting that you were supposed to give that lasix. When the doctor comes, he will say that you are not doing your job properly. Even if you try to explain, they don't understand. It makes me feel very bad, because if we were not short of staff, maybe I would have been able to give that lasix. Not giving the lasix could complicate patient's illness, so it affects the patient. (5 2/6)

The majority of nurses viewed doctors as their equals, colleagues within the healthcare equation. Yet, doctors' attitudes and behaviours toward nurses contributed to the day-to-day tensions nurses were juggling.

According to the nursing and doctor relationship, according to how it's supposed to be, we are supposed to be colleagues in the sense that we are all there for the patient. We are all working for the patient, for the benefit of the patient. That's why we are all there in the hospital. You find that there are some doctors who would take nurses as their handi-maid. They push you around. . .As colleagues you are supposed to talk to each other nicely. . . but doctors push nurses around. . . sometimes the nurses just keep quiet and they just take it as it comes which is wrong, because doctors are just colleagues. (6 12/2)

The general perception that their status and recognition within the eyes of the public had deteriorated compounded the sense of abandonment and blame felt by nurses. Not only was this view overwhelmingly present within the testimonies, it was noted to be worse since the 1990's. When asked whether the public view nurses as caring:

Nurses are always the blame for everything in the public! The public doesn't appreciate the nurses at all, especially KEH. They also appear in the paper that KEH nurses are like this and like this. You never have other hospitals appearing in the papers. It's because the shortage of staff, shortage of

attention. (5 1/6)

Some understand, but no. It's the way they talk. It's not like it was before. Like we used to wear nurses' uniform with pride. But now there is no pride with wearing a uniform. Maybe if we are in the taxi, somebody starts saying to the person next about being taken to the hospital, and they say bad things. I stay quiet. (6 12/12)

The majority of people don't take us as caring people. You should see what relatives expect nurses to do. I'm talking here about government hospitals. They expect wonders, because they don't know exactly what is going on and there you are three nurses on the ward, and the ward has maybe fifty or sixty patients - then the relatives come along. And, because they don't know your procedures and your routines, they just don't feel that you are doing enough. . . they've got negative attitudes. (6 12/2)

Nurses claimed that race influenced the way they were perceived and treated by the public and other occupations within the healthcare system. Notwithstanding the level of educational preparation and performance, many felt that black nurses were expected to be strictly relegated to manual functions. These feelings prevailed as a source of frustration.

You know, in our black society, it's very funny. If I were to be seen sitting as a black sister, the way that they would feel to see a white sister sitting is different. For them to see a white sister sitting and writing it is acceptable, but for them to see a black sister sitting and writing it's considered unacceptable. I feel it's in us, because most whites they have been seen to be holding the better positions, and blacks have been seen working for whites. (6 12/2)

Nurses freely spoke of the obstacles to care provision that resulted from shortages of material resources and personnel. The difficulty of concealing chronic frustrations and fatigue impacted on the quality of care. Although their aggravations were played out locally within institutional relations, they were often linked to the broader relations of difference, disadvantage and historicity.

> Patients, some of them, they are not pleasant. They do not want to be admitted to the hospital. They say the nurses are rude, [that] they don't care. They always say they liked the nurses before. The nurses now are just nurses by uniform. They are correct, yeh they are correct; some of us, due to the shortage, we've got no time, because they must do the survey, they must do ...[goes on to list the range of duties beyond patient care] The thing changed in 1990. Nurses have changed because there was too much work. (5 1/6)

> When I'm at work I provide the same care, but because someone is behind me and because of the shortage of everything, and the conditions of the ward, I have to just give the care. You have this thing, where you wish you could really give the proper care, but it is really impossible, because there is so much to be done. Instead of saying, let me give a bed bath to Mrs. So and So, that she can be really comfortable; these days, it's let me give a bed bath because it has to be given. Otherwise if I don't do it I'm in trouble. (6 12/2)

> Once you lose kindness, patients don't trust. It's a big problem here. Some people are so rude. Some I've talked to, I only find the problem is at home. They carry over a problem from home and display it at work here. It's very difficult to be a single parent. Paying for a child at school, transport, lunch, the electricity, rent, everything; and without someone helping you it's very difficult, it's difficult. (6 2/7)

Clinical settings were demanding sites where nurses dealt with shortages of staff and equipment, admonishment from doctors, matrons, senior nursing staff and the public. Their attempts to hold true to the ethics of care bore a range of outcomes. For some, there was a sense that a workable team environment bolstered their strength to persevere.

> As I have been observing myself working with these nurses here, always when you are somebody in charge of people, you need to be a role model. The caring is gone, but if you try to bring it back, you have to be a role model. You can't expect them to go into work, in which way do you want them to work if you don't show them how to do it, the best way you want it. Show them how to do, the time you say, you see what I've done, so do as I've done. In that way they see. Because the thing that is killing people is the short[age] of staff. You can even see, they have given me so few nurses, even others are not even here, so they say: "Oh, please try and do whatever". These shortages make people feel unhappy. So if you are there in those crisis situations you can't go in and be functional with them, they become angry. They say, "you can't even help us, now you say do the best, when you can't even give the best". (6 2/2)

> Here we are a group team. Because if the sister in charge says, I'm short here, won't you go. If someone is sick among us we don't hesitate to take that place. (5 1/6)

The energy brought to these statements provided evidence of localised attempts to maintain responsive and a semblance of order. At the same time, the consensus from nurses was that conditions had reached a point where their capacities for maintaining an acceptable ethos of care were significantly impaired. A general sense that their concerns were not validated by supervisors added to their overall frustration.

At the present moment, that caring is no more there. It is no more there. It's very few that are still in that caring mode. But otherwise it's just dead. What has replaced it is just anger, frustration. I mean maybe it's because of changing circumstances or at the present moment the socioeconomic part of the world is just like that. Really caring in nursing is no more there. It's just dying away. At a meeting I told this matron that if they can design something, in-service, or do something for the nurses to bring back the caring part of it. It's just dead. . . They say, thanks, that's a good point. (6 2/2)

By way of summary, most nurses considered 'caring' to be the main ingredient of the unitary practice of the profession. Notions of nursing as a profession encompassed altruistic terms, centering on discourses of 'caring' for most nurses interviewed. Yet perceptions related to caring: who cares, how care occurs, where nurses of various categories are placed vis-à-vis caring, varied and generally contributed to views of themselves as professional care providers, as overseers of caring, or as care-givers as workers.

It is well-established knowledge that conditions in the public health sector facilities that were historically designed to service the black population impaired capacities to care. Nurses repeatedly noted the progression of declining conditions from the early 1990's, linking their observations to the changing socio-political terrain in South Africa. These testimonies reflected chronic issues not yet redressed by the new administration and pointed to serious institutional problems.[102] Emphasis by the new Government on

---

[102] Most recently reaffirmed by Prof. Peter Cooper in "Health care still in critical state". Weekly Mail: August 6 to 12, 1999.

shifting resources to a workable community-based primary health care system since 1994 translated into few remedies for the critical conditions within these environments.

Nurses' frustrations to the obstacles to care were rarely acknowledged by other members of the medical team. Nurses felt blamed for failing to provide adequate care resulting from shortages of equipment and staff.

Most nurses acknowledged that the quality of nursing care at KEH had deteriorated, a situation which resonated in nurse-patient, nurse-doctor, nurse-public relations. They responded to this reality with ambivalence and concern about the compromise to patients and with interest in strengthening their roles and responsibilities for the general well-being of the patients. Generally, nurses felt isolated, disillusioned and demoralised in their ongoing attempts to care.

> The public don't view nurses as caring; not at all. But, there is something funny. Whenever they are in trouble, when they are sick, they want a nurse. 'Where is the nurse!' But when they are outside they don't care. . .they are saying [nurses] are just doing nothing. Just walking up and down. To them we are doing nothing. (6 2/2)

7.3.2 Indoctrination to institutional hierarchies

This section examines nurses' testimonies regarding indoctrination to hierarchical relations. Since the 1970s, changing institutional relations of power increased educational opportunities and the integration of black nurses into positions of authority (Marks, 1994). Notwithstanding the changes, the narratives provided ample evidence that nurses treaded through a number of intersecting, yet distinct hierarchies: those established within institutional relations with the medical profession, the nursing services, and, as exterior regulators, the nursing council and professional association. Manifest within these were the imperatives of gender, race and class. The changing dynamics and the rigidness of these hierarchies informed and reinforced disciplinary technologies that could be viewed as central buttressing elements of nursing and hospital hierarchies.

Set within this terrain were the novices, women entering nursing from different eras, histories, backgrounds and predispositions to the occupation. Their educational process and clinical training, leading to subprofessional or professional nursing certification, evolved through a series of discourses mandated by the regulatory body, SANC. The training process prepared nurses for hospital relations and predisposed them to divergent subjectivities, shaped by the multiple discourses influenced by their occupational category. The women who underwent educational and situational instruction during the late 1950s and early 1960s experienced the changes resulting from the 1957 Nursing Amendment Act that

segregated the profession. Nursing militancy that flared in response, primarily among black nurses, was quelled following the Sharpeville massacres, as the regime and its supporters in nursing showed less tolerance for dissidence. Nurses beginning their training during this period were introduced to racial divisions and inequities wherein salaries were determined and scaled by race. Nursing uniforms and insignias were racially differentiated as the National Party's ideological practices were integrated into hospital and health care environments. Notwithstanding this, the social location of black nurses within their own communities improved[103] as they represented the largest single group of educated women in their locales, a status which appointed them profound influence in settings where to be black and a woman generally culminated in low status.

The senior supervisory nurses, or nurse managers, educated in the 1950's and 1960's did not dwell on the memories and dynamics of basic training. One nurse provided a somewhat romanticized account as she reflected on the constructive outcomes of that period.

> It was tough in those days. There were no general assistants,[104] so we did all the work: the washing up, nursing the patients, seeing to the visitors, the counselling. Training made us mature. It helped us to grow. (8 ½)

Opportunities to enrol in post-basic training improved in the late 1970s and early 1980s, coinciding with expanding access to senior positions and, by

---

[103] Noted by Hilda Kuper (1965) as well as McLarty (in Marks, 1994:158).

[104] Subprofessional categories of nurses were introduced into the syllabi and practice in the early 1970s.

1978, to undergraduate nursing degrees.[105] Possibilities arose within the hospital for advancement, and as noted in the testimonies of nurses of this era, the additional credentials and higher ranks enhanced their status within communities and homes.

The senior supervisory nurses experienced their college education during a particular period of South Africa's apartheid history. The opportunity for this education offered possibilities for relief from the material conditions endured during their childhood and, for some, hopes for transcendence from the gendered location within patriarchal and racialised home and community settings. Even though this period of apartheid witnessed the growth of dissent and social movements contesting discriminating policies, including some nurses aligned with the South African Congress of Trade Unions (SACTU) and the Federation of South African Women (FEDSAW) (Walker, 1982; Marks, 1994), the nurses in this sample were not among those who joined the ranks of protesters. Rather, they all opted for the possibility of career advancement without contesting the racialised power relations. As Marks (1994: 178) indicated, National Party planners needed strategies that would legitimise their discriminatory laws and did so by linking into existing hierarchical and professional structures of nursing.

---

[105] According to Radloff (in Marks, 1994:266) of the 69 training schools providing post-basic training for nurses in 1969, only three catered for black women. By the 1970s post-basic training for black nurses began to expand, coinciding with the growing need for greater nursing expertise in the public system, a consequence of white nurses shifting into the private system with better salaries and conditions. By 1978, under the leadership of Charlotte Searle, UNISA opened its doors to black nurses, offering access to post-basic degrees in nursing.

This was also evident among professional nurses, many of whom underwent nursing training in the 1970's and the 1980's. There were nine nurses in this category, four of whom underwent basic training prior to 1980. Since training, all of the professional nurses had worked at the bedside, under the supervision of nurse managers and were responsible for the surveillance of subprofessional nurses and students. Of these nurses, three had completed undergraduate degrees in nursing and several had enlisted for post-basic nursing courses. All had completed midwifery in addition to their basic training.

Discussions with bedside professional nurses began to illustrate the formative nature of discipline during their educational programme. For one nurse trained in the early 1970s, discipline was considered to be necessary for engendering 'civilising' practices to replace the 'evil' of their former ways. Disciplinary discourses served to socialize students to a particular code of behaviour within hierarchical relations.

> [The matron] was teaching all the new nurses. She was
> teaching us ethics of nursing. She was a very good teacher.
> She was very strict, so I could say my foundation is very, very
> good. We knew who we were, where we were going. She taught
> us manners, ethics, [that] we must do away with 'evil'. We
> were there for our future. And she was in place of our parents,
> because when the kids are away from home they start doing
> nasty things and we were working for the community and not
> for money. We were paid little, but we knew we were there to
> serve the community. . .When you're talking to an elder [you
> were told] to stand up straight and look at that somebody
> straight, stop fidgeting. And when an elder or anybody senior
> passes, you go aside and let that senior pass. . .I'm a
> professional nurse today because I listened to her. (7 21/5)

Attitudes are very important as a nurse. Nurses should look professional. There must be respect for seniors. . . [We are taught] to stand up and give way for seniors. (6 12/2)

One of the respondents, whose overall comments during the interview were more critical, indicated that her response to relations of authority and disciplinary discourses was reconciled by the promise of material rewards.

We were not aware. The only thing was, we were interested in wearing nice clothes. (7 1/8)

Disciplinary discourses applied during the professional nurse programme enforced their location within institutional relations, shaping ideas and perceptions of themselves in relation to the 'other'. In many respects, the 'other' represented the social backgrounds they left upon entry to nursing, in one nurse's recollection it was the 'evil' to be purged and replaced by the manner consistent with the pristine white uniform. It also represented their prescribed category, distinguished by uniform, roles and relationships that position nurses in relation to others.

Nurses of the subprofessional categories were responsive to this aspect of the interview. They recalled the disciplinary discourses which oriented them to their location within hierarchical and institutional relations. For many of them, the authoritarian relations during the training programme represented their first encounter with what were portrayed as contradictions between notions of caring and caring for the care-givers. As another nurse described,

> We were too scared of that matron. She was supposed to be a
> mother, but she used to harass us a lot. You had to stand
> waiting for your seniors to go inside the entrance, when you
> were going into the dining room. . . As a junior you would go
> last. . . You can imagine, at times you would come at 1:10 into
> the dining room and you would still be waiting until 1:30,
> nobody cared. She used to tell us that seniors are seniors, and
> we were nothing. We must know that we are nothing. We are
> just like dust. (3 2/5)

The testimonies of subprofessional nurses made no reference to the

teaching of ethics or of being encouraged to embrace a sense of

professionalism and status. Rather they emphasized devaluing and

humiliating discourses that forged an understanding of their subordinate

location.

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

Despite the hardships, training as enrolled nurses and enrolled nursing

assistants offered a reprieve from the challenging daily existence of rural

and township life. These women had few options outside of nursing. Thus

they were powerless in the face of threats and coercive treatment by their

nursing tutors.

> We didn't do anything about it because we were scared. By
> that time it was very strict in nursing, because you were
> scared that if you complain about something you would take
> your suitcase and go and not finish training. Yeh, they used to

threaten us, even if there is something wrong, they were going to chase you away, take your suitcase and go back home. (4 6/9)

When asked how they interpreted this treatment, one nurse described how she tried to make sense of the matron's treatment:

> I don't know if she was born hard hearted, I don't know, but maybe she was trying to control us. She didn't want us to look down upon her. She was too high. I don't know. (3 2/5)

For two enrolled nurses (3 5/6, 3 2/5), dismissal from the professional nurse programme in the 1960s was a form of punishment for failure to comply with the moral codes of nursing. Their testimonies reflected the lack of tolerance shown for young women who became pregnant and little appreciation of cultural practices. For one nurse, the treatment was particularly demoralising, as she was led down through hospital corridors prior to being expelled:

> She took me straight away the same time. She took me to the matron. She never talked to me. She asked me why I was hiding, why I didn't tell anybody about this pregnancy. Was it because I wanted to kill the child or what? I said I was waiting until I would go on leave and I would tell my mother first, before I could tell anybody. She said, "no, you wanted to kill this child." So then I kept quiet. You couldn't argue with her. [At the matron's office] there was a clerk who was very harsh, too. She never says anything, she just said, "you are pregnant, you came here to train, and now you are pregnant. What a bad girl you are. Get out of my sight!" . . . I was given some forms to sign. That was the end of me. I had to go home. I only saw the clerk. It was the clerk acting like a matron. . . I was terribly demoralised. I just kept quiet. I went back to the nurses' home and collected my things and left straight away. .

.My mother said, "I sent you to get some epaulettes and you are coming with a baby." (3 2/5)

The sense of intolerance these women felt as young students was extreme in its embodiment of distrust, lack of empathy or concern for the personal dilemma in which they found themselves. The consequences of pregnancy extended beyond personal rejection to the loss of career opportunity and income.

Through their narratives, nurses from the subprofessional category provided stark testimonies of their subjection to harsh disciplinary practices aimed at relegating them to specific roles and locations within institutional relations. Although several of these nurses attested to being motivated toward nursing due to general interest in 'serving the community' (3 2/5, 4 6/9) and others reflected on their nursing aspirations with 'caring' discourses (3 5/9, 5 6/9), their testimonies did not reflect support or affirmation of these qualities. Rather, their experiences illustrated a break with unitary motifs of caring and an unfortunate schism between nurses of the professional and subprofessional categories.

The student nurses interviewed were at various stages of the four-year comprehensive programme. All these nurses came from township backgrounds. All except one entered nursing due to financial constraints. A number of major events marked the studies of the student nurses. The most significant were the first democratic elections and the ensuing years of labour unrest among nurses. The way these young women related to issues,

the way they perceived institutional relations, and the resulting interactions between ranks and categories, was tempered by their recent entry to nursing and the hospital, as well as by the rapidly changing environment around them.

For all the students, the exposure to patient care was portrayed as a rewarding, yet challenging experience. Their relationships with the tutors were mostly viewed positively, albeit a somewhat tolerant light.

> I take them as my elders, my mothers. Some of them, when they would meet me in the corridors used to tell me, "eh, you know when you came here, you were so naughty, so childish and we've just watched you grow." . . .At home they tell me, remember what you went there. Don't focus on any other thing. My mother used to say, "any road that leads to something successful is always bumpy, it's not as smooth as you would like it to be". Whatever comes my way, I used to take it as, oh, maybe that's what my mother used to say. It has trained me to know now that I am going to be successful in what I want to be. Yes, things here are very authoritative, but I give them their positions, because they have started and they have ended in these positions. So I take whatever they do. (2 23/10)

For another, the college programme was considered to be more consistent with a high school, where nurturing and discipline was considered to be inappropriate for the task at hand.

> What I don't like about the way in which nursing is taught is that it is as if we are in high school. When you are late you get punished. I think if it were more like a tertiary setting it would be nicer. Here you sit in your desk, and there is a class mate who has to sit next to you all the time. Its taking us back to high school, that is why we are not so much responsible,

that's why most of the time we make noise, and then they would come and tell you to stop making noise. It is the way they are treating us, it is as if we are in high school and the result with us is that we automatically start to behave like high school children. (2 28/7)

This young woman had prior exposure to university studies where she experienced more autonomy as a student, where the resources were suitable to independent learning and where exposure to diversity in the classroom broadened her perspective.

It doesn't make us responsible because the teacher would come there and treat you like high school teachers, not like the lecturers in varsity. Most of the people here have never been exposed to tertiary education, they leave high school and they come here. For example, we are not accustomed to using the library and the information is very scant in our library, so it's not really challenging. (2 28/7)

The student nurses expressed issues with their educational experience that they were unable to channel effectively. Some expressed the fear of being labelled as troublesome.

What I can say about nursing is that it is not easy to raise issues. You must just take it as it is and tell yourself that it will soon be over and then you can go. If I were to stand up now and go to the principal's office so that I could tell her what I feel, I know that nothing would be changed. She would say that others have survived in this situation so why can you not survive. And then she would start seeing you as a troublemaker. (2 28/7)

For all of the women interviewed, who entered nursing during different historical moments of South Africa's history and during different eras of nursing and health care, institutional relations buttressed by patriarchal, racialised and capitalist relations of power rippled through and influenced their earliest experiences within the profession. For all, disciplinary technologies were a central feature of their training programmes, imparting important messages related to racial, gendered and categorical codes that influenced interpersonal relationships and practice. They issued directives ensuring the reproduction of authoritative practices and hierarchical mandates, with little evidence of a reliable mechanism or process for addressing the issues that concerned them. Through these discourses, practices and relations of power, these nurses were regulated, and shaped to assume and accept the prescribed positions and locations within institutional relations.

7.3.3 Professional Practices

This section explores narrators' views on notions of 'profession'. Many nurses spoke at length about their roles as professionals, and of professionalism during the course of the interviews. The testimonies provided insights into how professional discourses buttressed institutionally driven practices. I have termed these *discourses of profession* as they project a unitary body of knowledge and practice through which meaning and station was appropriated. At the same time, these discourses were confronted by contradictory practices which reinforced the divisions and

disparities noted in the previous sections.

Nurses in the supervisory ranks referred to themselves as professionals. Their location within the hierarchy substantiated this perception, as did their links with the systems that governed health care and nursing. While some of these nurses played leadership roles within local SANA branches, all reported to the highest echelons of nursing within the hospital, while overseeing the work of others. Most viewed their roles as supporting and maintaining the institutional relations of power. These nurses were considered to be the older generation of nurses. Their credentials were earned through ongoing educational upgrading, years of practical and supervisory experience, and through discipline and training. As one nurse stated,

> I'm a professional today because I listened [to the matrons]
> discipline. (8 1/9)

For nurses of this category, the professional identity offered status and recognition within the hospital setting and within the community. The notion of the profession was one that was most clearly achieved through rigorous training and a sense of professional etiquette.

> It was tough in those days. We had no general assistants. We
> did all the work, the washing up, nursing patients, seeing to
> the visitors, the counseling. In a little mission hospital you are
> everything. Training made us mature, it helped us to grow. It
> was not a big teaching hospital, so we did rounds as a
> professional. (8 ½)

The link between the status of professionals and improved material realities in society recurred within these testimonies. For these women, who enjoyed authority and autonomy within their working environments, professional status accorded them social upliftment and security in the face of dismal options.

The tensions between the senior nurses and more junior nurses interfered with the sense of professionalism felt by nurses. The older generation of professional nurses maintained authoritarian practices, yet the changed racial demographics of the hierarchy marked a softening of relations.

> I generally enjoy being a nurse, but nurses always get suppressed by people in authority. It's like the post-basic education. There is no reason why we were kept waiting so long. Black nurses grew up in regions where doctors and white women had more prestige. [I] view myself as a professional. [I'm] working hard to have nurses see themselves that way. Most nurses see themselves as workers. Nurses discredit themselves. Now they are teaching them something called the nursing process. Nursing was an authoritative profession in the past. But the present matrons are taking a fairly democratic route. I think it has changed, but I don't know how those below us feel. There are always attitudes towards the matrons, they still regard us as people who tend to be authoritative. I think those attitudes are diminishing. (8 6/12)

The professional nurses interviewed generally considered themselves to be professionals. As one nurse announced,

> I'm proud to be a nurse and my kids are proud. (6 12/12)

Although professional nurses have decision-making responsibility in their patient-care roles, they perceived public opinion of their functions to be ambiguous and non-affirming of the levels of training and responsibilities they assume. As another nurse stated,

> Some people don't think that nursing is a profession. . . I personally think that it is a profession. . .[I am] someone dealing with the human being's needs, [and that requires] special training. When people look at us they see us as inferior. Bed making and bed baths are only part of our patient care. We try to achieve the health of the patient. Our job is not to prescribe. We try to solve the patients' problems. It's not an inferior job. We do things with knowledge. Professional nurses are trained fully and we know what we are doing. (6 12/2)

These nurses expressed overall pride in their role, their training and their accomplishments. Yet they were wrestling with a number of tensions linked to the transitional events. For some, resistance and protest were considered taboo and inconsistent with the integrity inherent to the profession.

> I think that nurses are confusing democracy with professionalism. The standards are going down. Attitudes are very important [in nursing]. Nurses should look professional, uniforms should be the same. There must be respect for seniors. If you ask them, they say, "it's the new South Africa – democracy!" (6 12/2)

Nurses' efforts to redress their conditions of work through union activity were inconsistent with the precepts of professionalism.

> They are doing so in ways that are inconsistent with professional standards and codes. (6 12/2)

For most of the professional nurses interviewed, professional integrity was challenged by their subordination within the poorly resourced workplace setting compounded by unrealistic expectations of them. These feelings instilled a sense of isolation within an environment that predisposed them to risky practices.

> We cover most of the body of the health team. We frequently perform tasks we are not trained to carry out. If all goes well, great! If not, no one will cover you. If disaster comes, doctors put all the blame on nurses. Nurses hold the blame. (6 12/2)

Professional nurses stated that the poor working conditions impaired capacities to maintain their professional 'standards of care', as was evidenced in the narratives on caring.

> So all those things you are being confronted with, staff shortages. You are trying to do your best but there are barriers between you and this person and there are things that you can't go beyond to help this person, and at the end, you yourself, when you are working hard, people never appreciate it. When the matron comes in, she never sees the good things you do. You're always being accused. (6 2/2)

The difficult working conditions debilitate professional nurses' capacities to function effectively, resulting in complex feelings of demoralisation, fragmentation and alienation.

> I have seen how the work is done from a patient's perspective. King Edward doesn't compare. It's not even a hospital. There are no interpersonal relationships. There is no control, no resources. Nobody cares what is going on here. I have been exposed to other hospitals. I know what needs to be done. I would call for a whole reorientation and reconstruction. Everyone would have to be taught a new ethos. This is partly due to environmental details. Most of the people at King Edward have been trained here, so they don't know the

difference. Some were born here, got married here and there is no exposure to outside things. It's a closed thing that is difficult to penetrate. I don't know how it can be changed. (7 1/8)

For nurses of the subprofessional categories there seemed to be a general acceptance of nursing as a profession, yet two major issues arose. A pronounced awareness of their exclusion from the status and privileges appointed to 'professionals' was stressful and humiliating to the respondents. These nurses were clear about the division of labour within the hospital setting, which reinforced their status of 'workers'.

> We are cheap labour. Interpreting is out of our scope of practice. (5 6/9)

As was the case with the professional nurses, the conditions of work were considered antithetical to professional practices, and remuneration was viewed as inconsistent with the work load. These nurses were at the bottom of the hierarchy, where contradictions seemed sharper. This nurse's testimony expressed the impact of a heavy workload on the central discourses of the profession, caring:

> [We] do a lot of work. [We're] at the bottom of the hierarchy where we catch a lot of the physical work. It's because we are not learned. It's better to be a sister or a staff nurse at least. . .Sometimes if its full, I can't keep that thing [caring]. If you are working, if it's busy, [caring] no longer exists in you. Sometimes nurses shout at the patient – sometimes. So I don't know whether it's because of strain or what. . . As I am growing, there is no caring now in nurses. I don't know whether it's because of the strain or because of the money or what. It's changing now. (3 6/9)

As with the professional nurses, the conditions of work and staff shortages frequently place nurses from the subprofessional categories in vulnerable positions. One nurse, who referred to subprofessional nurses as the 'Jack of all trades', was clear about the parameters and limits of her practice. However, the realities of the staff shortages and high patient volumes subjected them to performing functions outside of their prescribed scope of practice.

> It does happen that the Sister is off sick and they do not
> replace her. We have to take all the responsibility there. You
> can even manage the ward alone if the staff are not there. We
> do things that we are not qualified to do, but we are doing it
> because of the conditions. (4 6/9)

The student nurses were principled in the way they viewed their status as professionals. These young women overwhelmingly deemed dignity and status as key to the nursing profession, notwithstanding the fact that most of them entered the college programme by default. For some, the lingering images of nurses in their white uniforms persisted when reflecting on the nursing profession. In their narratives, the student nurses emphasized the qualities of professionals, suggesting the divisions within institutional relations, as this student's sentiments captured:

> [I am] a professional. When you are a worker, you are just
> working, carrying on for the duties allocated for that day. You
> finish up at a certain time and you have to go off and
> tomorrow you start fresh. Early in the morning you have to do
> this and that, in the afternoon, it's this and that. When you
> are a professional, on the other hand, you have to do [your
> duties] in a professional way. Even the manners of a person
> who is working and the manners of a professional are
> different. Respect is not the same. Dignity is not the same. But

> there is that difference. Even the way of talking. [As a]
> professional, you cannot walk along the street eating, but you
> can find a worker eating, walking along the street. But the
> professional, she would find a place to sit down to eat. (2
> 31/7)

All of these students valued the dignity, ethical standards and integrity of

the profession. Their subservient location within the medical hierarchy and

the conditions of work that challenged their capacity to adhere to these

roles posed a threat to their sense of the profession.

> You know in nursing there are some things that I hate, like
> acting like a doctor's servant, you know, fetching something
> for the doctor and all that. I understand that you have to carry
> out orders from the doctor, but acting as a doctor's servant,
> "please fetch that plate", you know, minor things like that,
> makes it unprofessional. We're trying to talk to our tutor who
> is teaching us, and, you know, it seems as if there is nothing.
> That's because the old nurses in the ward, they still carry [on]
> that way. So it's difficult to just come and just change the
> routine. We were just discussing it among ourselves, and we
> came up with the solution that maybe we should be assertive.
> (2 8/7)

This student went on to outline a variety of strategies she and her student

colleagues planned to implement on the wards in order to assert a shift

from the nurse as 'handmaiden' to nurse as 'professional'.

While it seemed apparent that the student nurses were critical of the

subordinating practices of the medical hierarchy, their own views and

approaches to nurses of the subprofessional categories reinforced

hierarchical discourses and practices.

When you are a worker, you are just working, carrying on for the duties allocated for that day. You finish up at a certain time and you have to go off and tomorrow start afresh. Early in the morning you have to do this and that, in the afternoon, it's this and that. When you are a professional on the other hand . . . you do it in a professional way. . . As you are a student you end up being professionals. The enrolled nurses are starting to become professional. [They] are doing bridging courses because they want to become professional. . .The student nurse is always on the right side of the professional nurse, because she is the one who is next to her. The EN and the ENA have been exposed to training and to the wards working them. You, as a student, have been told to not do everything that you come across. You have to apply what you know. In this hierarchy, you start with the PN, then the students, then the EN, then ENA. (2 31/7)

In summary, narrators responded to questions of how nurses viewed themselves as professionals, how they viewed the profession of nursing, and the obstacles and reinforcers of both these areas. Discourses of the profession were distinct within these testimonies and were extended in a number of ways:

- through notions of the 'professional': a contextualisation of the nurses' location within the profession;

- professionalism: generated through discourses applied by regulatory and professional bodies and translated through different codes of conduct, then interpreted and applied (or diverged from) by nurses; and,

- professionalisation: the practice of applying the characteristics central to notions of the profession.

Two main observations emerged from these narratives. First of all, perceptions of professional location and the interpretation of the experience of being a professional varied according to the nursing category. Secondly, the reaction of nurses to the notion of the profession, contextualised in the current environment and historical moment, was in a state of crisis. For many, contradictory practices within their work experience confounded capacities to provide care according to the acceptable precepts of professional discourses.

Nurses' views of their location and roles as professionals varied by category and signalled serious cleavages that were visible within the ranks. Whereas those nurses designated to be in professional categories seemed to embrace their status and distinct responsibilities as professionals, PNs working at the bedside and the subprofessional groups of ENs and ENAs were more vocal of the difficult clinical conditions which impeded their capacities to 'care'. Indeed these were posited as antithetical to professional practice. Implicit to these narratives were implications that race and gender compounded their situational difficulties. Chronic subjection to difficult conditions, the inability to legitimise issues, the entrenched perceptions of black nurses as inferior and the expectations of medical staff undermined their autonomy and sense of worth as professionals.

The professional hierarchy, designed to ensure smooth institutional practice, was rife with tensions related to cooperation and coherence. Many nurses experienced a sense of abandonment and in the workplace. In

essence, discourses of the profession operated as an adhesive, bonding nurses to their locations, and enhanced compliance within institutional relations. Lack of recognition and inconsistent, ineffectual communications were apparent. These narratives dealing with nurses' notions of the profession and professional relations served to illustrate the crisis of meaning and practice in the occupational realities of these women.

7.4   Relationships, home, community

Only half the respondents discussed their domestic and community lives beyond disclosing their marital status or their number of children. Of the eleven women who spoke about their home lives, five were professional nurses (matrons and senior professional nurses) and six were from the enrolled nurse's category.[106]

These nurses spoke of the struggles of balancing low salaries, shift work and arduous workplace conditions with their day-to-day domestic responsibilities. The burden of support extended beyond the financial means of one nurse's salary to the impact on it has had on their health.

> My salary is a big problem. I net R1,200. The family is managing, but we battle with the kids at school. [Look at the] strenuous jobs we are doing here. Look at all these nurses who have worked. Their ankles are big. If the matron were to find us here [sitting], we are not supposed to sit. (4 3/4)

---

106 Students do not feature in this grouping as they were still living with parents when not in residence.

Beyond providing primary support for their children, the single parents interviewed referred to the financial support provided for members of the extended family. Nurses testified to the need to share meagre incomes with ageing parents, unemployed siblings and their sibling's children.

> Oh, it's difficult, really difficult. [As a single parent] you have to look after your child while she is still young. You have to beg for the father because he is not aware that he has to look after his own child. What I can say is that the men don't feel the same. . .So you have to ask and beg from the father, sometimes until you have to take the matter to the court that you have got a problem with the father not supporting the child. . .And now I've got this big family: the four sons of my deceased brother, my two sisters. One sister is working. The other sister is not working. And I've got my brother who is not working. His wife is not working. They have two sons. So it is a really big family that I am looking after. (3 5/9)

A few of the women, like Mrs. Chiliza, worked additional shifts beyond their 40-hour week, a common practice called 'moonlighting'.[107] Notwithstanding their full-time employment and efforts to augment their income through working additional shifts, the physical demands and financial responsibilities within the home weighed heavily. As single parents, securing the greatest benefits possible for their children through educational and material gain was a goal that often pre-empted their own perceived personal and developmental needs. Some women prioritised their children's mobility at the cost of their own.

> I brought them up myself. Even today I'm struggling with them. They are at a very difficult age, [it's hard] bringing up

---

[107] This practice supplemented incomes until 1998, when budgetary cutbacks at KEH eliminated overtime and additional shifts for nurses.

teenage children alone. So I was unable to improve myself or further my education because of these two kids. I didn't have enough money. (7 13/12)

The feelings of betrayal and disenchantment with men, and their subservience as partners, was common among the married women, single parents and those whose fathers failed to live up to the moral obligations of offering coherent parenting.

> I chose nursing to lighten the family load. It's very hard. My husband is a school teacher. He has always taken me as a child. There is always somebody looking over you. (4 3/4)

For one woman, relief was clearly expressed about being married.

> [I married the] father of these kids. He was a gift from God.
> The father of the same children. Not different fathers. (3 6/9)

As part of her testimony, this nurse spoke of the need to account for and request permission for her every movement outside her work environment. Yet, for this woman, the fear of facing poverty as a single parent seemed to underpin her decision to accept subordination to her husband's authority.

Whereas a number of women provided testimonies of marital abuse, only two identified their relationships as abusive.[108] Both women reflected on how their determination to passively resist the threats and intimidation of a series of violent and abusive encounters with their former husbands enabled them to leave their relationships.

---

[108] Narrators shared details of abuse outside the sphere of the interviews. Thus, although these recollections provide stark testimonies of abuse and their capacities to survive and remove themselves from these situations, specific information will not be disclosed.

Both these women were married to men who experienced less status and material success. Their spouses struggled to maintain jobs, in a society and at a time when racial practices impeded personal and career mobilisation, unlike their wives who gained status and recognition as nurses. As Kuper (1965) described, the shifting of gender relations outside socially scripted roles introduced tensions to relationships that were often insurmountable. As illustrated in the previous chapter by Mrs. Nyuswa's comment:

he saw me as a woman, not as a nurse. (8 ½)

Some testimonies illustrated the determination of women to achieve personal autonomy within social settings deeply inscribed by patriarchal and racial norms. The will to overcome prescribed passivity, powerlessness and submissiveness to authority was aided by the subjective locations achieved as professional women within defined institutional relations. For some, nursing offered a reprieve from the stressors and disappointments of home life.

> At home, I am that woman who is unfortunate, we have problems, but I don't bring them at work. The sisters find me ever smiling. When I go home, I am the most miserable woman in the world. Firstly, I was divorced. I couldn't take anything from my house. Then the young son raped and killed. He is in a life sentence. And they burnt my house, they loot first, then they burnt the house. Nothing was done to me. I'm miserable. But at work, I make myself happy with my colleagues. (5 1/6)

The high proportion of single parents within this small grouping pointed to some of the challenges facing these women. It represented an important area for further research into the personal burden of responsibility nurses

endure, the impact it has on life choices and options, and the impact of their dual roles as nurses and nurturers as the primary wage earners within relationships.[109]

7.5   Resistance Within the Work Environment

The study partly aimed to identify how nurses dealt with the frustrations of the workplace. It was found that nurses of all categories resisted the relations of power inherent to their work environments. Forms of resistance were both subtle and strategic in their focus, while undertaken as a means of enduring, altering, stabilising or reinforcing subjectivities. As Foucault (1990:95) noted, resistance is multidirectional and plural in the forms it takes. The use of resistance introduces the potential to displace dominating relations of power. The forms and focus of resistance evident within these narratives were disparate and generally operated within particular practices. They generally posed little threat to institutional relations of power, yet seemed to be a means of maintaining elements of control.

There were definite distinctions between the experiences of nurses at different locations within the hierarchy. The older, more senior nurses, who have endured the constraints of earlier administrations through subtle forms of resistance, engaged strategic practices to navigate the system and

---

[109] The national survey of nurses conducted at UND in 1997 vindicates these statements through data which shows the high rates of single parent families headed by nurses, and the prevalence of single wage earner extended families, again often headed by nurses. These findings were discussed in chapter two.

ensure survival and success. As Mrs. Molepo recalled about her earlier years,

> I was looking at my life, at how I suffered with nobody looking at me when I actually had the potential. I had become angry with myself for not having challenged those issues. . .I couldn't challenge some of the issues and could see what was exploiting me. Something was being compromised as far as I'm concerned. (8 1/9)

Mrs. Molepo made several references to the 'grapevine' as her means of gathering information that helped in strategising to alter or secure career mobility. Additionally, her use of a 'recognition ceremony' was constructed to acknowledge the efforts of selective staff, thus affirming her position of authority within the hierarchy. She claimed that it also provided a mechanism for communicating a message to the professional nurses from her area. Through exclusion, the message seemed to mark her disapproval of their challenges to her authority.

In a different vein, Mrs. Nyuswa's testimony marked resistance to her gendered location within a marriage and community and aimed to maximise recognition of her professional status. In the process, she became firmly aligned with hierarchical and organisational discourses that were challenged through transitional dynamics.

Interestingly, the matrons interviewed placed little emphasis on the material inequities that most nurses contested. Their narratives did not overtly acknowledge concerns expressed by their subordinates' regarding the

conditions within patient care environments, nor were issues central to the grievances of nurses legitimised. These issues were veiled by comments about the pressures they felt from nurses and the reactions aimed at maintaining control and authority, as shown by Mrs. Molepo's remarkable comment,

> I made it clear, if only I chop off their hands and look after their hands, I'll be the happiest woman. (8 1/9)

The matrons focussed on their mandate and role to 'maintain order' within the wards and corridors of the second largest hospital in sub-Saharan Africa, yet their hold on authority was tenuous. As Mrs. Molepo's testimony illustrated, the demands of nurses for improved conditions within the work environment, culminate in challenges to the leadership.

> As matrons we are not trusted. They negotiate, if there are no results, they fight. . .They say we are their mothers who leave them to toyi-toyi. It doesn't threaten me. I know what it's about. (8 1/9)

The matrons also cited moral discourses in their defence to the resistance displayed by subordinates:

> [I] would like nursing to be a profession. With the attitude nurses have now, [I] can't see it as a profession. . .[We] must be realistic when asking for salary increases. [Nurses] are not what they are supposed to be, not what they used to be. They should be caring, compassionate. . .(8 ½)

The matrons' testimonies affirmed their roles as hierarchically driven, a reality they buttressed with moral discourses. They emerged as a group of women co-opted to the imperatives of institutional relations yet sandwiched

in their location between the administrators and practitioners, an isolating

position which threatened to de legitimise their authority during the labour

unrest. For the most part, their leadership styles were authoritarian, driven

to maintain order and personal effectiveness. Their narrative accounts were

silent on the workplace conditions and difficulties expressed by their staff.

Rather, a fairly strong message of disapproval permeated their relations,

one emanating from the perceived challenge to their own positions as the

vanguard of institutional order.

The senior professional nurses, as supervisors in the ward settings, had

direct contact with patients and doctors and reported directly to the

matrons. Their narrative accounts of the workplace acknowledged the

concerns of their subordinates, as they were in closer proximity to resistive

strategies. However, they expressed cynicism of the potential for resistance

to succeed in altering relations of power, partially due to the ineptitude of

senior nurses to alter current circumstances.

> Yes, we are training nurses in a certain situation. They are
> going to be like us. There is no equipment there, there is no
> proper communication, there is no ethos of a hospital, the
> hospital is dirty, there is no control. If you could see how a
> hospital is run. You just have to take one look and you know
> what I mean. Even the college is horrible. The office I have is a
> hovel. Every day I come to this place, there is nothing. Maybe
> it's the system that has made people like that, because you
> weren't allowed to open your mouth, as I have said. It has just
> become an internalised situation. So deeply entrenched it
> would be difficult to do anything. Who will [the new nurses]
> take their ideas to? To who? To me, who is also in the
> situation I am telling you about. Will I carry them forward?
> They would face a stumbling block. Because we are the ones

who are not progressive, the older generation. In any case, they are also casualties from the high schools they have come from. All they know is oppression. They don't know any other way of achieving their goals except by aggression. (7 1/8)

SPNs seemed to be caught between the resisters and those enforcing institutional practices and, as the previous quote suggests, there was a feeling of complicity derived from their hierarchical and generational location. Another nurse cited the generational tensions within the work environment, which she attributed to the shift in political environment.

> Nurses of the old government were submissive. We didn't query. We were told what to do as the bureaucratic leadership didn't allow us to do anything. We weren't allowed to think. In the wards we were just following the medical model, even up to now. We were not contributing much to rounds or even with the matrons. The hierarchy is flattening now. On the wards we are trying to be at the horizontal level with the doctors. (7 6/12)

Several nurses reflected on the changed racial dynamic within nursing hierarchies. They commented about the recent past when there was little opportunity to resist the racialised hierarchy.

> I've always had problems with my seniors. You couldn't even give a suggestion. I complained that the water was cold for the patients, even in the bathrooms. I was brave enough to raise it with them and I got punished for that. Instead of fixing it, I was told to supply for them, by nine a.m. the following morning, which ward in the hospital had hot water and which ones had not. . .That was not necessary. It was just to thwart me so that I don't raise such issues in a meeting. (7 1/8)

> They used to sit in the duty room and give instructions. We know our black nurses are always afraid of the whites. We

now know that those white nurses were not thinking of us as people. These matrons are more approachable. If you are not happy, you tell them right away. (7 13/12)

The altered racial composition of the hierarchy may have resulted in the matrons being 'more approachable'. Notwithstanding this, they sensed a tenacity in the younger nurses for change.

> We do talk and then we put some understanding. We go up to the nurses who are from the new generation, who resist change, who resist everything that is being said by an old person. They say "those were your days, today is another day, there must be changes". (7 13/12)

Among the professionals, subprofessionals and students were nurses who formed the upper crest of resistance and protest to the conditions of work. They were vocal about the tremendous strain they experienced in the work environment and pointed to the staff shortages, unavailability of resources and over-occupancy as issues that compromised their performance and capacity. They noted the added strain imposed on their interpersonal dynamics.

> We do things that we are not qualified to do but we are doing it because of the conditions. (4 3/4)

These categories of nurses referred to the lack of coherence and cooperation within the patient care environments that they linked to hierarchical tensions. These dynamics interfered with care provision as issues were not acknowledged, thus they were ineffectively addressed.

Matrons have the power to improve conditions of work. [I] don't know why they just don't do it. (6 12/12)

Seniority was considered to be an obstacle that reinforced disempowering practices from the very point of entry.

> If you are working, as I am working there, I'm trying to do my best. But there are things that are outside my means, to try and solve myself. When I'm trying to tell somebody above me that if you can do one, two, three for me I'll be able to function better. Only to find that person on top of me, instead of solving my problem, frustrates me a lot. I end up being frustrated. Somebody coming in wouldn't know that I am frustrated, so I end up displacing that frustration to that person. Because I feel angry inside. . . All those things makes people frustrated and angry, and there's always when you complain, nobody attends to your complaint. . .This frustration goes on and on. We don't ever have somebody specifically for nurses where we have to go there and sit there and say, "I've got this problem". . .All our frustrations we just swallow them. . .All these things make us fight with one another, amongst ourselves. (6 2/2)

Their frustrations and the resulting resistance were turned inward, toward nurses of other categories, and directed at patients and medical staff.[110] This grouping of nurses was also besieged by a sense of isolation. The failure of supervisors and medical staff to acknowledge material and personnel constraints undermined their issues, reinforcing a sense of isolation which challenged their capacities to resist. Their narrative accounts also illustrated the inconsistencies between nurses' and their beliefs regarding ethical and moral obligations and the need to participate in action to resist the status quo.

---

[110] Narratives of 6 2/2, 5 6/9, 4 3/4, 4 6/9, 3 5/6 present some evidence of these dynamics.

The tensions existing in the work environment were acute and distinctly present. Frustration with the many issues raised in this and previous sections was visible, yet forms of resistance were generally directed toward one another, and lacked the coherence to transform institutional relations of power.

7.5.1 Inconsequential resistance: nurses on strike

During the course of interviews, nurses were asked to describe how the 1994-5 strikes affected them. The question elicited views on the causal issues, the impact of the strike, their work relations and dynamics and the ensuing outcomes. Many of the nurses found this issue difficult to discuss. It incited a range of emotions from fear, anger and deep anxiety, to frustration and disappointment. The strike affected all these women's lives. For some, intimidation and ridicule within their communities threatened their sense of safety and tarnished hard earned status. For all, it challenged a deep sense of professional morality, called into account by actions considered contradictory to the ethical code of behaviour.

The strikes destabilised the technical and social operations of the hospital, throwing routines and relationships into turmoil that dealt a direct blow to the status and authority of the matrons. Throughout, their roles were seriously undermined by their subordinates. In most cases, the matrons claimed that they did not understand the frustrations of the nurses and the issues raised during the strike.

I don't know much regarding the issues (8 6/12).

They must be realistic when asking for salary increases (8 ½).

Even a year following the strikes there was little empathy expressed for nurses and the issues forwarded during the labour unrest. The matrons, grounded in principled professional and class attitudes, considered the 1994 strike to be a "shocking experience", "handled badly by the hospital" and poorly organised by the protagonists. As one said,

> They should have done other things first. It was badly organised. I thought nurses could organise themselves better. They must have been desperate. (8 6/12)

The matrons portrayed the behaviour of nurses as irresponsible and a betrayal to their ethical code. They did not discuss the intimidation that forced many highly principled women away from their patients' bedsides and onto the streets to 'toyi-toyi'.

The Committee of Ten, a grouping formed after the strike to air and resolve causal issues, involved the Superintendent, the Chief Matron, hospital workers and bedside nurses. Their exclusion was a serious affront to the matrons. In doing so, the Chief Matron's strategy was to create an unthreatening atmosphere for discussion. As the forum provided nurses with a platform to lodge criticisms about the Matrons[111], these senior managers felt betrayed.

---

[111] Based on interview with key informant, 2.5.96.

> The Committee of Ten see themselves as more active and able
> to deal with problems reported by staff; to relieve the burden of
> competence being sent to the Chief Matron. [They are] like an
> executive body. They view management negatively, as
> authoritative and slow to deal with problems. The Committee
> of Ten was formed to deal with such issues. I'm unsure of
> what it has achieved. (8 6/12)

This initiative was controversial and created a rift between the most senior administrators and the managers. It elicited bitterness and undermined the leadership of those whose day-to-day functions involved direct supervisory contact with these employees.

> The strategies to seek information and develop links with the
> grassroots is questionable. By creating this communication
> committee, voice has been given to nurses canvassing for
> unions. This committee doesn't threaten me. I know what it's
> about. They are twisting management into conceding on
> issues. They will end up coming back to us [the matrons]. (8
> 1/9)

The senior professional nurses understood and described the strike as the culmination of chronic, unresolved grievances.

> One could say that the strike had to take so long. Why didn't
> the administration take action, because they had to pay
> eventually? (7 13/12)

Most in this category considered the strike to be inappropriate, an event that could have been averted by negotiations, an intervention that in some way could be explained by generational differences, as one nurse said,

> I am from the old people, but these days, our children, they
> strike every time. (7 13/12)

Although the SPNs were aware of the causal factors that led to the labour unrest, they claimed that 'hearsay' about irregularities and corruption fuelled emotions during the strike. There was little clarity concerning this claim, which underlined the problems of poor, inconsistent communications that predisposed employees to unreliable information.

> The SPNs felt the most pain. As the people in charge we were
> guilty for not advising our staff. It was beyond my control.
> Very confusing. There was no guidance. We didn't expect it to
> happen. (7 6/12)

For these women, there was an overwhelming sense that many nurses had little choice but to join the strike, as chaos and force joined hands to instill a sense of threat. The strikes were generally viewed as ineffectual and void of meaningful outcomes.

> The strikes were some eruption of discontent, but not
> organised. The other people were just following. It was a
> wildcat strike. It was not an organised strike. I don't see any
> change. Some were those like me, who see the head, this
> authority where you can't do anything wrong. Some of us
> didn't help either, because we're threatened by the strike. We
> were concerned about our own safety, not about what the
> objectives of the strike were. It wasn't a strike that was
> organised with certain goals and objectives, so it was a one-off
> thing that couldn't be suppressed by tactics of suppression. It
> fizzled out and no one talks about the strike. It's not
> mentioned anymore and nothing has changed. (7 1/8)

The allegations of force used to mobilise nurses were consistent in the testimonies, reinforcing implications that many nurses had little choice.

> [They] were muscled out of wards. They just came in through
> the door and said "out!" Some were armed. (7 11/95)

Despite feelings of threat, some nurses continued with their nursing duties. One nurse gave a poignant account of negotiating her own safety in order to actualise her commitment to patient care.

> I was acting matron. I was grouped with other matrons unfortunately. Fortunately they didn't do anything to me they used to with the other sisters. With me I used to talk nice to them, at least say something which is constructive and they used to say, "OK sister, we do understand your point." (7 13/12)

She was permitted to care for the patients remaining in her wards, strategising to consolidate and care by soliciting the support of volunteers to feed patients and wash linen. She claimed that the medical staff maintained routine and unrealistic expectations of nurses during the labour unrest, which demanded clarification.

> Doctors used to come. They used to want to come and do rounds with me and I said, "To hell with you! I cannot cope. You are going to do rounds and you are going to carry out these orders that you wanted to be done, because there are no nurses. I am the only one. What I can help you with: if you want a drug, I'll take it out for you, then you'll be the giver and I the supervisor! (7 13/12)

Although this testimony reflected the dynamics undertaken by some to survive the chaotic circumstances to which their patients were subjected, the lack of recognition from the highest political leaders dealt a harsh blow to their sense of worth as committed professionals. Recollections of comments made during the heat of the strike by the Minister of Health, implying that nurses could be replaced by anyone from the streets, surfaced in a number of testimonies.

Nobody would like to be nursed by an illiterate somebody who doesn't know anything. (7 13/12)

Nurses' feelings of ambivalence about the strike prevailed. To some extent, it forced them to face their duplicity, their lack of power and vulnerability within their public and private realities.

> You know, I am not a militant person. I am just like all the others who have been disempowered. I am aware of my limitations. I can't say I played an important role. I have not taken an active role that I was supposed to take. If I was a leader, I would just stand up and organise a strike and say, "down with everything that is going on here!" If I was an empowered person then I wouldn't let this happen, I would have the capacity to do something about that. What I'm saying [is that] I'm also part of the whole submissive, disempowered, pseudo-elite. I'm just all the labels that I've talked about. I am not happy, but at the same time, I cannot take the plunge. There is too much at stake. At stake is my livelihood. I am not willing to risk my livelihood for that. There are lots of things that make you sell people out. If you are not hungry, you can stand on top of these things and be able to assert yourself. (7 1/8)

Nurses entering the final decade of their careers seemed uneasy about their personal circumstances and conflicted by the ingrained compromise to the standards of care. They were empathetic, yet trapped by fear; capable, yet confounded by the trust they placed in the system; proud, yet grieving their loss of self-worth in this contradictory location; and, ultimately, they were very disillusioned.

The professional nurses held different views of the strikes. The realities of the conditions of work, the obstacles presented by management's failure to acknowledge or resolve the issues, and the under valuing of their work were views which Miss Ngcobo detailed through her testimony.

> All these things make us fight with one another, amongst ourselves. As a nurse you must have a clean environment. After you bath the patient you give the food. After the ward is cleaned. You have to work in a clean environment. Clean the patient with clean water, not with dirty water. So now if you don't have enough general assistants you have to, as a sister, do the job. All that makes us unhappy and whatever you complain to management about, no answers. It's always that they can't do anything, no money, nothing . . nothing. They can't do anything. All these things [are] boiling to nurses. At the end of the day we go on strike. (6 2/2)

She stood out as an exception to other nurses, who although concerned about their working conditions, did not participate without hesitation in the strike action.

> And all those things we see that our people are suffering. Maybe somebody will listen after the nurses go on strike. When we went on strike last year, we didn't go particularly for our problems, but on behalf of our patients too. Because of the thing, you see, not that the government can't do it, but is done purposely to oppress us. (6 2/2)

For another, the threat to her own safety was something she emphasised.

> I'm not satisfied with some things, but I didn't feel the strike was appropriate. A 'go-slow' would have been more appropriate. I felt intimidated by the strike. If you didn't go out you [might] lose your life. Your family may lose you. (6 12/12)

Despite their criticisms of workplace conditions, the enrolled nurses and the enrolled nursing assistants were, on the whole, intimidated by the strike, and continued to be affected by the outcomes. One nurse, who was generally an enthusiastic narrator, refused to comment about the strike. Attempts to pursue the issue caused some emotion and insistence that the issue not be mentioned.

These nurses were aware of the issues that provoked the strike and felt, as one nurse said,

it was important to be heard (4 3/4).

However, the mechanisms used to involve staff left them feeling

very scared(4 3/4),

intimidated by job security (4 3/4), and

threatened (3 6/9).

Many nurses were forced out of hiding places to join the strike, while some chose to stay away from work and, ultimately, when they had to return to work,

just decided to go along with it. (5 6/9)

These nurses reflected on the status affirmed by their communities as it provided them with a degree of dignity and respect that had been eroded by the strike. The experience was traumatic. Their subservience and sense of low status within the nursing hierarchy had placed them in a vulnerable position, as was evident in the testimonies of the intimidation and the loss of security experienced throughout the labour unrest. For many, the

benefits derived from the strike were not evident, rather there was a residual loss of dignity and pride in their work.

The student nurses were highly sensitised to the issues affecting nurses and patients, and of the process undertaken to negotiate resolution. For two of these nurses, previous experience in the Student Representative Council (SRC) involved them in negotiations for improved conditions within the residences which, they claimed, was ultimately achieved through the strike.

> It was the strike for students, in fact we first negotiated about the conditions in the nurses' home, that were horrible, and then after that there was no response for several times. So we decided to embark on action and we went on strike. (2 8/7)

For the others, living in the nurses' residence may have kept them abreast of the issues and debates advanced by the labour unrest. Their perceptions that the1994 strikes resulted in positive outcomes were unanimous.

> I know what they were striking for, so I thought it was quite reasonable. It could have been easily prevented by easy negotiation, because the nurses were actually ready to negotiate, but the management wouldn't want to negotiate. So that resulted in strikes. So their grievances were quite understandable. Their salary goes through the communication channels, but those channels, some of them are blocked. So they couldn't get ahead, so they resorted to strike. (2 23/10)

Although relatively new to the hospital settings and for the most part, forced by economic reasons to enter nursing, the students understood the potential for labour unrest to improve conditions of work and benefits for patients.

If you go to the ward by that time, you can see how much work has been put on the nurses. They find the patients sleeping down on the floor. [They] have to kneel to make the beds on the floor. Then you can suffer from backache and nobody cares after that. It's your life, you see, and the way the salary is worth. I think the management, or the people above the management, have to consider the life of the nurses, because the well-being of the nurse means the well-being of the patients, because they are the ones taking care of the patients. The people on top wouldn't listen to the grievances. The nurses started to negotiate first and then, because they were not given an ear, they embarked on action. (2 8/7, similar concerns by 2 28/7 and 2 23/10)

The students generally expressed solidarity with hospital staff involved in the labour disputes, and referred to joining a broader forum as,

[they] could not separate [themselves] from them. (2 8/7)

For all these nurses, a mechanism had been put in place for the negotiation of issues, but it had failed, highlighting the tensions between decision-makers and care-givers.

You know actually, it was organised that as they first laid their grievances to the management there must be a skeleton staff that will remain in the ward, while others go on strike. They organised it, that's why the patients were in here. And then, after that, because the management wouldn't listen to the grievances, they decided that everybody must go out of the ward and must go on strike. And then, that's the time when the patients were transferred to other hospitals. (2 8/7)

The students were disappointed by the unsympathetic media coverage, and for the Minister of Health's statements that undermined the worth of nurses. Although concerned about the potential of being labelled as a 'bad

person' and

> taken as unprofessional because it involved toyi-toying and all
> that (2 8/7),

the strategies to threaten nurses as a means of defusing participation in

resistance were noted and, seemingly, not as effective with students as they

were with the older, more marginalised nurses.

> You know, there were those threats like because you have
> behaved like this you won't get work after you've finished the
> course, and all these things. It's all in your record. But you
> know, there are people who were with us and they've got work.
> They are working now. There is no problem. Its okay. (2 8/7)

The outcomes of the strike were viewed differently. Although nurses' salaries

did not improve, the practice of filling the wards beyond capacity was

stopped. For another, the sentiments of many nurses were captured when

she said,

> Lots of things need to be changed, but they have not been
> changed, not that they don't see the need. I think that they do
> realise the need, but they don't do anything about it. I think
> that nursing as a whole is about that. When we are suggesting
> change, it takes a long time to do anything. That's why nurses
> now are organising themselves for strikes. When we suggest
> things, people don't listen to them. So they have to strike. But
> unfortunately for us, even when we do strike nothing happens.
> (2 28/7)

The labour unrest was interpreted in a variety of ways by the nurses in

different categories: from a sense of having their authority undermined (the

matrons' grouping), to a deep sense of fear and concern for their personal

safety (the SPNs, PNs, ENs and ENAs), and for most a grave sense of having

achieved little more but a tarnish to their white uniforms. The students and

one professional nurse were amongst the few who seemed to articulate the importance of protest action and its value in resolving some of the issues. For most, the outcomes were inconsequential, apart from significantly eroding morale and pride.

7.5.2 Organisational perspectives: unions, professional bodies and the unification process

The nurses were asked about their affiliation to unions and to professional organisations, and to discuss their involvement in and awareness of the unification process. The matrons were all SANA members and were aware of the process underway to unify nursing associations. Two of the matrons were active members of their local branches of SANA, the others, although well informed about current events, did not actively participate in monthly meetings. As was evident in Mrs. Nyuswa's testimony, affiliation to SANA acknowledged her leadership role. She had been appointed a local branch leader by the Matron of the day, a position which reinforced her sense of professionalism and status. For another active member, affiliation seemed to offer a site of collegial social exchange and valued services, such as indemnity coverage.

Notwithstanding their ongoing affiliation, all four matrons voted for the dissolution of SANA[112] and were of the opinion that SANA should have

---

[112] SANA held a vote for dissolution in October 1995, claiming it was a constitutional imperative. As described earlier, the vote was unsuccessful, which meant the organisation would not proceed with dissolution to join DENOSA.

found ways to dissolve in order to proceed with unifying the nursing profession. The failure of SANA to represent nurses effectively in salary negotiations, the 'top-down' mechanism of relating to the branches and members and, more recently, the failure of the dissolution vote were all points of criticism. Although it became evident that they felt disillusioned with SANA, they seemed unwilling to challenge the Association. As Mrs. Nyuswa indicated,

> people are burnt-out, no longer interested in what is
> happening. (8 ½)

Affiliation to unions had not been pursued by most of these nurses, except one who had joined DENOSA in addition to her membership in SANA. This matron had participated in the forums held by DENOSA and claimed to be hopeful about the role the Organisation could play in representing nurses. The other women had not participated in the forums. Two were concerned about the ethnic composition of DENOSA, expressed as the 'Zulu-ness' of the Organisation and its links to the KwaZulu-based political organisation, the Inkatha Freedom Party. This concern could not be undermined as ethnically-based violence was prevalent throughout the political transition in South Africa, particularly in KwaZulu-Natal.

The senior professional nurses were vocal about affiliation to organisations. It was interesting to note the caliber of their disclosures, which were less candid and controlled. These nurses were all paid-up members of SANA, yet none were active in its structures. Views about the professional association were critical, as they posited SANA as racially non-representative,

ineffectual, non-consultative and not accountable to its membership.

> What has [SANA] ever given to me? Most officers of SANA are
> white and discriminatory. No one has liked them. SANA's
> raised their membership fees without consulting us. We have
> never seen financial statements. I once passed through their
> offices. They're posh! It makes you think of your contribution.
> (7 11/95)

The comments raised a number of criticisms based on the racialised and authoritative nature of the leadership, yet there was little evidence of interest in resisting, opposing or choosing other alternatives. As one said,

> there is no point in raising issues (7 1/8).

In some cases this seemed to rest with the notion that, notwithstanding its limitations, SANA had offered these nurses stability as a known organisation. It may have been the indemnity coverage, mandatory for nurses employed in the public sector, as well as the need to be affiliated to a professional body, that reinforced a sense of status and belonging.

> SANA did little [but] since developing myself I can see that
> SANA does a lot for nursing. I try to read *Nursing News* and
> attend meetings, but there is very poor attendance due to the
> shift work. (7 6/12)

Although two of these nurses were paying dues to public sector unions, unions were considered by most to be contradictory to the ethos of nursing and a threat to professional discourses. While one nurse (7 11/95) viewed unions as 'one of the evils', 'unprofessional' and 'disrupting authority', another considered access problematic due to her location in the hierarchy.

> When you are senior, you don't come into the unions. They
> always say you're red! (7 13/12)

Affiliation to DENOSA and views of the unification process were mixed among this group. For some, the process was desirable, however, their uncertainties regarding the composition of DENOSA, its origins and the outcome translated into an unwillingness to affiliate. Where there was tacit support for the process, nurses claimed that their financial situation precluded affiliation to both organisations. None of these nurses felt secure in leaving SANA. As with the Matrons, they criticised the 'ethnic' composition of the leadership.

> I have the feeling they are mostly IFP. It is known that people who were in the KwaZulu Nurses Organisation had to abide by the IFP. (8 1/12)

For most, the recognition that SANA was a formidable force instilled faith in the Association.

> As far as I am concerned DENOSA had to be born. As far as I am concerned, it's tough for DENOSA to deal with a tough organisation, one that has been dominant like SANA. DENOSA needs our support. They haven't got the funds that SANA has. Without the funds, SANA would claim all that membership. People are members of these bodies not only because they believe in them. There are group schemes. SANA has negotiated pacts with large insurance companies. DENOSA, with my apologies, hasn't got the leadership with a clout to get into the thing and push it. They haven't got the capacity for such a thing to mobilise the people, running a trade union and campaigns. They don't have the funds to do that. (7 1/8)

A broad disillusionment with SANA was evident in the testimonies. For most, it stemmed from their perceived exclusion from SANA's processes of

decision-making, the lack of consultation, and the dissemination of information. Yet the services SANA provided and the stability it represented as a professional body for nurses, won the Association ongoing support.

Similar views were expressed among the professional nurses. SANA was viewed as non-representative and authoritarian, but two of these three nurses maintained affiliation. SANA's handling of the unification process was considered to be suspicious. The nurses were not informed about the genesis and composition of DENOSA. Their views on the newly formed organisation mirrored the reservations of other respondents. Suspicion concerning the intention of DENOSA also emerged, with two nurses suggesting the potential for elitism and corruption through the mismanagement of funds.

Miss Ngcobo affiliated to SADNU and NEHAWU following the strikes. Disillusioned with other initiatives, she continued to criticize hospital practices following the strike and invested her energies in contesting strategies. Through a leadership role, she aimed to represent the interests of nurses and expressed, rather emotively, the ineffectual history of nursing structures and organisations.

Nurses in the subprofessional categories reflected the same concerns about SANA as an organisation. The Association was criticised for poor racial representativeness and weakness in its response to the issues confounding nurses. Five of the eight subprofessional nurses remained affiliated.

> I'm a member. They do nothing for me. But the hospital
> doesn't ask to see the receipts from DENOSA or NEHAWU. (4
> 3/4)

In this grouping, three nurses were members of NEHAWU with one of these who retained affiliation to SANA. One nurse found NEHAWU better suited to handle 'worker' issues during the strike. She intended to cancel her membership.

> I joined NEHAWU to be my mouthpiece, but it is strong for the
> labourers and not for the nurses. (4 6/9)

Two of these nurses expressed an interest in joining SADNU. They had heard about the initiative in the hospital and intended to redirect their membership dues to the new organisation, due to ready access to the organisational representatives at KEH.

Awareness about the unification process and DENOSA was limited among the subprofessional nurses. Three embraced the notion of a unified and representative organisational structure for nurses, yet none had been exposed to DENOSA's campaigns.

The student nurses were uncertain about the function and merits of professional organisations. They expressed little inclination in participating in any of these structures. Affiliation to SANA had been brief, as all of them withdrew their membership when affiliation was no longer mandatory, mostly for financial reasons. One of these nurses, who had been a representative on the SRC, had joined NEHAWU. However, she expressed

concerns about being labelled as 'unprofessional' by management, who she felt was pressuring her to join SANA. This nurse had also attended DENOSA rallies, but claimed no interest in affiliating.

Besides this, none of the students talked about the unification process or DENOSA. Most of the students seemed to be disillusioned by the choices in professional organisations and seemed reluctant to resume protest action.

> I think the [nursing profession] must be improved. Lots of things need to be improved; need to be revised and improved. The way things are, when you try for years to make things improve you are taken as somebody who does trouble and all that. Here you are better if you just sit and look at the things and only solve the problems that come direct to you. (2 23/10)

> I'm scared. Like I said, I think it is fear that is guiding me. Because I'm so scared to have all these things against my name. I think maybe I feel that, like if I'm going to apply for jobs somewhere, what if, in that place, when they go through my file, they find that I'm a member of an organisation and maybe that will be of a disadvantage for me or something, because I don't have much of an understanding of how they go about analysing you having an organisation. So I don't want to have it. (2 8/7)

Given the students' critiques of the work conditions and discursive contradictions, these comments were not expected. The experience introduced the students to the cleavages within the hierarchy and the profession. The absence of coherent organisational leadership, the divisions within nursing, the challenging conditions and overall events of the strike introduced the students to the frank realities of nursing.

7.6   Nurses in Subaltern Institutional Relations

This chapter presented a comprehensive analysis of the 'voices' of nurses at KEH. It aimed to illustrate the complex subject locations and multiple relations of power nurses navigate from their point of entry to the profession. The narrative accounts illustrated the dimension of nurses' experiences within hierarchical and categorical practices central to institutional relations, while introducing the many tensions, contradictions and inequities that confound subject positions. The limited capacities of nurses to launch and sustain effective forms of resistance were given salience through the situational challenges, categorical divisions, obstacles to recognition and validation of issues, that permeated these institutional relations.

Chapter Eight

Complex Subjectivities: Understanding Nurses

Failure to Seize the Transitional Moment

8.1 Introduction

In the past three chapters nurses' voices and the contexts within which they lived and worked were brought to the fore to illustrate the different dimensions that nurses experienced and navigated, primarily in their workplaces. The narratives were presented in two ways. In chapter six, narratives of four nurses were constructed as a means of intensifying insights into lives of these black, South African women. Their narratives were distinct in terms of the specific contextual and relational experiences. However there were many features of the narratives that resonated with the others, particularly in terms of the prevailing socio-historical backgrounds, their occupation, occupational experiences and reactions to the transitional events.

In chapter seven, their voices were pulled into a theoretical analysis of relational discourses and practices that were central to the constitution and regulation of their experiences. These two methods jointly recorded the elaborate arrangement of nurses' voices and illuminated the interaction of relations of power inherent in the South African condition, in the patriarchal environments central to their realities, and in the

institutional settings within which they practiced their trades.

Principles of feminist post-structuralism were integrated into the analysis to determine prevalent discourses and practices that mediated in nurses' lives. This approach facilitated inquiry into the social and institutional contexts, where power relations resided and intersected to reinforce the subjugation of women. Weedon (1987:25) wrote,

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

Theorising the narratives in this way revealed the multiple, varied and evolving discourses and practices that operated and succeeded in maintaining 'useful and docile' bodies within dominant relations of power. It contributed to recognising the shift and flow of power through a range of normative and disciplinary discourses, pointing to the contradictions inherent to institutional relations, and to identifying where subtle defiance or resistance operated as a means of enduring or confronting unacceptable practices. It contributed to the identification of broader attempts to alter the relations of power during South Africa's transitional moment, specifically through labour protest and the unification of nursing organisations.

In this penultimate chapter, an interpretive discussion ensues from theorising the narrators' voices. A framework that explains the operation and intersection of knowledge, practices and technologies is described. The chapter proceeds with a discussion of the dominant relations of power emerging from 'constituent knowledges', which I argue plays a key

role in mediating the realities of these women. The section on 'constitutive practices' explores the locations of women upon entering nursing as factors that guided questions of career choice. The next section, 'regulating practices', considers two main points: the dynamic forces at play at all levels of nursing, institution and society subjugating and constraining these women to multiple yet particular realities, and the interplay of power dynamics through discursive arrangements and practices.

The section on 'enervating practices' posits that the accumulation of inconsistencies within the relations of power combines with discursive contradictions to frustrate the realities of nurses and lessen their ability to react. The following section on women and resistance discusses events and outcomes of the labour unrest and the process to unify nursing organisations. This framework aims to contribute to an understanding of *why nurses have been unable or unsuccessful in responding to their circumstances in an environment of considerable social and political transformation.*

8.2 Constituent Knowledges

Nurses' testimonies illustrated a range of power relations and interactions that informed their lives and framed their realities in South Africa. The term constituent is employed as these power relations form the basis of social and contextual experience. The sites and processes of relations of power reveal the dynamics, technologies and strategies that invoke and alter subjectivities. From this research it was evident that the

construction of the subject location of nurses had been most acutely affected by the impact and continuous intersection of varied relational forces. I suggest that these constituent knowledges operate most distinctly from three sites: patriarchal, within which capitalist and racial relations emerge, and institutional relations of power. Emanating from these two sites is the third relational power dynamic, which I refer to as organisational relations of power. I have termed the confluence of these power dynamics subaltern institutional relations.

Illustrations of patriarchal power dynamics surfaced in both the literature and analysis chapters. The narrative accounts, illustrating the gendered role of women within family relationships, the contained opportunities assigned to women, and the constraints of customary law, posited numerous examples of the ways women's interests have been subordinated to those of men. Further, patriarchal relations of power were projected and buttressed through a number of sites, specifically through capitalist and racialised power dynamics and their interconnections. Much of the evidence for these claims has been evinced through the literature exploring South Africa's historical evolution, linking the particular form and success of capitalism to racial policies, from segregationist policies of colonial powers, through years of apartheid which succeeded in entrenching an ideological racism that will challenge social and political transformation for years. Many of the testimonies resonated with this history, revealing experiences of economic marginalisation and frank racial subjugation. Some examples emerged as the respondents cited exposure to segregation practices and to 'removals', or subjection to laws prohibiting supervision of white subordinate staff.

These illustrated not only subjection to racialised relations of power, but the interconnectedness of racialised, capitalist and patriarchal relations of power serving the interest of a racially specific, and for the most part, male elite.

Institutional relations of power refer to the dynamics creating, guiding and reproducing tertiary relations. They arise from patriarchal, racialised and capitalist forces in that many of these relations serve to buttress a male-dominant, racially-stratified and materially-differentiated order. Much of this has been apparent through the years of KEH's existence, as discussed in chapter five. Institutional relations at KEH bore characteristics similar to tertiary settings world wide in that they were driven and maintained by a range of distinct, intersecting hierarchies. These set the platform for interactions specified by intersecting relations of race, class and gender, circumscribed by the socio-historical context.

Organisational relations of power issue the professional discourses and practices that subjugated nurses to occupational roles, images, codes, and 'scopes of practice'. These relations, that are intended to strengthen the autonomy of the 'profession', ironically reinforced patriarchal and institutional relations. Their dispersal and infiltration occurred in the general absence of a critique of societal and institutional obstacles to nurses.

These power relations form subaltern institutional relations, a term that captures the complex intersections of power that contributed to the development, subordination and subjection of nurses within this

institutional setting. Patriarchal relations and the contextual manifestations of this particular colonial history of capitalism and racialism evinced diverse practices within the hospital regime which were sensitive to the evolving parameters of context, difference and historicity.

This study shows how constituent knowledges influenced the realities of the narrators, and served separately yet in an interconnected way to shape their subjectivities. As I will discuss in the next section, these relations of power were immediate forces through which a regime of micro regulations and disciplines operated to instill, manouevre and regulate a complex web of subject locations.

8.3   Constitutive Practices

Constitutive practices refer to the range of meanings and experiences that underpin diverse subject locations that have operated during the period of socio-political transition in South Africa. They represent the perceptions, experiences and conditions explicit in local environments that were embodied by the narrators.

The value of exploring these practices was underpinned by Foucault (1975), who argued that there is no one discourse of power, rather discourses were considered to be tactical elements that operate in the field of force relations. Weedon (1987:111) and Turner (in Peterson & Bunton, 1997:xi) elaborated this point when they asserted the importance of examining discourses within a specific historical context in order to determine the process of subjection and the interests being served at

particular times.

The combination of context and historicity, Touraine's (1988) conception of society acting upon itself, were employed as a means of exploring the range of forces informing, altering and forging subject locations, many of which are fragmented through social and political tensions. Considering the interplay of disadvantage and difference, as forwarded by Cock and Bernstein (1998), encouraged the examination of contextual factors that influenced nurses' experiences. At the core of many of these women's existences was a vulnerability forged by unstable material and personal realities compounding the fragmented nature of their subject locations.

The transitional moment in South Africa surfaced many of the disparities that were differentially, yet chronically, endured throughout years of racialised oppression. This period witnessed the reordering of power arrangements, the conflation of heightened expectations, and the shifting, re-entrenchment and, at times, deepening of socially defined relations. Depicted earlier as the 'clash of two moral economies', nurses found themselves wavering between imperatives of national responsibility, ethical duty and the frustration of realizing there was to be no escape from their personal vulnerability. The transitional moment formed an important backdrop to this study, one which is somewhat fleeting as the dictates of time and power relations evolve.

The constitutive practices contribute to explaining the choice of career. In the majority of situations, nursing was chosen by default, as nursing and teaching were the available career options for black women. More

recently, the lack of resources and material constraints displaced other options, as remuneration during college nursing training was desirable to the women who played supporting roles in their disadvantaged families. Although many nurses seemed tired and disillusioned with their work, they lacked career options. As well, they were essential breadwinners in their domestic arrangements.

Notwithstanding the evidence that nursing was rarely a 'chosen' career, self-subjection to the foundational discourses was reflected by 'motifs of care'. Nurses' testimonies illustrated the moral responsibility they valued in their occupation, that reinforced a sense of commitment. Further, the representational significance of white uniforms, caps and capes was noted in a discussion of icons of care. These seemed to signify access to dignity, autonomy and control. Thus, despite the limited career options, either as a consequence of patriarchal forces or material realities, motifs of care played a useful role in constructing an alternative reality which served to legitimise nursing, displacing the 'lack of choice' with a self-subjection to gendered and moral discourses of 'caring'.

The socio-political contexts particular to South Africa, the dramatic events and transitional moment prevailing through the years and the many differences and situations of disadvantage served to direct women to a variety of diverse, divergent and vulnerable subject locations. The women participating in this study focused on the nebulous nature of their social, financial and personal securities. Although entry to nursing was predominately based upon limited choice or material constraints, the gendered and moral discourses of caring contributed legitimating and

appealing terms. The penchant for nurses to emphasize their conviction to work as care-providers, despite the many situational frustrations, resonated throughout the course of these narratives as a common thread to this community.

8.4   Regulatory Technologies

Hospital nursing programs, hospital environments and the relationships within perpetuated discourses that buttressed institutional relations of power. Discourses that introduced theoretical and practical knowledge prevailed along with disciplinary discourses that served to induce conformity to the hierarchical and categorical arrangements. I refer to these as regulatory technologies. They produced a series of diverse and conflicting self-identities and roles organised under a unitary code, known as the nurse. Regulatory technologies were varied dynamics and practices to which nurses often subscribed.

Institutions are sites of discursive conflict over how subjectivities and social relations should be constituted and social control exercised (Weedon, 1987:110). Institutional relations of power were sustained through forms of normative coercion and disciplinary processes dispersed through diverse discourses and practices. These served regulatory functions of subjecting nurses to varied locations by occupation, category and rank, in many ways initiating them through harsh scenarios that were contradictory to acceptable notions of caring. Regulatory practices operated as a means of separating, analysing, differentiating and binding nurses to their varied categorical, hierarchical and rank-based locations.

College educational programs and clinical training involving the dissemination of scientific theories, ethical codes, specialised knowledge, messages of professional competency and technical preparation served a strong normative purpose by issuing the discourses and practices guiding development, to which nurses identified. The total immersion of novices into residential apprenticeship, with long and intense hours of clinical work served to remove young women from the broader discourses in society, drawing them into the enclosed terrain of hierarchical practices. This practice marked one level upon which isolating practices permeated nurses' occupational realities. The use of isolating practices and their reinforcement in relational spheres of the occupation, category and rank, was intended to maximise the integration of these women within systems of efficient controls, in Foucault's (1975:135) terms, to create useful and docile bodies. Isolating practices produced gendered, over arching discourses of caring that instilled a strong sense of moral obligation that served to erase the self while inscribing a political quiescence into the body of nurses. Add to this the conditioning impact of professional discourses that appropriates status, inclusivity and dignity as inherent parts of the nursing order. The inscription of these features in the icon-like symbols of white uniforms and epaulettes (albeit differentiated) attests to the point that uniforms represented a discourse of their own.

Discourses of caring and profession presented a field of practice with a strong moral tone to which many nurses related, and which they linked to ethical practice. The pride and esteem nurses achieved through discourses of care, rank and profession displaced the many detractions consistent with other subject realities, most profoundly their racial,

gendered and disadvantaged locations in their private.

Turner (in Peterson & Bunton, 1997:xii) described how self-subjection is achieved through discourses underpinned by moral obligation. Nurses were in no way the objects of unidirectional power relations, rather the study found that nurses adapted and responded to their subject positions reflexively. Self-subjection was one mechanism which operated through the identification with moral codes and ethical beliefs (Turner, 1997). For example, moral and ethical tones inherent to the discourses of caring and of profession imbued, in varying degrees, perceptions of benevolence, worth and autonomy. Nurses' self subjection to these two discourses resulted in adherence to their occupational roles and aspirations, tempering the detrimental, limiting practices central to the gendered-ness of professional roles, and the cleavages within nursing hierarchies. Nurses succeeded in displacing subject locations of disadvantage and gendered subordination by adhering to motifs of caring, yet were also noted to adapt and reproduce practices as they were integrated into positions of authority and control.

Together, these discourses constituted truths issued through fields of knowledge which were produced and reproduced to sustain the community of nursing. They dominated, displacing many contradictions inherent in the day-to-day reality at KEH. A subtext of Foucault's (1980:93) conjectures regarding 'regimes of truth' was to question which truths adhere. The experience of nurses within this context illustrates how these truths adhere so forcefully.

The subjugation of nurses reinforced disjunctures between nurses of different categories and at every level of the hierarchy. Their subordination and oppression cannot be reduced to any singular category or practice. Rather the strict and complex hierarchical relations, the practices construed through discourses of category, rank, race and role served to subject these women to a variety of locations. As one nurse stated, "here we meet under one banner" (8 1/9), a discourse which marks the notion of community yet masks the fragmented, diverse and discordant subjectivities converging on a daily basis.

Disciplinary practices were a prevalent means of constraining individuals and populations, operationalised through normalising strategies and techniques like surveillance. These strategies functioned in a number of ways. They achieved visible compliance that was most clearly displayed in the 'apparatus of allocation'. Details of attendance, patient transfer, aberrant incidents, system failures, staff absence and usual or unusual events that transpired within the corridors were systematically recorded through the practices of allocation.

The outcomes of regulatory practices were nurses who were acutely aware of their subservience or positions of authority within institutional relations, noted in hierarchical relations of occupation, category, rank and, until recently, in the constraints embodied in distinct forms of racialism. While the propensity for nurses to note with disdain or frustration their subjugation to authoritarian and hierarchical locations was a highlight of the testimonies, it was clear that positions of authority and power served the normative function of reinforcing conformity in a

sphere of immense differentiation. These characteristics were reproduced in their everyday relationships, as was evidenced in the testimonies of unsympathetic matrons, bullying sisters and frustrated nurses. They were displayed in authoritarian behaviours displayed in interactions with doctors and in nurse-patient relations, where struggles for power were frequently depicted.

Although disciplinary practices frequently illustrated contradictions to discourses of caring, their ultimate purpose was legitimised in the testimonies of nurses. For example, nurses often normalised harsh treatment during training as a function of transforming the initiate, in one woman's terms: to 'civilise' students, thereby contributing to self-subjection and normalising practices. Testimonies frequently illustrated the influence of disciplinary discourses and practices in shaping how nurses articulated their experiences, in the way they spoke of the many inconsistencies, thereby serving maintenance and reproductive functions.

8.5   Enervating Practices

Enervating practices was employed to represent the build-up of diverse contradictions and inconsistencies that contributed to nurses' inability to contest. The term enervating, which means to "lessen the vitality or strength . . . to reduce the mental or moral vigour"[113], seemed to capture the impact of protracted frustrations and tensions.

---

[113]

Definition from the Merrium Webster's Collegiate Dictionary (1993).

Discursive contradictions were prevalent within most sites of the personal and private lives of nurses. Those that undermined valued practices of caring and professionalism were most damaging to nurses. The testimonies pointed to a number of tensions and contradictions inherent to institutional relations of power at KEH. These were maintained in dynamic tension throughout the institutional order and served to catalyse and reinforce dominant power relations and thereby frustrated the sensibilities of nurses. At the same time, they presented the potential for creating, widening and sustaining a discursive gap that predisposed institutional relations of power to resistance. This is the space resulting from increased frustrations due to the persistent displacement of possibilities, in this case, for nurses.

Hierarchical arrangements, divisions of authority and power were characterised throughout these testimonies as extreme in their disciplinary and authoritarian nature. These rigid hierarchies, informed and reinforced through disciplinary technologies, buttressed hospital, medical and nursing hierarchies. The divisions established within hierarchical relations were noticeable at all levels of practice: from the nurse managers who resented the practices of previous managers, to nursing sisters indignant about managerial authority, to nurses from the subprofessional ranks who felt the sting of hierarchical power the most. For many in the subprofessional sphere, hierarchies installed cleavages which were linked to 'segregationist practices', a surprising insinuation cited within the context of KEH.

The consistent obstacles to providing good care, as was depicted in motifs of care and the extreme gendered-ness of their professional make-up, represented sites of serious contention in the realities of these women. Further, relations amongst nurses of various ranks and categories were rife with dehumanising and conflicting practices. Condescension motivated by educational superiority, the use of threats and coercion were frequently cited as tools used to reinforce a relational and subordinating dynamic.

Relations between nurses of different categories, ranks and hierarchical locations were infused with tensions. Compounding these were a series of inconsistencies experienced and endured at KEH, most the direct result of the apartheid legacy. Highly inequitable and under resourced hospital conditions, punitive policies prohibiting the replacement of sick nursing staff and an intense sense of hierarchical isolation all served to compromise the care of patients. In addition to these factors, severely disadvantaged salaries, intensified social instability during the 1980s and 1990s, uneven power dynamics of gender and status that destabilised personal relationships, and extensive financial responsibilities further compounded the contradictions experienced by these women.

Organisational relations infused contradictions which pervaded the testimonies of many of these nurses. Professionalising discourses have been intensely mobilised by the nursing elite since the 1920s, but most powerfully since the 1940s when Charlotte Searle came to the helm of nursing. For the next 50 years South African nurses followed the example of global nursing counterparts in their determination to 'professionalise'

without effectively displacing mechanisms subjugating nurses to patriarchal, capitalist, and institutional relations of power. Nurses continue to be socially isolated, proletarianised, disadvantaged and, until recently, stratified by race.

The role of the professional and labour representatives was of strategic importance to nurses, particularly in terms of redressing chronic disparities. The South African Nursing Association, through which professional discourses merged from the 1940's, was repeatedly viewed ambiguously due to their complicity with the imperatives of the National Party. Most of the respondents attested to their sense of alienation from the SANA, an organisation viewed as supportive of apartheid policies. At the same time, affiliation to the organisation designated the status of 'professional', valued for the role it played in providing membership to an occupational community while displacing their subject location as black women in a racialised and patriarchal society.

8.6   Women and Resistance

Despite the multiple and significant contradictions displacing discursive unity within these women's experiences, the general day-to-day operation of KEH remained intact. Regulating practices worked in complex and intersecting ways to induce uniformity. Personal and social realities were such that few options existed for the women who nurse at KEH, resulting in most of them choosing to cling to their identities, to their fragile communities and to jobs as nurses despite poor salaries and working conditions. The strict and established hierarchies of power relations

provided an efficient means of subjugation. For nurses at KEH, social constraints and disadvantage pressurised most to safeguard their employment security, while the status gleaned from their subject location as nurses, especially as professional nurses, provided some compensation and served to displace their compromised location as women. This perception changed as general dissension mounted from the early to mid 1990's.

Many separate and intersecting contradictions increasingly eroded the unity sustained by discourses of care, profession and morality. The testimonies cited prevalent forms of resistance undertaken by many of the narrators during the course of their careers in response. Resistance to subject locations as subservient women in relationships resulted in a subject preference for professional discourses. Resistance to professional complicity by SANA with forces of apartheid was withstood through partial and, subsequently, substantial withdrawal. Resistance to subservience based on the imperatives of race was taken up by forming alternative support networks and through vigorous professional upgrading. Resistance to the strict and authoritarian hierarchies emerged repeatedly within the testimonies, however, the cleavages at every level of the hierarchies sustained each rank and category as distinct and separate, which was clearly a serious point of contention. Resistance to broader grievances was in many ways turned inward, directed toward hierarchical relations, presenting little coherence for challenging broader institutional relations of power.

When opportunities to challenge contradictions, in the wake of the social transition toward democracy began to emerge in the early 1990s a destabilising ripple moved through KEH. The 1994-5 labour unrest affected everyone within the corridors of KEH. Most nurses criticised the strike on moral and ethical grounds. Although evidence showed broad agreement about disparities related to conditions of work, strike actions were considered inappropriate by the narrators as they compromised patient care. Although nurses justified their opposition to strike by using discourses of caring, other explanations resonated more accurately.

Nurses were frequently framed discursively, within their social locations, as women and mothers, a reality which often confines the perceptions for acceptable protest to these arenas. Whereas this has at times legitimised women's participation in protest, in this context nurses were severely chastised for betraying the moral discourses of caring and of duty. In this way, the significance of the grievances that motivated protest action was seriously undermined.

The union leadership made a number of strategic mistakes and failed to achieve a coherently collective response to the grievances. They were criticised by respondents for disorganisation and for the failure to unify divergent grievances, in essence missing the opportunity to mobilize nurses as a community. In this respect, the most serious damage has resulted from the failure to enforce a code of conduct. The use of coercive, threatening and violent interventions to pull nurses into the protest arena destroyed buy-in by nurses. Not only did these women feel highly vulnerable within KEH, their sense of insecurity within unstable

communities and home environments and their worries about financial security were heightened by the uncertainty of retribution within and away from the work site.

The labour unrest at KEH damaged the tenuous hold most of these women had on the fragments of dignity and self-respect gained through their affiliation to this profession. The narratives illustrated a consistent perception that few positive outcomes were achieved. Despite the victory of a change in uniform, the larger battle for altering dominant power relations was lost. The labour unrest did force the administrative powers to divert from hierarchical reporting structures, and to set up systems where nurses could meet with them directly. Although this intervention seemed placatory as a means of retrieving stability, it held possibilities for reflection and scrutiny of the exaggerated use of authority and rigid hierarchies that constrained in the work environment.

The unification of nursing organisations involved resistance that was, in many ways, inaccessible to nurses at KEH. The process was protracted due to internal tensions, which I have argued, were based on the promotion of divergent discourses of transformation, inherently rooted in notions of reform versus structural change (Webber, 1997). To nurses who hoped to retrieve coherence of their profession, the failure to unify was disheartening and exacerbated the fragility of their occupational community.

Although most nurses were critical of SANA's failure to represent their interests, they remained affiliated. Part of this was explained by the indemnity coverage they gained as members, a mandatory prerequisite issued by the employer. The status gained through affiliation to SANA seemed to weigh just as heavily. However, an interesting point arose in many of the narratives where a number of nurses criticised the newly formed DENOSA, rejecting affiliation due to its 'ethnic' or 'elite' leadership.

The most visible DENOSA leadership within KwaZulu Natal came from two principal backgrounds (Webber, 1994). The main transformational thrust within DENOSA was spearheaded by Durban-based nurses of CONSA, many of whom were university-based nurses who held political pedigrees for their contributions to the liberation struggle. At the same time, the first president of DENOSA was a university professor from a KNA background, an organisation historically linked to the IFP. So, for the most part, these nurses did represent a highly educated elite grouping.

Additionally, the unification process was undertaken during a period of heightened politically-motivated violence, particularly within KwaZulu Natal where the tensions between the IFP and ANC introduced insecurities in black communities. The suspicious and guarded reactions of nurses were rooted in their sense of concern resulting from the political tensions and violence within the province.

This explanation introduced an interesting paradox to the narrators' explanations of preferred affiliation to SANA rather than DENOSA. After all, the historical dominance of white nurses was central to the narrators' critiques of SANA as elitist, as historically linked to the apartheid regime, as non-representative racially, and as an organisation which essentially failed to effectively address the chronic issues that plagued the profession and its nurses. The personal status meted through affiliation to SANA countered by the tensions and insecurities resulting from the 'black-on-black violence' may explain the preference. As one nurse cited, "better the devil you know, than the devil you don't" (8 1/9).

Thus, resistance strategies, although prevalent, were for the most part disparate and taken up in isolation to others with similar grievances. Although nurses were vocal about the obstacles in their employment environment that impaired the quality of care and work relations, they clung to the regulator discourses that retained them within their fragile occupational community.

8.7   Compound Contradictions – Complex Subjectivities

This chapter discussed the failure of nurses to successfully contest the persistent disparities within an environment of social and political transformation in South Africa. Nurses were actively subjugated by dominant patriarchal, institutional and organisational relations of power operating within the nexus of subaltern institutional relations. The discourses and practices emanating from these sites, separately and jointly, dominated the realities of these women in all spheres of their day-

to-day activities. They shaped subject positions with intersecting conditions, some of which served the interests of nurses.

In keeping with post-structuralist propositions, these testimonies illustrated certain key points. Firstly, nurses actively negotiated diverse subject locations constructed and influenced by the many spheres upon which power relations operated. These were further dissected by a range of contextual conditions, parameters of difference and disadvantage, and the particular intersection of historicity mediating this terrain. The concept of subaltern institutional relations was employed to denote the diverse relations within the framework of a complex contextual environment, multiple subject-locations and the evolving socio-political landscape. As a consequence of their subjugation within organisational, institutional and patriarchal relations, through which the imperatives of capital and racialism were channelled, the subject locations of nurses at KEH were diverse, divergent, fragmented and vulnerable.

Secondly, subjection to professional discourses and institutional practices displaced feelings of subjugation to their social, cultural and material realities as women. Discourses elicited through motifs of care and dignity were upheld by nurses within the varied subject positions. Despite the challenges to the provision of adequate care, they served to preserve the essence of nurses' roles within the occupation, to some extent bolstering resistance to the many contradictions inherent to their work environment. Discourses and practices emitted through motifs of care, hierarchies and organisation introduced a range of converging scenarios that frequently contradicted the general tenets central to the

universal ethos of health care.

The issues compounding capacities to care extended beyond the sphere of nursing, and were primarily related to South Africa's particular socio-political history. Nevertheless, nurses felt they were the main targets of denigration and blame for the shortage of material and personal resources which seriously constrained capacities to care. The frustrations nurses experienced and displayed impaired their sense of legitimacy. They felt their status and sense of dignity had been steadily eroded in their relations with medical staff, patients and the public.

Throughout this transitional moment in South Africa, nursing as an occupation, and nurses specifically at KEH, were undergoing a crisis of meaning. The evidence depicted through constituent, regulating and enervating practices provided illustrations of the discourses and practices operating at a range of levels, to entice nurses to their occupation, govern their actions, while frustrating capacities to realize preferred outcomes. Their multiple subject positions were interwoven such that the capacity of nurses to contest their tertiary subject positions was acutely impaired. Contradictions dominated their day-to-day environments. The vulnerability nurses experienced within many subject-positions, and their fragmentation as a workforce, sustained through rigid hierarchical arrangements, reinforced their isolation, incapacity and unwillingness to challenge the subaltern institutional relations.

Chapter Nine

Conclusion and Recommendations

9.1 Introduction

The final chapter summarises the main theoretical contributions and
findings of the research, integrating this with a discussion of the
background theory and the ethnographic and feminist post-structural
approaches. The significance of this analysis to the field of social inquiry
is discussed, as are the contributions and limitations of the study.
Finally, I have advanced recommendations for further study.

The theoretical constructions articulated in this work may be viewed with
some sensitivity by those who perceive the findings to be critical of nurses
at different levels and sectors of the profession. Rather, the intention has
been to heighten the visibility of nursing, to give more prominence to
nurses' voices, particularly at a moment when their sense of loss (of
dignity, of the battle for descent wages and improved conditions of work,
of professional recognition) is acute. I believe that through these
experiential portraits, this study provides important insights into the
many challenges and obstacles that are structured, reinforced and
reproduced within nursing, the institutions where nurses work, the
organisations that represent them and within the many social terrains

that frustrate their realities as women.

At the same time, this account illustrates the creative ways that nurses have not only survived various inequities and forms of domination, but in many cases have displaced vulnerable subject positions with those that instill a sense of greater autonomy and worth. Their testimonies do not indicate defeat, nor do they demonstrate passivity, complacency or uncaring positions. Rather, as many narratives illustrated, these nurses have actively interacted on the behalf of their patients, have confronted the disparities in their environments and have steadily attempted to improve their challenging locations. Despite the many obstacles that confound capacities to provide adequate nursing care, the narratives consistently resonate with clarity and compassion for their roles, an observation that needs to be emphasised.

9.2   Summary of Main Theoretical Contributions and Findings

This section integrates an overview of the main theoretical and methodological approaches and the research findings with a discussion of the contributions and implications of this work to the sociological field. The theoretical contribution is threefold, providing novel concepts for further institutional studies.

9.2.1 Contributions to the literature

As the largest grouping within and often the entry point to the health care system, and as predominately women, nurses and nursing represents an important field of inquiry, one that calls for extensive research initiatives. This is particularly true during the socio-political transition in South Africa, when health care is undergoing important and exciting transformations, changes nurses should actively participate in forging.

The literature review considered research accounts of nursing in South Africa, noting recent developments in the realm of critical, historical and qualitative analysis of the occupation. Analytical perspectives of nursing from the late 1980's explored the links between apartheid governance and the disparities experienced by women in nursing. Nurses in South Africa have constructed a formidable literature intent on forging and strengthening professional autonomy. In earlier chapters, the inward focus of nursing research was noted. This focus has been rooted within the precincts of the main discourses underpinning the profession, its evolution and matters that pertain to its practice. While the contributions are important, the absence of an analysis that incorporates broader contextual considerations represents a significant gap within the literature and does much to reinforce the isolation of nurses within their own landscape.

This limitation has considerable implications for nursing and the women who are nurses. Professional nurse researchers, entrusted with the imperatives of the trade, must acknowledge the merit of understanding the links between social realities and professional outcomes. Enduring inward glances continue to exacerbate isolationist practices that constrain nurses and, I would argue, in the long-run confines possibilities for the profession to actively challenge constraining relations.

The critical analysis of the subjugation of nurses within a series of dominant relations of power provides a contribution to this gap. This study may be of interest to researchers in labour, development and gender studies, as well as to nursing researchers. Theorizing workplace experience contributes to the growing body of literature on the quality of working life. Linking the study to this body of research has the potential for strengthening insights into the impact of poor quality of work experience and environment to job satisfaction and performance, thereby making the case for improved quality of work environment and experiences as a means of maximizing human potential. Nursing and feminist researchers may be interested in furthering this line of inquiry to develop strategies for strengthening nurses roles within health care and within other spheres of social life.

9.2.2 Theorising nurses' voices

The theoretical approach based upon feminist post-structuralism provided a meaningful framework to guide this study. Foucault's (1980:97) central question about the need to explain the subjection of

individuals and the constitution of subjects has had particular resonance within this research process. His (1973, 1974, 1980, 1990) view of power as 'capillary' contributed to important analytical shifts, from privileging binary constructions linking power and structure, to contributions in understanding the dynamics of power operating at diverse relational levels. Foucault designated discourse and knowledge as the engines of 'truth', strategies and mechanisms through which power is mobilised, shifted, altered and relocated. These key tenets of his ideas have directed the theoretical constructions of this study, focused upon the intersection of power relations and the diverse discourses and practices operating in the field of inquiry. It enabled investigation into the tertiary settings and the social dynamics within and outside this setting, the multiple subject locations of nurses, the difference and diversity forged in the lives of these women through these methods, and responses to the changing socio-political environment.

Feminist critiques of Foucault's anti-humanist stance, limited in its appointment of agency and self-determination of subjects, were integrated into this approach. These critiques were highly relevant to the political and sociological imperatives of acknowledging the reflexive strength of subjects, their power to understand the subjugating nature of discourses and practices, and their capacity to exercise choice in the subject locations they occupy. Weedon (1987:111) captures the essence of this when she wrote,

> To be effective [discourses and social practices] require activation through agency of the individual who they constitute and govern. . .subjectivity is the site of consensual regulation through the identification by the individual with particular subject positions within discourses. [They are] always in constitution.

Within this work they helped to inform perspectives acknowledging the extent of subjugation experienced by nurses, and they strengthened insights into subtle forms of defiance and involvement in resistance.

Foucault's (in Sawicki, 1991:18) reflection upon difference, forwarded by Sawicki (1991) as the 'politics of difference', encouraged analysis of the strategic potential of diversity. To this, Cock and Bernstein's (1998) imperative of acknowledging the centrality of disadvantage, and linking it to difference in the analysis of women, has been influential in this study.

9.2.3 Ethnography in the study of nurses

The narratives of 26 nurses, constructed through ethnographic approaches, illustrated the complex interactions and diverse meanings intersecting this research site. A series of methods was used at different stages of the inquiry. In-depth interviews and a variant of participant observation, described as participant-as-observer, were the main methods appropriated in the field. The interviews provided valued information of the narrators' lives, experiences and perspectives. In this way, the narrative content was prescribed by the narrators, contributing partial yet determined accounts, and consequently partial constructions to theorise. My presence within the hospital extended beyond the interview site to one of 'frequent observer' of the day-to-day transactions, viewed within a variety of clinical and administrative settings.

One of the main challenges to ethnography was the management and organisation of the voluminous field notes and transcripts. The experience of well-published researchers guided the development of some approaches to the preparation of 'data' for analysis. The decision to construct two distinct analytic chapters, buttressed by a historical and organisational account of KEH, enabled the explanation of complex interactions which prevailed in the temporal and spatial realities of the narrators.

The ethnographic approach was suitable to a feminist, post-structural theoretical perspective. Examining the intersecting nature of discourse, knowledge and power at the level of the day-to-day realities and practices of nurses called for being situated in the field. This in turn facilitated insights into the interrelationship of context, historicity and difference.

9.3   Nurses in Transition: Sociological Significance

Most of the research undertaken in the areas of nursing in transition, nursing and labour unrest, and nursing and organisational change has been quantitative in nature and frequently focused on a specific issue (such as recruitment or curriculum development) or a transitional event. The multiple and ongoing literature searches uncovered few accessible qualitative research projects, none of which entailed investigating nurses' reactions to transitional imperatives during this time. Of the qualitative work, little exists which situates inquiry in the broader contextual fields

of these women's experiences[114]. Therefore, this study addressed a gap in the literature that is distinct. It was driven by ethnographic methods, undertaken over the course of four years, and focused on engaging interpretative methods in the theorising of narratives to explain the constraints that impaired nurses from benefiting from transitional dynamics.

Locating nursing within the broad social terrain of investigation strengthens the social profiles of nurses, making visible the forms of domination that constrain change, and the contradictory discourses and practices that sustain inequities and moral/ethical inconsistencies within their workplace settings. It is imperative that research contributes to the chipping away of the isolation nurses experience in hospitals, nursing schools and organisational dynamics. Hopefully, bringing these discourses, practices, and their realities into the wider field of social inquiry will advance this process.

Although this study did not focus on power per se, the narratives have pointed to forms of power nurses have and which they exercise in various relations. Nurses actively engage in dynamics with colleagues, tertiary employees, patients and families on a day-to-day basis. The reproduction

---

114

Authors who have undertaken qualitative approaches of this nature include Diana Gibson's (1993) in a case study into clinical interactions between doctors and nurses at a Cape Town teaching hospital, and Liz Walker's (1993, 1996), whose investigation into reproductive politics and abortion undertaken in the early 1990's amongst African primary health care nurses at Soweto clinics.

of dominant relations of power in nursing, that many find objectionable, was illustrated in narratives describing how nurses adopt many of the controlling discourses and practices.

The observation that discourses and practices are multiple, linked and often contradict the central moral and ethical fabric of health care has implications for KEH, health care planners and policy makers. This is an important consideration during these transitional years when questions of redressing inequities have high priority. The reality that the majority of patients treated at KEH represent indigent categories adds a critical light to the objectionable conditions of care expressed by nurses. Workforce and workplace issues, such as shortages of staff and resources, create enormous tensions within the hospital environment. They constrain capacities of nurses to provide adequate care and they serve to heighten dehumanising perceptions.

Added to this is evidence showing women's moral commitment to health care. Women's testimonies revealed that the majority entered nursing by default, primarily driven by lack of choice or material imperatives. Notwithstanding this, most nurses adopted discourses of caring, that inspired moral commitment to patients. Contradictory practices such as poor conditions, strict, ineffectual hierarchies, and isolating practices have visibly eroded commitment and capacities to practice effectively, increased inter- and intra-occupational tensions, and disheartened many nurses.

Nurses' testimonies pointed to the constraints of inadequate remuneration. The work is demanding, the conditions are hard, the staff shortages compound work loads. In addition, many carry the added burden of financial support to extended families, which is an enormous load for those who are single parents. These findings were largely supported by a UND nursing survey (Sitas, et al. 1998). In all, they have important implications for the institutions and organisations which educate and represent nurses, in particular for those who claim to support the professional and labour interests of nurses.

The testimonies are an illustration of the many subject-locations navigated by these women who are located within the nexus of subaltern institutional relations. The interpretative style employed has been instrumental in capturing and illuminating their multiple realities and dimensions of experience while being aimed at redirecting perspectives beyond that of a nurse, to the many fields they navigate. Bringing the voices of nurses to the fore intended to unsettle constructions and perceptions held by African nurses and others that permeate current social understanding of these women, care-givers and professionals. As noted in chapter three, these voices have rarely been heard within the lexicon of relations in South Africa. They are voices historically veiled by constraints inherent to their locations within patriarchal and colonial power relations, and the many hierarchies within their occupation. Hearing their voices, making visible their realities and pursuing insights into the subaltern institutional relations contributes to the way social meaning is constructed, and thus, to a knowledge and understanding of

these women and the social forces they navigate.

9.4   Limitations of this research

Language, specifically the inability to communicate with narrators in their mother tongue, limited the depth of the conversations with the narrators. The interviews were conducted in English, and whilst the training and work environment, and interactions with doctors, managers and colleagues were primarily conducted in English, their skill and comfort in speaking English varied.

In addition to this, cultural, racial and, importantly, historic differences presented limitations to my perceptions and interpretations of meaning and experiences. These differences presented obstacles to analytical sensitivity of nuanced data, inevitably constraining analysis and interpretation. Aware of this, I remained sensitive to these constraints throughout and incorporated approaches to buttress theoretical rigour. However, I was aware that these factors imposed limitations to this work.

A central aim of the research has been to project the 'voices' of nurses into the stories and narratives, thus increasing the visibility of these women in this research. However, theoretical analyses and selection of whose voices were heard, when and for how long, was my undertaking, The construction of narratives required more 'choice' on my part, editorial in nature. Whilst I aimed to maintain the overall intention of statements, comments of nurses were occasionally streamlined and perhaps more determined than they were in the field. This resulted in a particular

construction, which narrows the reader's access and orders the experiences of some of the women who spoke.

A growing tendency within feminist and social science research involves engagement in 'action-oriented' and participatory methodologies that involve interactive strategies with research participants. The merit of incorporating strategies such as these is to magnify the 'voice' of participants while engaging them in the development of the data. Although these approaches were initially entertained, the acute tensions existing within the nursing staff and workplace, the constraints upon nurses' time and conditions of work, and the tense transitional moment surrounding the field work precluded these approaches. I perceived this to be a limitation.

An important limitation to this work was in the area of linking these findings with those of the earlier study into the transition of nursing organisations. As noted, feminist, post-structuralists assert that subject positions are accepted when they intersect with the interests of individuals (Weedon, 1987:112) and that social actors are produced when values and mores become coherently linked with that of others (Smith, 1973:101). Linking these insights with the findings from the earlier study might contribute to strategies for the constituents of academic settings, institutions and organisations, and the alleviation of issues discussed in this study.

9.5   Recommendations for further research

This study pointed to the ways that pressures experienced by nurses are compounded by discourses and practices which serve to reinforce their isolation. The discussion regarding the narrow appropriation of discourses of caring, the disabling aspects of hierarchies, the restraining contradictions of gendered professionalism are all areas that would merit further qualitative investigation. Investigations into the impact of difference and disadvantage on occupational realities, that bear in mind race and gender as significant imperatives, would be valuable elaborations.

Approaches that aim at strengthening links between nurses and representative organisations, wherein enabling strategies could be developed, would be worthwhile courses to take. Further research that contributes to this concern might involve evaluation of institutional and organisational relations and priorities, of obstacles to women's empowerment, and the identification of strategies and capacities to alleviate the inequities and contradictions nurses negotiate. Organisations such as DENOSA and NEHAWU would be valuable to examine, as well as other organisations who aspire to or claim to represent nurses. Nursing programmes at university and college facilities would also be fascinating sites of research into such questions.

The study found that nurses valued discourses of caring, yet their own sense of dignity and professional integrity has been eroded because of chronic and unresolved disparities within their occupation and work site.

Findings pointed to the divisiveness and unsupportive character of relationships nurses have with colleagues of different nursing categories and within different spheres of work, such as general workers and doctors. Notions of team work as a practice did not often emerge, yet collaboration and cooperation were noted as a means of maintaining function in the light of shortages of staff and difficult conditions of work. Action-oriented or participatory research in these areas would be valuable to understand the complex nature of these relationships and to inform strategies related to building more coherence, support and respect within institutional environments. This may also help to diminish feelings of isolation while improving job satisfaction and performance.

This research did not involve interviews with doctors, yet nurses frequently referred to the disjunctures in their working relationships. On occasion doctors inquired into the research and volunteered views and perspectives of their interactions with nurses, the role of nurses, and often, the problems with the nurses. Research into doctors experiences, perceptions, attitudes and behaviours toward nursing and nurses would be valuable and would potentially provide insight into ways of resolving differential perceptions of power and care.

The healthcare system in South Africa is undergoing important and timely transformation, with considerable attention being paid to decentralising care, shifting the focus from a strict allopathic model and implementing an accessible district health care system based upon a community-based primary health care model. It is imperative that nurses participate in the process of shaping these changes. It would be

worthwhile to investigate nurses' absence from the arenas of policy development, and explore curriculum and technical requirements that would build capacities in this area.

Nursing has evolved globally at a different pace. In exploring literature from Canadian sources, there is a growing prevalence of critical inquiry into the area of power, feminism and autonomy in nursing. Comparative research to explore developments regionally and internationally, to evaluate what has worked and strategies that might suitably be employed within the South African context might be of merit. At the same time, nursing in other parts of the world has undergone similar issues and is enduring the effects of restructuring health systems and health care reform. Trade barriers are changing to meet the needs for material and human resources resulting in a global push and pull for nursing human resources. Comparative research into workplace and workforce issues impacting upon nurses globally would contribute to understanding these trends and facilitate human resource planning.

9.6   Conclusion

Nursing in South Africa has arrived at an important juncture. The crisis in the profession has endured through the transitional period in South Africa and has the potential for intensifying as the profession and country compete in the global economy. The challenges to the profession, its leaders and stakeholders will mount as HIV/AIDS prevalence strains the health care system and as the borders open, luring well-qualified nurses to foreign employment opportunities.

This study demonstrated the power relations that intersect to form barriers confronting nurses in their working lives. It described the discourses and practices that have presented formidable obstacles to the provision of quality nursing care and, due to their longstanding impact, has eroded the morale of nurses and the pride they once held for the profession. Self subjection to the discourses of care served to instill a sense of autonomy that lent coherence to the fragile occupational community. Indeed, nurses demonstrated a strong commitment to their roles of care-givers.

While the study pointed to the many issues that intensified the frustrations within the work environment, it also suggested that the contextual and historical disadvantages that the nurses negotiated within their social and domestic environments intensified institutional isolation and personal vulnerability. Ultimately, these women were unable to actively alter their chronic institutional disparities due to the fragmented, isolated and vulnerable subject positions they occupied.

Resolution of these realities requires concerted strategies extending beyond individual support to the complex sites of dominating relations of power. Hierarchical dynamics, divisiveness within categories, ongoing isolation of nurses, and the reproduction of gender inequities are issues that require further multi-disciplinary research. The complexity of these issues merits attention by organisations who represent nurses, the institutions which educate and employ them, and the policy makers and planners within the public and private sectors.

NATALSE PROVINSIALE
ADMINISTRASIE

NATAL PROVINCIAL
ADMINISTRATION

HEALTH SERVICES BRANCH

☎ :

FAX :

King Edward VIII Hospital
Private Bag
CONGELLA
4013

7 June 1995

Ms June Webber
Faculty of Social Science
Department of Socialogy
University of Natal
King George V Avenue
DURBAN
4001

Dear Madam

RE : PERMISSION TO CONDUCT MASTERS LEVEL RESEARCH INTO THE : "TRANSITION OF NURSING ORGANISATIONS IN SOUTH AFRICA.

Your letter dated 4 June 1995 refers.

Permission is granted for you to conduct the above research programme.
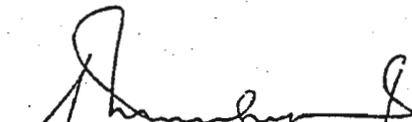
L DWARKAPERSAD
CHIEF MEDICAL SUPERINTENDENT

Bibliography

Acker, J., Barry, K. & Esseveld, J. 1983. "Objectivity and Truth" in Fonow and Cook.(Ed.) **Beyond Methodology.** Bloomington: Indiana University Press.

Adam, H. 1971. **Modernising Racial Domination: South Africa's Political Dynamics**. Berkeley: University of California Press.

Adler, Patricia A. and Adler, Peter. 1994. "Observational Techniques" in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research.** London: Sage.

African National Congress. 1994. **The Reconstruction and Development Programme: A Policy Framework.** Johannesburg: Umanyano Publications.

Alant, C. (Ed.) 1990. **Sociology and Society: A Humanist Profile.** Cape Town: Southern.

Alexander, M.J. & Mohanty, C.T.(Ed.) 1997. **Feminist Genealogies, Colonial Legacies, Democratic Futures.** New York: Routledge.

Altheide, David L. and Johnson, John M. 1994. "Criteria for Assessing Interpretive Validity in Qualitative Research", in Denzin, N. and Lincoln, Y. (Ed.) **Handbook of Qualitative Research.** London: Sage.

Anderson, R.E. and Carter, I.1990. **Human Behaviour in the Social Environment: A Social Systems Approach** .(4th Edn.) New York: Aldine de Gruyter.

Appignanesi, Richard and Garratt, Chris. 1995. **Postmodernism for Beginners.** Cambridge: Icon Books.

Armstrong, P. 1993. "Women' Health Care Work: Nursing in Context" in Armstrong, P., Choiniere, J. and Day, E. **Vital Signs: Nursing in Transition.** Toronto: Garamond Press.

Armstrong, P. & Armstrong, H. 1990. **Theorizing Women's Work.** Toronto: Garamond Press.

Aronowitz, Stanley. 1988. "Forward" in Touraine, Alain. **Return of the Actor**. Minneapolis: University of Minnesota Press.

Ashley, J. 1976. **Hospitals, Paternalism, and the Role of the Nurse.** New York: Teachers' College Press.

Atkinson, Paul and Hamersley, M. 1994. "Ethnography and Participant Observation" in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research.** London: Sage.

Babbie, E. 1995. **The Practice of Social Research.** Belmont: The Wadsworth Publishing Company.

Bailey, K.D. 1987. **Methods of Social Research.** New York: The Free Press.

Baly, M.E. 1980. **Nursing and Social Change.** London: William Heinemann Medical Books Ltd.

Barrett, M. 1991 **The Politics of Truth: From Marx to Foucault.** Cambridge: Polity.

Barrett, Michele and Phillips, Anne. 1992. **Destabilizing Theory.** Cambridge: Polity.

Barthes, Roland. 1972. **Critical Essays.** Evanston: Northwestern University Press.

Batth, Indy and Reid, Colleen. 1998. "Class, Race and Issues of Voice: Confronting Some Ideals of Feminist Research". Paper delivered at Qualitative Health Research Conference, Vancouver.

Beall, Jo. 1989. "Confrontation or Solidarity" in **Agenda.** No. 4.

Becker, Howard S. 1986. **Writing for Social Scientists.** Chicago: University of Chicago Press.

Beinart, W, Delius, P. & Trapido, S.(Eds.)1986. **Putting a Plough to the Ground: Accumulation and Dispossession in Rural South Africa.** Johannesburg: Ravan.

Benner, Patricia. 1984. **From Novice to Expert.** California: Addison-Wesley Publishing Company.

Benner, P; Tanner, CA; Chesla, CA. 1996. **Expertise in Nursing Practice: Caring, Clinical Judgement, and Ethics.** New York: Springer Publishing Company.

Berger, Iris. 1992. **Threads of Solidarity: Women in South African Industry, 1900-1980.** Bloomington: Indiana University Press.

Bezuidenhout, F.J. 1982. "Socialisation of the Student Nurse in the Nursing Profession" in **Curationis**. Vol. 5 No. 1.

Bonner, P. (Ed.) 1977. **Working Papers in Southern African Studies.** Johannesburg: African Studies Institute.

Bonnin, D., Gwagwa, T., Issacs, S, and Sitas, A. 1994. "Strikes and Worker Expectations in KZN" in **South African Labour Bulletin**. Vol.18. No.5.

Bowden, P. 1997 **Caring: Gender-Sensitive Ethics**. London: Routledge.

Bozzoli, Belinda. 1983. "Marxism, Feminism, and South African Studies" in **Journal of Southern African Studies**. Vol.9, No.2 p.139-171.

Bozzoli, Belinda. 1987. "Class, Community and Ideology in the Evolution of South African Society" in Bozzoli, B. (Ed.). **Class, Community and Conflict: South African Perspectives.** Johannesburg: Ravan Press.

Bozzoli, Belinda and Delius, Peter. 1990. "Radical History and South African Society" in **Radical History Review.** 46/7; p.13-45.

Bradford, Helen. 1987. "We are now Men: Women's Beer Protests in the Natal Countryside, 1929" in Bozzoli, B. (Ed.) **Class, Community and Conflict**. Johannesburg: Ravan Press.

Bryman, A. and Burgess, R.G.1994 **Analyzing Qualitative Data.** London: Routledge.

Budlender, Debbie (Ed.). 1996. **The Women's Budget.** IDASA

Bulmer, M. 1984. **Sociological Research Methods: An Introduction (Second Ed.).** London: MacMillan.

Bunting, Brian. 1986. **The Rise of the South African Reich.** International Defence and Aid Fund for Southern Africa. (First published by Penguin:1964)

Burgess, R.G. 1993. **In the Field: An Introduction to Field Research**. London: Routledge.

Callinicos, Alex. 1987. **The Revolutionary Ideas of Marx.** London: Bookmarks.

Campbell, Catherine. 1990. "The Township Family and Women's Struggles in **Agenda.** No. 6.

Castells, Manuel. 1986. **The Rise of the Network Society.** Oxford: Blackwell.

Castells, Manuel. 1987. **The Power of Identity.** Oxford: Blackwell.

Castells, Manuel. 1998. **End of Millennium.** Oxford: Blackwell.

Clandinin, D. Jean and Connelly, F. Michael. 1994. "Personal Experience Methods" in Denzin, N. and Lincoln, Y.(Eds.) **Handbook of Qualitative Research.** London: Sage.

Clifford, James and Marcus, George (Eds.) 1986. **Writing Culture: The Poetics and Politics of Ethnography.** Berkeley: The University of California Press.

Cock, Jacklyn. 1980. **Maids and Madams: Domestic Workers under Apartheid.** Johannesburg: Ravan Press.

Cock, Jacklyn. 1990. **Colonels and Cadres: War and Gender in South Africa.** Cape Town: Oxford University Press.

Cock, Jacklyn and Bernstein, Alison. 1998. **Diversity and disadvantage: Perspectives from the USA and South Africa.** Unpublished paper presented at the South African Sociological Association Conference, Rand Afrikaans University, RSA.

Cohen, J. 1985. "Strategy or Identity: New Theoretical Paradigms and Contemporary Social Movements" in **Social Research.** 52: 4.

Concerned Nurses of South Africa. 1993. Minutes of the First National Consultative Conference.

Coser, Lewis A. 1994. **Everett C. Hughes: On Work, Race, and the Sociological Imagination.** Chicago: The University of Chicago Press.

Cousins, Mark and Hussain, Athar. 1984. **Michel Foucault: Theoretical Traditions in the Social Sciences.** London: MacMillan.

Critical Health, No 24, October, 1988. "Special Issue on Nursing in South Africa"

Damane, T.V.P. 1992. "Factors Influencing Job Satisfaction and Dissatisfaction of Professional Nurses Employed by the Department of Health: Transkei". Unpublished Masters Dissertation. UND.

Derrida, Jacques. 1978. **Writing and Difference.** London: Routledge & Kegan Paul Ltd.

Denzin, Norman K. 1994. "The Art and Politics of Interpretation" in Denzin, N. and Lincoln, Y.(Eds.) **Handbook of Qualitative Research.** London: Sage.

Denzin Norman K. and Lincoln, Yvonna S. (Eds.) 1994. "Introduction: Entering the Field of Qualitative Research", in **Handbook of Qualitative Research.** London: Sage.

De Kiviet, C.W. 1941. **A History of South Africa: Social and Economic.** London.

Dobson, S.M.1991. **Transcultural Nursing.** London: Scutari Press

Dreyfus, Hubert and Rabinow, Paul. 1986. **Michel Foucault: Beyond Structuralism and Hermeneutics.** Sussex: Harvester Press.

Dumont, L. 1970. **Homo Hierarchicus: The Caste System and its Implications.** London: Weidenfeld and Nicolson.

Dyck, Isabel, Lynam, Judith & Anderson, Joan. 1985. "Women Talking: Creating Knowledge Through Difference in Cross-Cultural Research." in **Women's Studies International Forum.** 18:5/6

Dyer, C. Adams, E.B., Seedat, A.M. & Morfopoulos, J. 1986. "Fifty Years at King Edward VIII Hospital, Durban in **South African Medical Journal.** 70

Easle, B. 1981 **Science and Sexual Oppression.** London: Weidenfeld and Nicolson.

Fillingham, Lydia Alix. 1993. **Foucault for Beginners.** New York: Writers and Readers Publishers Inc.

Fine, Michelle. 1994. "Working the Hyphens: Reinventing Self and Other in Qualitative Research" in Denzin, N.K. & Lincoln, Y.S. **Handbook of Qualitative Research.** London: Sage.

Fisher, Foszia and Mare, Gerhard. 1974. **The Durban Strikes: 1973.** Durban: Ravan Press.

Fonow, M.M. & Cook, J.A. (Eds.) 1983. **Beyond Methodology: Feminist Scholarship as Lived Research.** Bloomington: Indiana University Press.

Forrest, Kally. 1996. "Mapping out the Future: The Public Sector in the Wake of the Nurses' Strike" in **South Africa Labour Bulletin.** Vol. 20. No. 1.

Foucault, Michel. 1973. **The Birth of the Clinic: An Archaeology of Medical Perception.** London: Tavistock Publications.

Foucault, Michel. 1975. **Discipline and Punish.** London: Penguin Books.

Foucault, Michel. 1980. **Power / Knowledge: Selected Interviews and Other Writings 1972-1977.** London: Harvester Press.

Foucault, Michel. 1986. "The Subject and Power" in **Michel Foucault: Beyond Structuralism and Hermeneutics.** Sussex: Harvester Press.

Foucault, Michel. 1990. **The History of Sexuality.** (Vol.1) New York: Vintage Books.

Fox, Nicholas J. 1993. **Postmodernism, Sociology and Health.** Buckingham: Open University Press.

Fraser, Nancy. 1989. **Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory.** Cambridge: Polity Press.

Fraser, Nancy. 1998. **"The Politics of Redistribution and Recognition".** Unpublished paper delivered at University of Natal - Durban to be published in forth-coming book with Honnet. .

Friedan, Betty. 1963. **The Feminine Mystique.** London: Penguin.

Fuchs, R.A. 1995. **The Essentials of Sociology.** New Jersey: Research and Education Association.

Gamson, William. 1992. "The Social Psychology of Collective Action" in Morris, A. & McClurg Mueller, C. **Frontiers in Social Movement Theory.** New Haven: Yale University Press.

Garvey, Nicola. 1989. "Feminist Poststructuralism and Discourse Analysis" in **Psychology of Women Quarterly.** No.13, 459-475.

Gibson, Diana. 1996. "Bodies, Space and Time: Contestation and Social Differentiation in Interaction Between Doctors and Nurses - An Intervention Case Study in a Teaching Hospital in Cape Town, South Africa". Paper delivered at the PAAA/AASA Conference on Anthropology and the Social Transformation of Africa: UNISA

Gilligan, Carol. 1982. **In a Different Voice**. Cambridge: Harvard University Press.

Giddens, A. 1989. **Sociology.** Oxford: Polity.

Giddens, A. (Ed.) 1992. **Human Societies.** Oxford: Polity.

Glaser, B.G. and Strauss, A.L. 1967. **The Discovery of Grounded Theory: Strategies for Qualitative Research**. Chicago:Aldine.

Goldberg, R. 1989. **Grassroots Resistance: Social Movements in Twentieth Century America.** California: Wadsworth Publishing.

Goodson, I.F. and Rob Walker. 1991. **Biography, Identity and Schooling**. London: The Falmer Press.

Goodson, I.F. and Stephen J. Ball (Eds.) 1984. **Defining the Curriculum: Histories and Ethnographies**. London: The Falmer Press.

Gouldner, A.1971. **The coming Crisis of Western Sociology.** London: Heinemann.

Gramsci, Antonio. 1971. **Selection from the Prison Notebooks.** New York: International Publishers.

Guy, Jeff. 1990. "Gender Oppression in Southern Africa's Pre-capitalist Societies" in Walker, C. **Women and Gender in Southern Africa to 1945.** Cape Town: David Philip.

Gwagwa, Thembeka and Webber, June. 1995. "Striking Nurses: Trapped in Frustration" in **South African Labour Bulletin**. Vol. 19. No. 6.

Hall, Catherine. 1996. "Histories, Empires and the Post-Colonial Moment" in Chambers, Iain and Curti, Lidia. **The Post-Colonial Question: Common Skies, Divided Horizons.** London: Routledge.

Hammond, Merryl. 1982. **Nursing in Crisis: A Study of Contributing Factors.** Unpublished MA in Sociology, University of the Witswatersrand.

Haralambos, M. & Holborn, M. 1995. **Sociology: Themes and Perspectives** (4th Edn.) London: Collins Educational.

Haraway, Donna. 1991. **Simians, Cyborgs, and Women: The Reinvention of Nature.** New York: Routledge.

Harraway, Donna. 1989. **Primate Visions: Gender, Race, and Nature in the World of Modern Science.** New York: Routledge.

Harding, Sandra. (Ed.) 1987. **Feminism and Methodology: Social Science Issues.** Bloomington: Indiana University Press.

Harding, Sandra. 1986. **The Science Question in Feminism.** Milton Keynes, Bucks: Open University Press

Harding, Sandra. 1991. **Whose Science? Whose Knowledge?: Thinking From Womens' Lives.** Milton Keynes, Bucks: Open University Press.

Harrison, P.H. 1973. "Withdrawal of the South African Nursing Association from the International Council of Nursing" in **South African Nursing Journal.** (Sept.)

Harvey, D. 1990. **The Condition of Postmodernity: An Enquiry into the Origins of Cultural Change.** Cambridge: Blackwell.

Hassim, Shireen. 1991. "Conservative Politics and the Construction of Gender in South Africa" unpublished paper for CDAS, McGill University, Montreal.

Hassim, S. & Walker, C. 1992. "Women's Studies and the Women's Movement' in **Transformation.** 18/19: 78-85.

Health Systems Trust. 1995. **South African Health Review.** Durban: HST and Kaiser Foundation.

Heighway, VA. 1990. "A Case Study to Illuminate the Perceptions Developed by Student Nurses which result in Absenteeism as the Behaviour of Choice in Response to Difficulties in their Educational Programme. Unpublished MPhilosophy, University of Cape Town.

Hekman, Susan (Ed.) 1996. **Feminist Interpretations of Michel Foucault.** University Park, Penn.: Pennsylvania University Press.

Hemson, David. 1996. "For Sure You Are Going to Die!: Political Participation and the Comrade Momvement in Inanda, KwaZulu-Natal" in **Social Dynamics.** 22.2 p 74-104.

Hirson, Baruch. 1979. **The Year of the Ash.** London: Zed Press.

Horn, Pat. 1991. "Post-Apartheid South Africa: What About Women's Liberation?" in **Transformation.** 15:26-40

Hughes, C. 1994. "From Field Notes to Dissertation: Analyzing the Step-Family" in Bryman, A. and Burgess, R. **Analyzing Qualitative Data.** London: Routledge.

Hughes, J. 1990. **The Philosophy of Social Research.** London: Longman.

Jaggar, A.M. 1988. **Feminist Politics and Human Nature.** New Jersey: Rowman & Littlefield Publishers.

Janesick, Valerie. 1984 "The Dance of Qualitative Research Design: Metaphor, Methodolatry and Meaning" in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research.** London: Sage.

Jayaratne, T.E. & Stewart, A.J. 1983. "Quanitative and Qualitative Methods in the Social Sciences' in Fonow and Cook (Eds.). **Beyond Methodologies.** Bloomington: Indiana University Press.

Johnstone, F.A. 1976. **Class, Race and Gold: A Study of Class Relations and Racial Discrimination in South Africa.** London: Routledge and Kegan Paul.

Kaganas, Felicity and Murray, Christina. 1994. "Law and Women's Rights in South Africa: An Overview" in Murray, C. (Ed.) **Gender and the New South African Legal Order.** Cape Town: Juta Press.

Khun, Thomas. 1995. "on paradigms" in Babbie, E. **The Practice of Social Research** (7th edn.) Belmont: Wadsworth Publishing Co.

Kincheloe, Joe L. and McLaren, Peter L. 1994. "Rethinking Critical Theory and Qualitative Research" in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research.** London: Sage.

Kirby, LA. 1992. "A Recruitment Strategy for Student Nurses". Unpublished MCur, Rands Afrikaans University.

Knorr-Cetina, K. and Cicourel, A.V. 1981. **Advances in Social Theory and Methodology:Toward an Integration of Micro- and Macro-sociologies.** Boston: Routledge and Kegan Paul.

Kortenbout, W. 1995. "An Exploratory Analysis of Alternative Approaches in Distance Learning Programmes for Nurses". Unpublished Phd Thesis. UND.

Kunene, Phumelele. 1995. **Strikes by Nursing Personnel: A Challenge for Nurse Managers in KwaZulu-Natal Province.** Unpublished MA: University of the Witswatersrand.

Kuper, Hilda. 1965. "Nurses" in Kuper, L. **An African Bourgeoisie: Race, Class, and Politics in South Africa.** New Haven: Yale University Press.

Kuper, Leo. 1965. **An African Bourgeoisie: Race, Class, and Politics in South Africa.** New Haven: Yale University Press.

Kyriacos, U. 1996. "Ethics in Practice" in **Nursing News.**Vol. 20. No. 10.

Legassick, Martin. 1970. "The Frontier Tradition in South African Historiography" in Marks, Shula and Atmore, Anthony. 1980. **Economy and Society in Pre-Industrial South Africa.** London: Longman.

Lincoln, Yvonne S. and Denzin, Norman K. 1994. "The Fifth Moment" in Denzin, N. and Lincoln, Y. (Eds.) **Handbook of Qualitative Research.** London: Sage.

Loomba, Ania. 1998. **Can the Subaltern Speak? Postcolonialism, Postmodernism and Writing Subaltern History.** Unpublished paper delivered to the History and African Studies Seminar Series (No. 9) University of Natal - Durban.

Lombard, SA. 1994. "Fears and Phobias in Black Student First Year Student Nurses with Emphasis on Culture". Research undertaken in the Dept. of Nursing: Medical University of South Africa.

Lovell, T. 1996. "Feminist Social Theory" in Turner, B. (Ed.). **Social Theory.** Oxford: Blackwell.

MacMillan, W.M. 1919. **The South African Agrarian Problem and Its Historical Development.** Johannesburg.

Mafunda, T.N. 1995. "Socialisation of Student Nurses in South Africa". Unpublished Masters Dissertation. UND.

Makhathini, J. 1992. "An Evaluation of the Problem-Solving Ability of Diplomates from the Comprehensive Nursing Programme". Unpublished Masters Dissertation. UND.

Mama, Amena. 1995. **Beyond the Masks: Race, Gender and Subjectivity.** London: Routledge.

Marais, FAT. 1984 "The Unsuccessful and Unsuccessful Nursing Student: A Comparative Study". Research undertaken in the Dept. of Nursing, Rand Afrikaans University.

Marcus, George E. 1986. "Contemporary Problems of Ethnography in the Modern World System" in Clifford, J. and Marcus, G. **Writing Culture**. Berkeley: University of California Press.

Marcus, George E. 1994. "What Comes (Just) After "Post"? The Case of Ethnography" in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research**. London: Sage.

Mare, G. & Fisher, F. 1974. **The Durban Strike 1973: "Human Beings with Souls"**. Johannesburg: Ravan

Marks, Shula. 1987. **Not Either An Experimental Doll: The separate worlds of three South African Women**. Durban: Killie Campbell Africana Library; Pietermaritzburg: University of Natal Press.

Marks, Shula. 1993. "The Nursing Profession and the making of Apartheid" in Bonner, P., Delius, P. and Posel, D. **Apartheid's Genesis: 1935-1962**. Johannesburg: Ravan Press.

Marks, Shula.. 1994. **Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession**. Johannesburg: Witwatersrand University Press.

Marks, Shula & Atmore, Anthony. 1980. "Introduction" in Marks, S. and Atmore, A.(Eds.) **Economy and Society in Pre-Industrial South Africa**. London: Longman.

Marks, Shula & Trapedo, Stanley. (Eds.) 1987. **The Politics of Race, Class and Naionalism in 20th Century South Africa**. London: Longman.

Marx, Karl and Engels, Frederick. 1987. **The Communist Manifesto**. New York: Pathfinder.

Mashaba, T.G. 1986. **The Socio-Economic Status of Black Students of Nursing and Its Implications for Nursing Education**. RSA: University of Zululand.

Mashaba, T.G. 1995. **Rising to the Challenge of Change: A History of Black Nursing in South Africa**. South Africa: Juta & Co, Ltd.

May, T. 1993. **Social Research**. Buckingham: Open University Press.

McCaffery, P.G. 1978. **An OPD for King Edward VIII Hospital**. Unpublished MA in Architecture, UND.

McCoppin, B. and Gardner, H.1994. **Tradition and Reality**. Melbourne: Churchill Livingstone.

McCormick, Janice. 1997. **The Discourses of Control: Power in Nursing**. Unpublished PhD: University of British Columbia.

McDowell, L. & Pringle, R. 1992. **Defining Women: Social Institutions and Gender Divisions**. Cambridge: Polity Press.

McHoul, Alec and Grace, Wendy. 1993. **A Foucault Primer: Discourse, Power and the Subject.** Melbourne: Melbourne University Press.

McLellan, David. 1980. **The Thought of Karl Marx.** (2nd Edn.) London: Papermac.

McNay, Lois. 1992. **Foucault: A Critical Introduction**. New York: Continuum.

Mellish, M.E. 1978. **Ethos of Nursing: A South African Perspective.** Durban: Butterworths.

Mellish, M.E. 1984. **A Basic History of Nursing**. Durban: Butterworths.

Mellish, M.E. 1985 **Ethos of Nursing**. Durban: Butterworths.

Merriam Webster's Collegiate Dictionary (10th Ed.). 1993. Markham: Thomas Allen & Son Limited.

Mies, M. 1983. "Women's Research or Feminist Research?" in Fonow and Cook (Eds.) **Beyond Methodology.** Bloomington: Indiana University Press.

Millett, Kate. 1969. **Sexual Politics.** London: Virago Press.

Mohanty, Chandra T. 1991. "Under Western Eyes: Feminist Scholarship and Colonial Discourses" in Mohanty, C.T., Russo, A. and Torres, L. **Third World Women and the Politics of Feminism**. Bloomington: Indiana University Press.

Mohanty, C.T., Russo, A. and Torres, L. 1991. **Third World Women and the Politics of Feminism,** Indianapolis: Indiana University Press.

Moosa, Allie. 1986. "Appalling Death Rate Among Hospital's Gastroenteritis Babies" in **Sunday Tribune.** 31:8:86

Morris, Aldon and Mueller, Carol. 1992. **Frontiers in Social Movement Theory.** New York: Yale University Press.

Mouton, J. and Marais, H.C. 1990. **Basic Concepts in the Methodology of the Social Sciences.** South Africa: Human Sciences Research Council.

Myburgh, Jacqueline. 1990. **Unionism and Collective Bargaining in the Nursing Profession.** Unpublished MBA, University of Witwatersrand.

Nkonjera, N. 1995. "A Descriptive Study of a Theory Practice Gap in General Nursing Science Education". Unpublished Masters Dissertation. UND.

Nzimande, Blade and Sikhosana. 1995. "'Civil Society', Mass Organisations and the National Liberation Movement in South Africa" in Sachikonye, Lloyd. **Democracy, Civil Society and the State.** Harare: Sapes Books.

Nzimande, PN. 1993. "An Investigation into the High Failure Rate Amongst the University of Zululand First Year (Basic B Cur) Students". Research undertaken at the University of Zululand.

Olesen, Virginia. 1994. "Feminisms and Models of Qualitative Research", in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research.** London: Sage.

Personal Narratives Group. 1994. **Interpreting Women's Lives: Feminist Theory and Personal Narratives.** Bloomington: Indiana University Press.

Peterson, Alan and Bunton, Robin. 1997. **Foucault: Health and Medicine.** London: Routledge.

Phillips, Anne. 1997. "From Inequality to Difference: A Sever Case of Displacement" in **New Left Review.** 224: 143-153.

Phillips, N. 1990. "Stress and Stress Management in Nurse Managers". Unpublished Masters Dissertation. UND.

Platzky, Laurine & Walker, Cherryl. 1985. **The Surplus People: Forced Removals in South Africa.** Johannesburg: Ravan Press.

Poggenpoel, M. & Muller, M. 1996. " Challenges Facing the South African Nursing Profession". in **Nursing News.** Vol. 20. No. 10.

Porter, M. 1995. "Call Yourself a Sociologist: And You've Never Been Arrested?!" in **CRSA** Vol 32, No.4.

Porter, M. 1994. "Second-Hand Ethnography: Some Problems in Analyzing a Feminist Project" in Bryman, A. and Burgess, R. **Analyzing Qualitative Data.** London: Routledge.

Posel, Deborah. 1992. Women's Powers, Men's Authority: Rethinking Patriarchy. Paper presented at Durban conference on Women And Gender in Southern African.

Potgieter. E. 1992. **Professional Nursing Education: 1860-1991.** Pretoria: Academica.

Price, Robert M. 1991. **The Apartheid State in Crisis: Political Transformation in South Africa 1975-1990.** New York: Oxford University Press.

Pryed, MP. 1992. "A Marketing Strategy for a Nursing College". Unpublished MCur, Rand Afrikaans University.

Radloff, D.H. 1977. **Socio-Economic Progress for Nurses in South Africa Through Professional Organisation: 1914-1969.** Pretoria: SANA

Ramazanoglu, Caroline (Ed.) 1992. **Up Against Foucault: Explorations of Some Tensions Between Foucault and Feminism.** London: Routledge.

Randall, M. 1988. "Feminism and the State: questions for Theory and Practice" in **Resources for Feminist Research: Feminist Perspectives on the Canadian State.** Vol.17 No.3.

Ransome, Paul. 1992. **Antonio Gramsci: A New Introduction.** New York: Harvester-Wheatsheaf.

Richardson, Laurel. 1994. "Writing: A Method of Inquiry" in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research.** London: Sage.

Rispel, Laetitia. 1990. **Nurses' Attitudes to Different Organisations: Policy Implications.** Unpublished MA: University of the Witswatersrand.

Rispel, Laetitia. 1995. "Challenges Facing Nurses in the Republic of South Africa" in **Image: Journal of Nursing Scholarship.** 27:3.

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

Robinson, J. 1994. "White Women Researching/Representing Others: From Anti-Apartheid to Post-Colonialism?" Unpublished Paper: UND

Romm, N. 1995a. "Gouldner's Reflexive Methodological Approach" in Alant, C. **Sociology and Society.** Cape Town: Southern.

Romm, N. 1995b. "A Humanist Analysis of Marxism: Gouldner's Two Marxisms" in Alant, C. **Sociology and Society**. Cape Town: Southern.

Rowbotham, Sheila. 1992. **Women in Movement.** New York: Routledge.

Rowbotham, Sheila. 1996. "Introduction" in Threlfall, Monica. **Mapping the Women's Movement.** London: Verso.

Said, Edward. 1978. **Orientalism**. London: Routledge and Kegan Paul.

Said, Edward. 1993. **Culture and Imperialism**. New York: Vintage Books.

Sandelowski, Margarete. 1993. "Rigor or Rigor Mortis: The Problem of Rigor in Qualitative Research Revisited in **Advanced Nursing Science**. 16 (2):1-8.

Sanders, David. 1985. **The Struggle for Health**. London: MacMillan Press.

Sarup, Madan. 1993. **An Introductory Guide to Post-Structuralism and Postmodernism**. New York: Harvester Wheatsheaf

Saussure, Ferdinand de. 1974. **Course in General Linguistics** (Revised Edn.) London: Peter Owen.

Sawicki, Jana. 1991. **Disciplining Foucault: Feminism, Power, and the Body.** London: Routledge.

Schwandt, Thomas. 1994. "Constructivist, Interpretivist Approaches to Human Inquiry" in Denzin, N. and Lincoln, Y. **Handbook of Qualitative Research**. London: Sage.

Schwartz, H. and Jacobs, J. 1979. **Qualitative Sociology: A Method to the Madness.** New York: The Free Press.

Scott, Joan W. 1992. "Deconstructing Equality - versus - Difference: or, The Uses of Post-Structuralist Theory for Feminism" in McDowell, L. and Pringle, R. **Defining Women: Social Institutions and Gender Divisions.** London: Polity Press.

Searle, C. 1965. **The History of the Development of Nursing in South Africa: 1652-1960.** Pretoria: The South African Nursing Association.

Searle, C.. 1987. **Professional Practice: A South African Nursing Perspective.** Durban: Butterworths.

Searle, C. 1975. **Some Aspects of Nursing Education.** Pretoria: SANA.

Sitas, Ari. 1991. "The Comrades" in **Reality.** (May) p 6-8.

Sitas, Ari.; Burns, Catherine; Webber, June; & Phillips, Gary. 1998. **A National Survey of South African Nurses.** Unpublished survey commissioned by the Democratic Nursing Organisation of South Africa.

Smart, Barry. 1985. **Foucault.** London: Routledge.

Smith, A.D. 1973. **The Concept of Social Change.** London: Routledge & Kegan Paul.

Smith, Dorothy E. 1987. **The Everyday World as Problematic: A Feminist Sociology.** Toronto: University of Toronto Press.

Smith, J.P.1981 **Sociology and Nursing.** London: Churchill Livingstone.

South African Institute of Race Relations. 1994. **Race Relations Survey.** Johannesburg: SAIRR.

South African Nursing Association. 1990. **Report on the Inquiry into the Nursing Profession 1990.** Pretoria

South African Nursing Association. 1987. **The Professional Nurse in Private Practice: Position Paper** . Pretoria.

South African Nursing Association. 1980. **Nursing Service in the Republic of South Africa.** Pretoria.

South African Nursing Association. 1978. **Report on Nursing Education in the RSA and the Self-Governing Territories.** Pretoria.

Spivak, Gayatri Chakravorti. 1978. **In Other Worlds: Essays in cultural Politics.** London: Methuen.

Spivak, G.C. 1978b. "Can the Subaltern Speak" in **In Other Worlds: Essays in Cultural Politics.** London: Methuen.

Strauss, A. and Corbin, J. 1990. **Basics of Qualitative Research: Grounded Theory Procedures and Techniques**. London: Sage.

Tarrow, Sidney. 1994. **Power in Movement: Social Movements, Collective Action and Politics.** London: Cambridge University Press.

Taylor, V. and Rupp. L.J. 1983. "Researching the Women's Movement" in Fonow and Cook (Eds.) **Beyond Methodology.** Bloomington: Indiana University Press.

Themba, MP. 1995. "The High Failure Rate of Pupil Nurses during the First Year of Training at Bethesda /Mseleni Nursing College". Research undertaken in Dept. of Nursing, University of Zululand.

Thompson, Janice. 1997. "Knowledge, Identity and the Politics of Difference". Paper presented at the Eighth Annual Critical and Feminist Perspectives in Nursing Conference. Whistler, Canada.

Threlfall, Monica. (Ed.) 1996. **Mapping the Women's Movement.** London: Verso.

Tilly, Charles. 1981. **As Sociology Meets History.** New York: Academic Press.

Tong, R. 1993. **Feminine and Feminist Ethics**. California: Wadsworth Publishing.

Touraine, A. 1981. **The Voice and the Eye: An Analysis of Social Movements.** Cambridge: Cambridge University Press.

Touraine, A.1985. "An Introduction to the Study of Social Movements" in **Social Research**. Vol.52, No.4.

Touraine, A.1988. **Return of the Actor.** Minneapolis: University of Minnesota Press.

Turner, B. (Ed.) 1996. **The Blackwell Companion to Social Theory.** Oxford: Blackwell.

Turner, Bryan S. 1997. "From Governmentality to Risk: Some Reflections on Foucault's Contribution to Medical Sociology" in Peterson, A. & Bunton, R. **Foucault: Health and Medicine.** London: Routledge..

Uys, L. 1994. **An Investigation of Policy Options with Regard to a Regulatory Body for Nursing in South Africa.** Durban: UND.

Uys, L. 1988. **The position of Nursing Science in South Africa.** Inaugural Lecture delivered in the University of Natal, Durban 3 June 1987.

Uys, L. 1992. "Should Nurses Strike" in **Nursing RSA**. 7:3

Valodia, Imraan. 1996 "Work" in Budlender, D. (Ed.) **The Women's Budget**. Cape Town: IDASA.

Van der Merwe, A. 1996. **An Epistemological Study of the Power of Women as Nurses: A Phenomenological Approach.** Unpublished Phd Dissertation: University of Natal-Durban.

Van der Merwe, TE. 1993. "An Investigation of the Role of Personality, Gender Identity, Perceived Sources of Stress, and Major Life Events in Occupational Stress, Coping and Burnout Amongst Student Nurses". Unpublished MA Thesis, University of Natal Durban.

Van Tonder, Sally. 1992. "The Influence of Strike on Rights" in **Nursing RSA**. 7:3

Vicich, Arthur and Lyman, Stanford. 1994. "Qualitative Methods: Their History in Sociology and Anthropology" in Denzin, Norman and Lincoln, Yvonne. **Handbook of Qualitative Research**. California: Sage.

Vlok, M.E. and Lochner, M.M. 1983.**Manual of Basic Nursing**. Cape Town: Juta & Co, Ltd.

Von Holdt, Karl. 1994. "Strike Wave: Time for a Reconstruction Accord?" in **South African Labour Bulletin**. Vol. 18. No. 4.

Walker, C. 1982. **Women and Resistance in South Africa.** London: Onyx Press.

Walker, C. (Ed). 1990. **Women and Gender in Southern Africa to 1945.** Cape Town: David Philip.

Walker, C. 1991. **Women and Resistance in South Africa.** (2nd Edition) Cape Town: David Philip.

Walker, E. 1993. "The Responses and Understandings of a Group of Primary Health Care Nurses, Based in Soweto, to the Issue of Abortion". Unpublished MA, University of the Witwatersrand.

Walker, E. 1996. "My work is to help the woman who wants to have a child, not the woman who wants to have an abortion': Discourses of Patriarchy and Power among African Nurses in South Africa". In **African Studies**. 55:2.

Warren, A.B. 1988. **Gender Issues in Field Research.** London: Sage.

Webber, June. 1994. **The Concerned Nurses of South Africa and the Transition of Nursing Organisations in South Africa: 1994.** Sociology (Honours) Thesis: UND.

Webber, June. 1997. "The Transformation of Nursing in South Africa: Reality or Rhetoric." Unpublished paper delivered at the Critical and Feminist Perspectives Conference. British Columbia.

Webster, Eddie. (Ed.) 1978. **Essays in Southern African Labour History**. Johannesburg: Ravan Press.

Webster, Eddie. 1987. "Workers Divided: Five Faces from a Hidden Abode" in Bozzoli, B. (Ed.) **Class, Community and Conflict**. Johannesburg: Ravan Press.

Weedon, Chris. 1987. **Feminist Practice and Poststructuralist Theory.** Cambridge: Blackwell.

West, Cornell. 1993. "The new cultural politics of difference" in **Race, Identity and Representation in Education**. C. McCarthy and W. Crichlow (Ed.). New York: Routledge.

West, Guida and Blumberg, Rhoda. 1990. **Women and Social Protest.** New York: Oxford University Press.

White, R. (Ed.) 1988. **Political Issues in Nursing: Past, Present and Future (Vol.3)**. UK: John Wiley & Sons.

Witz, Anne. 1992. Professions and Patriarchy. London: Routledge.

Wolpe, Harold. 1988. **Race, Class and the Apartheid State.** London: James Currey.

Zald, Aldon D. 1992. "Looking Backward to Look Forward: Reflections on the Past and Future of the Resource Mobilisation Research Programme" in Morris, A. & McClurg Mueller, C. **Frontiers in Social Movement Theory.** New Haven: Yale University Press.