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EXPLORING IRISH NURSING CAREERS IN THE BRITISH NATIONAL HEALTH SERVICE

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This research has been carried our entirely by the author. No part of this has been previously submitted for a degree or other qualification in this or any other university.

ABSTRACT

Title: Exploring Irish Nursing Careers in the British National Health Service.

Background: The experiences of minority ethnic groups working in the NHS have been explored from a perspective of race ideas, primarily colour. Little is known about Irish nurses as a key group of actors and agents who have played a significant role in the reserve army of labour filling the ranks of the British health service. There are unanswered questions about their career progress and any commonalities and differences with other white and black nurses.

Aims: The study explores questions around career progress, specialisation and settlement in the UK for Irish men and women.

Design: The research is empirical and employs substantial secondary analyses of two large scale data sets.

Findings: Irish nurses are not merely a historical feature of the National Health Service; they continue to play a significant part in service delivery, management and education. Core peripheral relations continue to act as a mechanism in the numbers of Irish men and women seeking to pursue nursing work in the UK. They have achieved relative career success in comparison to other minority ethnic groups. The Irish appear to be collectively rewarded as a subaltern group in this post colonial job nurse market. Gender is highly significant with regard to career success.

Conclusions: The findings contribute to a more complex picture of Irish working lives in UK, from in relation to questions of ethnicity, gender, and occupational progress.

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CHAPTER ONE
INTRODUCTION

The genesis of this thesis lies within the stories told to me as a child by two generations of my family, Irish women who had trained and worked as State Registered Nurses in London before and after the Second World War. Their anecdotal accounts intrigued me as a child and offered challenges to histories of post-war migration which foregrounded colour, or race, in constructing ethnicity. Their personal experiences also jarred with my later readings of published historical and social analyses, which seemed unable to illuminate the particular experiences of Irish women in British society. Such gendered perspectives, often little more than footnotes, empathised with the plight of Irish men trapped within the British casual labour market, who were literally building a new model welfare state. Yet though the oral histories of my family acknowledged discrimination, they also emphasised settlement, inclusion and professional advancement in the British health labour market. Their stories are not matched in the literature on ethnicity and work in UK, which to date has not provided any substantive analysis of Irish nursing in this country.

This thesis, therefore, intends to explore the work experiences of Irish women, and men, in British post-war nursing. This has been partly enabled by the access I was granted to two, large-scale datasets, which provide a unique opportunity to specifically examine career success and patterns of settlement for Irish nurses. I particularly wish to interrogate the assumption that as an out-group they may have experienced discrimination in terms of career speciality and progression. Comparisons will also be drawn with other minority ethnic groups in British nursing with regard to relative career success or failure.

The National Health Service, so emblematic of the post-war British Welfare State, has always depended on overseas reserve armies of labour to fill the gaps in its ranks of medical and nursing personnel. The career experiences of Asian and Black health workers have particularly drawn policy attention towards issues of discrimination and equal opportunities for minority ethnic groups living and working in UK. Yet the well reported antagonism encountered by these minority

ethnic groups here and further afield in British society also reflects tensions expressed towards earlier incomers who, as internal immigrants, had also been seen collectively as a possible threat to the political and social well being of the United Kingdom. The Irish have remained both a significant reserve army of labour and a highly significant out-group in English and Scottish politics and cultures, throughout the latter part of the nineteenth century and into the twentieth century (Miles, 1982).

At the founding of the NHS in 1948, one in twelve nurses working in British hospitals were of Irish origin (Abel-Smith, 1960). Secondary analysis of the Beishon study data (Beishon *et al.*, 1995) undertaken here by the author shows that they remain the largest ethnic minority group working in England and Wales. Yet their experiences as an ethnically distinct group remain largely uncharted within the largest occupational group working in the British Health Service. This raises questions regarding the contemporary career status of Irish nurses against other minority ethnic groups competing for access to training and subsequent employment.

Early post-war British policy attempts to covertly favour Irish and European workers against Black and Asian immigrants seeking employment in UK had largely failed; labour demand simply lay within the hands of corporate agents (Archer, 1995). These agents were primarily private employers or autonomous public institutions like the NHS (Carter, 2000, p.124).[1]

The explicit adoption of discriminatory immigration controls from 1962 onwards opened a Pandora's box for those migrants now living and attempting to work in

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[1] Ironically, the suggested extension of the Aliens Act (1905) by a Government working party in 1950, to exclude overseas British subjects, collapsed in face of the likely administrative futility of monitoring a highly mobile group such as the Irish as aliens. It was accepted "that there would be few, if any, Irish workers whom we should wish to exclude" (Joshi & Carter, 1984, p62). Again in 1955 the estimated arrival of 250,000 Irish workers and the absorption of hundreds of thousands of European displaced persons under the European Volunteer Workers (EVW) Schemes undermined other arguments for blocking immigration from non-White, Commonwealth countries. This logic failed, however, to prevent the imposition of the 1962 Commonwealth Immigration Act (Carter, 2000, p.135).

UK. The state had permitted discourses on colour, identity and citizenship, amongst others that problematised ethnic, 'non-white' categories and alternately promoted, albeit unintentionally, counter discourses and mobilisation to resist structural discrimination in terms of employment, education and housing. As Carter (2000, p.138) argues: "this anterior distribution of structural and cultural resources gives us […] in 1948 actors and agents differentially placed to pursue projects and realise interests. Differing actors and agents are variously constrained and enabled by this distribution and in attempting to keep it as it is, they interact with each other." Some of the resulting processes of systematic colour discrimination and exclusion are now explicated.

Ethnic inequalities in pay were still evident in UK throughout the 1990s (see Blackaby *et al.*, 1994, 1998; Modood *et al*, 1997; Shields & Wheatley Price, 1998). For example, Blackaby *et al.*, (1994), using data from the General Household Survey, found that black workers, due to their more favourable observed labour market characteristics including flexibility and skills, should have experienced a 4.4 *per cent* wage advantage over white workers between 1983 and 1989. The actual wage differential was 12.1 *per cent* in favour of white workers, albeit with some evidence of a marginal narrowing of differentials in the 1990s.

Gender inequalities in pay have long been recognised as a characteristic of the British labour market, and have been the subject of much empirical work (Blackaby *et al.*, 1997; Renes & Ridder, 1995; Tzannatos & Zabalza, 1984; Wright & Ermisch, 1991). A general conclusion is that pay differentials are not fully explained by differences in the observable human capital characteristics of men and women. Wright and Ermisch (1991), for example, found that of the 48 *per cent* gender earnings differential observed in the 1980 Women in Work Survey, only 60 *per cent* could be attributed to differences in the labour market characteristics of men and women.

Some studies have suggested that these pay inequalities are largely attributable to the fact that women have lower promotion rates and are thus less likely to be found in higher paying jobs than men. It is often suggested that the existence of a 'glass ceiling' prevents women from advancing to the higher levels of the occupational ladder. Jones and Makepeace (1996), using personnel data from a large financial company, found evidence indicating that women must meet tougher promotion

criteria than men, and concluded that discrimination was evident in all promotions beyond the bottom of the job ladder.

In contrast, Groot and Maassen van de Brink (1996), using data from the British Household Panel Survey, found statistical evidence to suggest a rather different discriminatory mechanism. They distinguished between those jobs in which there was potential for promotion, and jobs with few prospects, finding that women are less likely to be appointed to the former. The recent literature on gender promotion differentials has been motivated by the model of Lazear and Rosen (1990), which predicts that women must have a greater ability than men if they are to be promoted. This is because women generally have productive tasks in the household that men do not, and thus have a higher risk of turnover. This reduces the net benefits to the employer from training and promoting women, so fewer women are observed in the higher levels of the organisation.

Nursing in UK is a large and important occupational group, with longstanding claims to professional status, and one where the internal labour market has several specific features. It is one of the so called 'caring' professions, and, therefore, considerations other than the usual economic ones were traditionally expected to play a role in pay and promotion, not least vocational assumptions around public service and altruism. It continues to be a female-dominated profession, with over 90 *per cent* of qualified nurses being women. Minority ethnic groups are also known to be over-represented in British nursing: 6.3 *per cent* and 14.7 *per cent* of female and male nurses respectively are from such minorities, compared to 3.6 *per cent* and 3.9 *per cent* in all employment (Beishon *et al.*, 1995).

Nursing is also unusual in that it is dominated by the public sector: only 16 *per cent* of the Beishon NHS-based sample ever worked in private sector nursing, and over 90 *per cent* of nurses are in the public sector at any time (Phillips, 1995). Beishon challenged the assumption that gender and racial discrimination are less significant in the public than in the private sector (Blackaby *et al.,* 1996). Nurses' pay is negotiated at the national level and pay differentials within grades are small, so promotion within NHS nursing has been an important issue for some time. Low morale and poor recruitment of school-leavers into nursing have been linked to poor promotion prospects, with only 20 *per cent* of white, 13 *per cent* of black and 12

per cent of Asian NHS nurses being satisfied with their promotion prospects (UNISON, 1996, Beishon *et al.*, 1995).

An intriguing potential data source is offered by a major survey of NHS nursing staff carried out by the Policy Studies Institute for the Department of Health (Beishon *et al.*, 1995). Data were gathered using postal questionnaires sent to one third of the permanent nursing staff from a stratified sample of 91 NHS employers in England, with ethnic minorities deliberately over-sampled. Fieldwork was carried out between February and April 1994. The response rate was 62 *per cent*, generating a sample of 8,178 female and 741 male Registered General Nurses aged 21-65. The survey gave a unique insight into work histories, allowing identification of actual years of nursing experience, total time spent out of nursing and the number of career breaks. It also gave information on household circumstances, the highest level of educational attainment, the age of first registration and the number of completed post-basic training spells.

A universal grading structure for NHS nursing staff was introduced in 1988, which for registered nurses spanned seven grades, from C to I. Enrolled nurses were generally graded at C, the most junior grade. Grades D and E were allotted to staff nurses, F and G for charge nurses or ward managers and grades H and I were reserved for senior nurses, including nurse tutors, and nurse managers. Table 1 shows the sample distribution of nursing grades by gender and ethnic origin. Membership of ethnic groups is as declared by the survey respondent. The 'black' group includes people of African and Caribbean origin, while 'Asian' includes those who are Indian, Pakistani, Bangladeshi and Chinese. Table 1 indicates that men are more likely than women to be at grade D and grades H and I. The crude gender differentials in nursing grades are considerably smaller than those found by Jones and Makepeace (1996) and Groot and Maassen van de Brink (1996). Unqualified, auxiliary and enrolled nurses (grades A-C) were also sampled. However, I have excluded these groups, who comprised only 16 *per cent* of the sample.

The thesis makes a contribution to the study of promotion between job grades as an element of the internal labour market, and particularly of the role of gender and ethnicity as influences on that process. The NHS nursing profession is an interesting one from this point of view, since it is a public-sector, female-dominated 'caring' profession, with a high proportion of staff from minority ethnic groups. One might

expect that a profession with these characteristics would be less likely than others to engage in racial and gender discrimination. The Beishon findings were not consistent with this view, this was particularly demonstrated by the significant advantage, in terms of speed of promotion, for white nurses against Black and Asian colleagues. This amounted, in cash terms, to some £40,000 more in additional earnings over a whole career (roughly 4-9 *per cent*). There was only very weak evidence of an advantage for male nurses over females, although a secondary analysis by Pugley *et al.,* (1998) found that interrupted career paths are more disadvantageous for men than for women in nursing. Neither study, however, extracted data on Irish nurses, whose career success, or otherwise, constitutes the critical focus of this thesis.

The following chapters will offer some empirical evidence to map out their distinct experiences. This thesis is concerned to make some sense of the contemporary professional lives of Irish nurses working in the British National Health Service. Moreover, it will examine career success following the assumptions of Beishon. The literature review in Chapter Two will examine something of this history within the broader context of Irish immigration to the UK. Mary Hickman (1998) and Bronwen Walter (Hickman & Walter, 1997) have broadly argued that the Irish in UK have been marginalised in terms of employment and housing. However, this thesis will explore whether this is evidenced within the context of nursing, a significant occupational entry gate for post-war, Irish migrant workers. This analysis must be considered within a broader framework of contemporary 'race relations', which has been shaped by responses to the arrival and settlement of other ethnic groups, where identity issues have been distinguished primarily by skin colour and the now rather quaint notion that UK had suddenly become 'multi- ethnic' and the host population must now deal with the novelty and uncertainty of ethnic diversity.

The four-nation history assumed of the British Isles perversely misunderstands how a British, white identity is the particular historical project of nationalist sentiments concerned with constructing citizenship (Samuel, 1998). Such views have played a significant part in shaping the life experiences of minority ethnic groups, and indeed in shaping the majority population perception of the rights of such minority groups. This homogeneous view of British national identity not only marginalised competing Celtic identities, but also traded on the language of 'race' in positing colonial and imperial identities.

The literature review will therefore establish the contextual features of the background and history of Irish immigration to Britain, specifically analysing the impact of differing policy strategies towards recruiting to NHS nursing, amidst co-existing, uneven and sometimes contradictory policy directions in managing multi-cultural diversity. Such strategies have seen overseas NHS nurses responding to policies moving from assimilation, to multiculturalism, and anti-racism. The discussion within Chapter Two will particularly explore how Irish nurses working in the British health service carry a social identity/identities derived from socialisation and interactions within the conditions created by pre and post war patriarchal relations of the Irish state and church. These shaping influences with regard to identity are not only an intrinsic product of Irish society and culture, but also an outcome of the broader economic core periphery relations between a nominally independent Republic of Ireland and post colonial Britain. These are then conditions for diasporic identity formation, and secondary socialisation within the UK. The core periphery relations in the context of the new British welfare state and economic stagnation in post war Ireland create the conditions for a category, Irish nurses, to perform a variety of subaltern identities shaped by gender, and ethnic perceptions of whiteness that are further considered within Chapter Three.

Identity is clearly a contestable concept. Chapter Three will especially examine the problematic of identity as a social category. The chapter will explore how doing social identity through categorisation critically informs the epistemology of this thesis. The core problem here is whether identities can be intrinsically understood by social categorisation, a process that methodologically underpins the Beishon and the UKCC datasets unpacked respectively within the following analytic chapters. Identity matters not only at the everyday encounter, but on wider stages, so understanding the workings of identity from a sociological perspective brings together what Jenkins (1996, p3) has termed our 'public issues' and our 'private troubles'. I will explore how social and individual identities are inextricably interwined in framing understandings of difference.

This analysis of the theorisation of identity deals with social construction and how identities emerge through social interaction and processes of exclusion. These 'relational identities' necessarily require what Hall has called the 'constitutive outside' of Western modernity, not only a division of labour, a global socio-economic order, but a self-identity constructed through its relation to the colonial

other (Hall & Gieben, 1992; Hall, 1992b), that is notions not only of other distinct categories that are other, opposing, and beyond the boundary, such as binaries of nationality, class or gender, but also more complex constructions of ethnicity and race that emerge through processes of affiliation, or exclusion. The chapter will further consider how nurses from a variety of subaltern positions attempt to negotiate their positions and identities in the NHS through the relational habitus surrounding supervision, a critical stage with regard to managing self. Successfully doing identity here is a key task in establishing position within the group, the analysis will discuss the implications with regard to ideological claims to autonomy, personal growth and the confessional nature of such power relationships in nursing. This will also be considered in light of theories of governance and struggles particularly marked by hegemonic constructions around gender, race and professional competence.

The chapter will also revisit the tensions around nursing as a gendered occupation and the provision of labour to the NHS, its treatment of other categories of nurse, i.e. Black and Asian nurses and men. The case of the Irish as an acceptable 'other', will firstly be based on shared 'culture' within groups, this will be elaborated on in an analysis of the interaction order around built around competence and govermentality of the self. This will particularly explore impact on identity as theorised in the work of Foucault, Hacking, and Rose on identity, discipline and govermentality and the contributions of Bordieu on habitus. The chapter will conclude on potential implications of a subaltern status for Irish nurses, noting particularly the gendered and ethnic nature of advances in occupational status at the expense of other minority groups, specifically the process of queuing as a racialised and gendered process excluding women and non white minority groups. This discussion will contrast the theoretical assumptions of Gramsci against the celebratory perspective of Indian subaltern cultural and historical studies.

The consequences for the methodology and methods of this thesis are explicated in Chapter Four. How 'White Irishness' as a theoretical concept becomes an operational concept will be discussed in relation to the employment of Office of National Statistics (ONS) ethnic categorisation procedures. In addition, Chapter Four will give a detailed justification of the methods of data collection and analysis for the quantitative procedures to be employed, particularly for establishing the validity of the findings from the two major datasets analysed for this thesis.

An in-depth, statistical analysis of the Beishon and the then United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) datasets is undertaken respectively in Chapters Five and Six. These empirical analyses provide cardinal evidence of the distinctive career histories of Irish nurses working in the UK. Beishon provides the most compelling data on professional progress across clinical specialities and up clinical grading ladders. The UKCC data provide an opportunity to scrutinise complementary data on minority ethnic representation across speciality, and in addition, comparative data on settlement patterns by ethnic grouping. This information is mapped out by postcode to district level across the UK, and the findings are presented and discussed in Chapter Six.

Chapter Seven summarises arguments for the distinctive career trajectories experienced by Irish nurses working in the UK, and gives consideration to further questions of policy and research in relation to securing equal opportunities and understanding processes of discrimination. The careers of Irish nurses, as explored in this thesis, will also add a richer theoretical dimension to questions of social identity and ethnicity in British society.

CHAPTER TWO

LITERATURE REVIEW

INTRODUCTION

This chapter will firstly review the literature on core and periphery migration between the United Kingdom and Ireland, with particular reference to how these structural processes have shaped the experiences of Irish women as social actors entering nursing in the UK. Secondly, I will move on to explore how this significant phenomenon has been addressed within the key theoretical and policy literature on questions of 'race relations' and their impact on post war British nursing recruitment. This will specifically focus on the experiences of minority ethnic groups working in the National Health Service. Finally, I will establish the rationale for this thesis and detail specific research questions for further exploration through the available evidence.

Irish women and migration to the UK

Ireland has been described historically as an 'emigrant nursery', supplying the labour demands of the British and global economies from the 19th century onwards (Mac Laughlin, 1994, 1997). A 'new wave' of post-civil war migration further fed on the embedded histories of migration within post-famine, Irish working class and rural families. Moreover, contemporary demographic analysis of British census returns shows that this pattern of migration continues today, most particularly to London and the South East of England (Walter, 1997).

Ravenstein's classic migration theory anticipated 'push pull' models of migration. 'Push' factors include lack of employment opportunities, poor wages and population pressures, as for example in the so called 'congested' areas of the Irish western seaboard. 'Pull' factors have been considered to include increased standards of living, increased work opportunities and the lure of an urban life (Delaney, 2000, p.8). Information has also been argued as an important factor in promoting further migration. Content analysis of Irish emigrant correspondence lends credence to this contention (*ibid*, p.11). Improved and cheaper transportation

links across the Irish Sea in the post-war period can also be taken into account. Increased numbers of return emigrants would also have added to the lure of England *(ibid*, p.12), and conversely the obstacles to success in pre-war America. The potential for remittances may also have influenced family pressures on individuals emigrating to support the household. Otherwise, migration theory tends to emphasis individual choice, linked to changing labour market conditions in sending and receiving societies (Delaney, 2000, p.14). Delaney proffers the view that a sociological account might alternatively start with migration as an element of social change. Such approaches have acknowledged historical context in examining "changing specificities of time and space" (Zolberg, 1989, p.29). This means that structural implications must be understood at differing regional, area and household levels against claims for a tradition of emigration, for example in the impact of agricultural mechanisation. Such analyses should explore differential emigration in terms of ethnicity, class and gender, and cleavages introduced by age, education, aspiration, family and kin structure, and occupation and income on decisions to migrate or stay.

Delaney observes that sociological enquiry has classically tended to examine changes within destination societies, and the forms which assimilation and integration might take. More recently, studies have reported on resistance to adaptation, including potential conflict (Morokvasic, 1984, p.18-19). Such resistance is linked to ethnicity, where ethnic group formation in host societies has been variously accepted, or has led to processes of marginalisation or exclusion (Castles & Miller, 1993, p.196). Rex (1983, p.5), drawing on Park's (1963) conception of identity formation through interaction, and Mason (1983) have also made useful theoretical contributions through 'race', and class perspectives, which recognise the socially mediated nature of race categories. However, Carter (2000), building on Miles' (1982, p.33) Marxist critique of the problematic of 'race relations', has challenged the ontological claims made for race relations by Rex, which leaves a restricted, possibly inactive sense of temporality. Carter also challenges under-theorised, post-modernist and feminist conceptions of race, notably the work of Rattansi (1992), not least on the contingencies that shift an understanding of identity from a critical realist perspective employing morphogenesis (Archer, 1995).

Carter frames his sociological history of the development of post-war immigration policy in the UK up to 1983 around critical realist concepts of morphogenesis. He

identifies a contradiction in the 'cultural system' between the Commonwealth ideal of equality and the presumed unsuitability of coloured immigration, and attempts to explain changes in government policy largely in terms of the need to resolve this contradiction. Structural conditions are understood mainly in terms of labour supply and demand, and cultural conditions in terms of the persistence of colonial relations between the UK and its overseas territories. Carter argues here that "realism points to the fact that interaction cannot produce its own conditions of existence" (Carter, 2000, p.107). The basic model echoes features of political economy: first, the conditions for interaction, which are held to consist of ordered products of past interactions – what Marx labelled 'dead labour'; second, interaction itself, or 'live labour'; and third, the products of interaction, which are embodiments of past interactions partly reordered by the current interaction. This requires the explicit adoption of a "stratified view of social action" (Carter, 2000, p.110).

Carter further offers a multi-dimensional theory of the social identity of human beings. First, they exist as persons with individual psychology and identity. Second, they are social actors, occupants of social positions and playing social roles. Finally, they are agents, that is, members of collectivities with similar life chances (Carter 2000, p.110-11). Carter further advocates an investigation of the use of race categories as an aspect of governance, as a means of regulating and surveying populations (Carter 2000, p.146-7). This point will be returned to later in Chapter Three with regard to theorising identity at the categorical level.

Carter's version of critical realism is complex and sophisticated, and the following account is necessarily a brief, descriptive summary. Five key elements can be distinguished: (1) analytical dualism, (2) the stratified nature of social reality, (3) a distinction between lay and scientific discourse, (4) an approach to empirical research based on the 'translation' of 'traces' of complex causal relations, and (5) a methodology based on Archer's (1995) 'morphogenetic cycle'.

(1) Analytic dualism means that structure and agency cannot be reduced to each other. The experiences of Irish nurses and other social actors cannot be conflated with processes of deindustrialisation. (2) The stratified nature of social reality follows Layder's (1990, 1997) theory of domains, in which social reality is said to consist of four relatively autonomous 'levels': psycho-biography, situated activity, social settings and contextual resources. This has implications for Irish and other

ethnic minority workers as social actors and agents. (3) Layder (1990) distinguishes between lay and scientific languages, arguing that race has a place in the former but not in the latter. This point has particular pertinence to questions of methodology and the conceptualisation of Irish identity, or identities, particularly in Northern Ireland. (4) Carter's approach relies on Pawson's (1989) model of generative mechanisms and emergent powers to construct the empirical data to be measured. This will be explored further with regard to modelling causality and claims for regularities. (5) Carter's methodology adopts a historical approach to sociological investigation, with the 'morphogenetic cycle' consisting of repeated sequences of structural conditioning, social interaction and structural elaboration. This narrative organisation is reflected in the two major themes of gender and nationality unpacked within this chapter with regard to the unique characteristics of the National Health Service as a labour market.

So, immigration policy shapes international migration as a distinctive social process (Zolberg, 1989). The resulting impact on Irish emigration to the UK is discussed further below with regard to inter-war restrictions on entry to America, and post-war settlement in the UK. British policy in this area fell into line with legislation in 1962, 1968 and in the Immigration Act of 1971, which effectively stepped back from a tradition of free entry (Holmes, 1988, p.309). Such moves mark State attempts to determine migration patterns, the failure of Fianna Fáil policy here is also explored below in relation to its broader political programme in modernising Ireland.

Global theorisation incorporates labour moving across national borders and internally, alongside movement from under-developed regions to industrialised areas. This work typically drew on a concept of core periphery driven by structuralist concerns, patterns of economic development and the production of an international division of labour. This theory also has ready application to internal rural and urban migration, a striking characteristic of Irish migration.

Core-periphery theory also emphasises that core absorption of peripheral labour and goods at the regional or state level prevents peripheral areas developing or restructuring their own market arrangements, thus leaving the periphery dependent on the core (Jackson, 1984, p.22). Mac Laughlin develops this position with regard to Irish labour entering post-war Britain.

Finally, a key factor in core periphery analysis, at least from a geographical perspective, is location. Delaney (2002, p.17) cites examples of adjacent states in support of this position, though she also recognises US Irish emigration as a challenge to this stress on geographical proximity. Network theory also offers helpful analytical tools in understanding who was influenced to migrate, or stay, and where Irish people initially settled in the UK.

Modern Irish histories have substantially drawn on anti-colonial discourses in explaining the driving forces on emigration and settlement. However, its contingency in contemporary Ireland has been too easily explained away as natural and traditional, and it has failed to address the underlying structural forces that continue to shape Irish society within the modern global economy. Past social and economic accounts relied heavily on the geographical and behavioural aspects of migration for explanatory purposes. Such accounts have exercised a hegemonic status which denies the potential of structurally-based critiques, especially those that can usefully draw on world systems theory (Wallerstein, 1979). World systems theory moves beyond dealing with *core* and *periphery* as merely spatial concepts. Core and periphery, from a Wallerstein systems perspective, are something more than locational, geographically-defined features; they are derived from structuring processes that underpin development and under-development.

Where a state, or zone or area, performs both core and periphery functions, they are 'semi-periphery' (Mac Laughlin, 1997, p.5). Taylor (1985, p.16) has demonstrated how such zones exploit, or are exploited by, other peripheral and core zones respectively, whilst Agnew (1982, p.162) has explored how migration has similarly structured the world economy. The implications of world systems theory for Ireland particularly challenge nationalist discourses on English colonialism in terms of Ireland as a peripheral location, and Irish emigration being constructed as an exceptional case. Rather, Ireland can be conceptualised in terms of peripheral status. Mac Laughlin further argues that the contemporary social sciences have also failed to move beyond geographical core-periphery theorising. Indeed, more is known about the famine and the status of Victorian Irish settlers in Britain and the United States of America than present-day experiences of Irish emigrants in the international labour market.

Mac Laughlin moves on to argue a 'hidden injury' thesis, in which a longstanding bourgeois hegemony and the growth of a petit bourgeoisie have, in combination, pushed young Irish people abroad to create and maintain political and economic space for a social ideal, gender-modelled by the so called 'thirty acre men' the vanguard of both Redmonite constitutional and Sinn Fein revolutionary nationalism (1994, p.6).

Historical and contemporary Irish migration flows can, therefore, be explicitly linked to other population shifts between North Africa, the Caribbean and Eastern Europe to the core economies of Europe and the global economy. World systems theory can also be utilised to question voluntarism in its behavioural assumptions, by pinpointing structural processes that operate within Ireland and at the level of the international economy.

Geographical 'locationalism' in traditional core and periphery accounts means that core and periphery become agents of change, operating as simple 'push' and 'pull' factors across the international economy. Simply, this would mean peripheries generate or produce potential emigrants, while cores attracted them. But world systems theory can firstly see Irish emigration as not accounted for by locational factors, or improved transport and communication systems (*ibid*, p.8). Systems theory can secondly be employed to conceptualise Ireland in relation to its peripheral *status* as the Irish State, rather than its peripheral economic *location* to the world economy. This means that no Irish Government could have halted the substantially involuntary emigration flows of the early 20th century. Wallerstein's global model thirdly offers a version of the reserve army of labour, in that Irish emigration is essentially rooted in the interface between a farming export economy and a global economy that placed new, commodifying values on its Irish rural and working class recruits, or rather conscripts, in particular values concerning their flexibility and cheapness.

So, Irish rural capitalism helped to facilitate huge labour and food surpluses, compelling young adults to seek opportunities abroad. Finally, unlike both theories of revisionism and modernisation, world systems theory has not merely reduced emigration to either historical 'causes', or to deal with emigration as a behavioural phenomenon. World systems theory can help explore links to the political and

economic structure of nineteenth Ireland, including the growth of an Irish bourgeois and petty bourgeois, nationalist ruling class.

Ireland can usefully be seen as an example of a semi-periphery economy exploiting and exporting labour and the commodities of agricultural labour. These processes helped the growth of a core within the productive rural hinterland so valorised by nationalist rhetoric, which fails to explain continued exploitation by the core areas of British and World economies (*ibid*, p.12.).

For Mac Laughlin (1997, p.12) emigration is a *social response* [writer's italics] to structuring and restructuring processes, at local, national and global levels. Mac Laughlin (1997, p.12) moves on to offer an extensive, historical Gramscian analysis of labour mobility and hegemony. In short, nation building and emigration ran hand in hand, poor law legislation in Ireland continued to be exercised against smallholders, and other poorest and most desperate sections of post-civil war Irish society, by Irish, Catholic propertied classes. Surplus land fell into the hands of 'improving' tenants and an emergent class of catholic independent farmers. Farming specialisation effectively pushed surplus 'offspring' on family farms towards migration. Arensberg claimed that: "[e]ight of ten people working on in agriculture in Ireland work not for wages and salaries but by virtue of their family relationship" (Delaney, 2000, p.53). Their lack of status is perhaps mirrored in the census category to which they were assigned: 'relatives assisting'. This becomes more problematic later for researchers trying to distinguish this category in emigration returns that might only denote them as labourers or domestic servants.

Thus, a Catholic, Irish 'middling' tenancy benefited from land acquisition and the consequent exclusion of surplus labour from the local market. Ironically perhaps, agrarian reform was no longer an issue of civil and economic independence; instead, reform now only meant the transfer of existing land from tenancy to outright proprietorship. The price paid for this within the stem family system demanded that usually only the male son and heir, and one daughter, were married and dowered, the former with the farm and the latter with the family fortune. The remaining siblings would be obliged to travel, a practice that was to persist until the late 1950s (Delaney, 2000, p.54).

Support for 'assisted emigration' also transcended religious and ethnic division from the late 19th century onwards. Advocates could be particularly found amongst the more substantial tenancy and the Irish catholic clergy. Support for this policy was especially strong in many 'congested' districts in of the west of Ireland.

> Irish nation builders, most notably the Catholic Church and cultural nationalists, tended to anglicise the causes of problems like rural poverty and large scale emigration and nationalised their solutions. (Mac Laughlin, 1997, p.21)

This meant implicitly accepting emigration as 'natural', and of course fitting the political and economic interests and goals of medium to large farmers. These 'thirty acre men', ironically such traditionally staunch adherents to the Home Rule campaign, now saw emigration as a useful tool in reducing small holdings and managing against divided inheritance. This exclusionary policy would drive out the rural poor, especially young women who could not accommodated in this Irish vision of a motherland (Mac Laughlin, 1994, p.74). For Mac Laughlin, they are transformed, or commodified, as international labour. Ireland would be built on assumptions of race, class and gender that endorsed a masculinised view of petit bourgeois citizenship, which could be constructed as "royally endowed with every attribute that goes to make up a peerless and magnificent manhood" (Mac Laughlin, 1997, p.21). So, a post-civil war, nationalist hegemonic discourse locked out the poor and women to preserve the idyll famously imagined by de Valera in 1937. The poor, and by extension women, in supposedly casting aside their links to the land, had made themselves unfit for the purposes of the new state.

Those who decided, or wished, to emigrate were implicitly challenging the utopian idyll offered by this nationalist discourse, which in turn very often stigmatised those who went (Delaney, 2000, p.57). Therefore, the Irish diaspora was economically commodified in terms of labour and remittances, whilst Irish emigrants found themselves as actors within the industrial and commercial revolutions transforming the North Atlantic world (Miller, 1985, p.7). Mac Laughlin posits here a 'Green' Atlantic, similar in concept to Gilroy's classic cultural critique of African settlement.

A mounting feminist literature across Ireland has critiqued the experiences of Irish women since the 1970s on, *inter alia*, questions of gender, hierarchy and subordination, gender roles and their social construction, and consciousness of group identity. The long, histiographical silence on the role of women in making

modern Ireland has to some degree been rectified over the past three decades by a developing feminist critique of their role as citizens (Shannon, 1997, p.239). Ward (1983) and others have provided a rich array of analyses that explore the exclusion and marginalisation of women in the culture and politics of post-partition Ireland up to the 'troubles' in Northern Ireland, and the so called rebirth of Southern Ireland as a Celtic tiger. Exploration of the salient writing here will help provide some context for the extraordinary gendered pattern of migration to Britain through the 20th century.

Whilst Irish women had supported and participated in nationalist and Republican struggles against British occupation, there was to be little room for them as fully fledged citizens in the foundation of the Free State, and more particularly, in de Valera's 1937 constitution. The social and economic position of women was substantially determined by the agrarian culture of post-independence Ireland, a set of norms maintained by both Church and State with regard to the acquisition and inheritance of land and the subsequent regulation of family and working life (Daly, 1995).

The new Free State, unlike its northern neighbour, was premised politically and economically on a rural ideal. The custom for all members of rural families by 1926 was to act as effectively unpaid labour for the paternal figure, typically the father, or more rarely, the widowed mother or oldest son (McCarthy, 2004, p.122). While the next oldest male, most usually the son, waited over many years to inherit the land, the oldest daughter was "dowered to a neighbouring farm" (ibid, pp.122). The remaining siblings were effectively disinherited in order to sustain a viable farm. This in turn left them with four choices: emigration, religious vocation, migration to the towns and cities of Ireland, or indefinite dependence on the eldest son as family labourers. Therefore, the acquisition and inheritance of land was essentially based on a dowry system and the chastity of the woman formed the basis of the contract, giving only a legitimate, male heir a claim to the land. McCarthy (2004) effectively argues that the arising socio-economic system conditioned attitudes towards gender that permeated both urban and rural life.[1]

Prior to the Second World War, a discourse of Irish womanhood was constructed on notions of marriage as a social goal, second only to entry into a religious life. Marriage necessitated children and the secondary role of women in lifelong

relationships as wives and mothers. Sexuality, and especially reproduction, was, therefore, tied to marriage, making illegitimacy even more stigmatising than elsewhere in Europe.

This was premised on another constructed reality, that the sexual urges of men could be barely contained by them, so women must police themselves in relation to matters of sexual conduct. This process was assisted by assumptions of a lack of desire and a proper concern for morality on the part of women. Trangressive conduct was the fault of the woman. The 'natural' domain of the woman was, therefore, outside the public world, and her role as a mother was closely defined. The Roman Catholic Church modelled family life on Marist principles, the ideal of chastity for the single woman, and a self-sacrificing mother love for the married woman (Mcloughlin, 1994).

Many women would simply accept the reality of their lives lived through this ideological frame, Inglis argues that they recognised possibilities in building religious and cultural capital in their status as mothers and housewives (Inglis, 1998, p.196), while others would either see themselves struggling towards its attainment, or be judged to be in failure. Other women might deny and attempt to resist its hegemonic status, but this gendered construction of women still trapped women at different, but interwoven levels of society, from large institutions such as Government ministries and the Church, to the local control exercised through neighbourhood gossip (McCarthy, 2004, p.123). Thus, a patriarchal system contained the unpaid work of women in the household, or on the farm, or family business, whilst marriage could be matched to the economic benefit of the father, without financial or emotional security for the daughter. Perceived failure to marry held consequences for status; the spinster was socially pitied, despised and ridiculed. Homosexuality, for either sex, was outlawed and male violence was denied by both State and Church in their concern to defend the private world of the family.

Throughout the second half of the 19th century, despite apparent public passivity towards domestic violence, there was regular press reporting of related court activity. However, Steiner-Scott (1997, p.125) notes the virtual disappearance of such press activity after independence, with the notable exception of the *Irish Citizen* (until its rediscovery in the 1970s by a second wave of Irish feminism campaigning

for women's refuges).[2] The absolute outlawing of divorce by the 1937 Constitution "merely copper fastened a long accepted reality for abused wives in Ireland: there was legally no way for them to leave their abusive husbands" (Steiner-Scott, 1997, p.126).

Nationalists were too willing to deny, or dismiss, such social ills as an outcome of English colonialism, something that would naturally be redressed by Irish men regaining the dignity of independence. Such views were firmly embedded in a nationalist discourse on the nature of Irish women, which also lead to the construction of the English other. Maud Eden could fancifully claim in 1919:

> [w]e have to avoid imitating England in this matter [... their] national characteristics are producing endless unhappy marriages, even the commercial bargains of the countryside are so much happier than the average British love-match (Steiner-Scott, 1997, p.142).

The foundation of the Irish Free State in 1922 ushered in a compact between Church and State that saw the family as the private domain of Irish men. The Catholic Church in Ireland closely followed papal orthodoxy on state intervention; particular interest was shown in the encyclical *Quadragesimo Anno* (QA), which emphatically rejected collectivist action upon the conduct of family life, even within its constitutionalist forms: "Religious socialism [or] Christian socialism are contradictory terms; no one can be at the same time a good Catholic and a true socialist." (Mullarkey, 1999, p.97)

The moral conservatism of *Quadragesimo Anno* strongly appealed to a broad swathe of nationalist opinion across the divisions of the civil war. Successive governments promoted cultural values that envisaged a step back to a more community-based, Catholic society, which also effectively excluded a still substantial Protestant minority in the Irish Free State. The new Fianna Fáil administration explicitly aligned itself to the QA goals of Pius XI in 1932. The subsequent election campaign of Éamon de Valera trumpeted through the party paper, the *Irish Press*, that there was not: "a social or economic change Fiánna Fail has proposed or brought about which has not its fullest justification in the encyclicals of either Leo XIII or the present pontiff" (Mullarkey, 1999, p.99).

Subsequent legislation further isolated and disempowered women in the home throughout the 1920s and 1930s. In 1920s County Clare, it was still considered

acceptable to beat an infertile wife. "To bounce a boot off her now and then" was one husband's explanation to interviewers (Arenberg & Kimbell, 1961). Even as late as the 1970s, the Irish government felt able to claim that wife-beating was a consequence of alcohol abuse, rather than power relations (Steiner Scott 1997 p.142). Excessive drinking itself could be attributed to the failure of Irish women to sustain a proper family home: "a cold hearth and a miserable feeding at home", Katherine Tynan explained to her readers in 1924, were the reasons men might turn to alcohol (Clear, 1997, p.190).

The post-war exodus of women to British and American cities and towns has been explained in terms of economic stagnation, unemployment and a rejection of the social and economic conditions of rural Ireland. In 1950s Ireland, matchmaking still prevailed and parental direction still mattered with regard to marriage. A widening gap in rural and urban living conditions may also have contributed. Daly shows from 1946 census returns that 92 *per cent* of urban households had access to piped water, yet over 91 *per cent* of rural homes depended on a pump, a well, or even a stream for domestic water. A broadly similar picture prevailed for other utilities, such as electricity and sanitation (Daly, 1997, p.206).

The provision of electricity was seen as a means of improving leisure and social activities, rather than as assisting with domestic work, including fetching water, which fell on the women of the household. This sits rather oddly with Governmental concern about post-war, rural de-population and decline, which included an awareness of the proportion of women leaving. The Commission on Emigration and other Population Problems in 1951 recognised that the drudgery of rural living emanated from lack of power, light, water and sanitation, but it argued that action could only take place when financial conditions allowed. Between 1950 and 1959, only 16,000 rural households had applied for grants to install running water, a tiny fraction compared to those who gained grants for new homes, or extensions (*ibid*, 1997, p.211). Local parish priests were divided on whether to support modernisation initiatives for rural homes. Some expressed hostility towards an innovation that might introduce an undesirable, modern lifestyle, or aspirations to seek such experience elsewhere. This would presumably undermine the morals of the rural idyll imagined by State and Church, and encourage the depletion of potential breeding stock through migration (Mac Laughlin, 1997, p.24). Clear (1997, p.191) argues against a hegomenous discourse intended to deny women's civil and

political equality. This argument is founded on the grounds that little state action was initiated, despite the ideal of the 'domestic' woman posited in de Valera's Constitution of 1937. But empowerment for women would have meant structural investment and state policy interventions on a level matching the post-war Marshall Plan followed elsewhere in Europe.[5] A policy of neglect appeared to be preferred.

Modernisation was clearly a gendered issue; reforms were blocked by an alliance between local authorities, farmers, and the Department of Agriculture which feared increased taxes on the farming community, or rather feared the men of that community. An outbreak of polio had no effect on this political outlook (Daly, 1997, p.212). The policy was reinforced by the publication of the white paper *Economic Development* which committed Eire to lower social expenditure in the drive towards economic independence from the UK. The corollary here would be lower social expenditure in the drive towards economic investments in exports and generating growth in national income.[4]

By the 1960s, Government members were more willing to criticise the traditional conservatism of men in rural households. This occasionally still required a claim to papal authority. In 1961, Sean Lemass, Taoiseach and former architect of the economic war, felt obliged to cite an encyclical in support of his campaign for equalisation of rural and urban services (Daly, 1997, p.216). Yet even by 1971, the census revealed that over 42 *per cent* of rural homes continued to lack running water. Better standards prevailed in households containing younger wives, who were better-educated and had worked outside farming, either abroad or in Irish towns and cities.

The impact of war on emigration

The great watershed in Irish emigration in the 20th century lies in the structural changes brought about by the Second World War. The UK subsequently became the main destination country for wartime emigrants and other succeeding generations, between 1936 to1946 showed a net emigration totalling 189, 942 according to Irish census returns. Economic depression in the 1920s, with 'landed alien' restrictions in the US, had made the UK a more likely option by the 1930s. Existing Irish networks in traditional areas of settlement, and chain migration, eased the passage of others following on (Connolly, 2000, p.121). The UK actively recruited for labour in Eire,

with the permission of the Irish authorities; this appears part of a broader de facto policy that de Valera operated in managing unemployment, in spite of the formally neutral status of the Republic. British appointed agents operated through Irish labour exchanges under the control of the British Department of Labour.

Employment within the munitions industries in the United Kingdom also meant that later settlement patterns would be influenced by the direction of labour, now largely engaged in the pursuit of a total war economy. Irish labourers were either housed in lodgings, or hostel accommodation, within urban wartime production areas of London, Birmingham, Manchester and Liverpool, or on their fringes in the construction of airfields.

The process was so systematised that labour recruits even wore their employers' names on their labels as they stepped off the ferries crossing the Irish Sea. The largest proportion of this wartime contingent came from Connacht, though Connolly presents some evidence for Dublin supplying 20 *per cent* of the overall total between 1940 and 1951 (Connolly, 2000, p.123). These were likely to be unskilled and semi-skilled labourers, now in high demand in the UK during a corresponding period of relative economic inactivity in Dublin. The city also incidentally supplied a high proportion of military volunteers; prior to independence, Dublin had consistently returned Unionist MPs.

The war also temporarily transformed the usual gender patterns associated with Irish emigration, a process affected by British recruitment of Irish military volunteers and an outflow of Irish labour literally filling in the gaps left by British male conscription (Doherty, 1999; Travers, 1995, p.147). Wartime Britain offered Irish women employment opportunities beyond the pre-war tradition of domestic service. Factories, agriculture, hospitals, especially through the Emergency Hospital Service (Berridge, 1999, p.13), all drew large numbers of young Irish women (See Table 2.1).

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Table 2.1: Work permits granted for Irish women travelling to Britain and Northern Ireland (Source: Trinity College Dublin March 8300/1-31 (Adapted from Connolly, 2000, p.128))

	1939*	1940	1941	1942	1943	1944	1945	Total
Nursing	3,132	1,634	785	2,283	2,838	1,125	3,523	15,320
Agriculture	57	492	176	657	422	302	466	2,572
Domestic	5,396	5,285	1,343	6,037	9,125	2,760	4,719	34,665
Other (incl. factory work)	1,350	1,125	789	5,060	6,255	1,591	1,694	17,864
Total	9,935	8,536	3,093	14,037	18,640	5,778	10,402	70,421

* Data available for September to December only

Between 1941 and 1945 the Department of External Affairs produced estimates of annual emigration to Britain and Northern Ireland, of adults of working age, based on the issue of work permits (See Table 2.2). This totalled 172, 574 permits between 1941 to1945. The war provided opportunities for statistics collection not available in previous peacetime conditions, though work permits did not necessarily equate with actual travel (Delaney, 2000, p.39).

Table 2.2: **Estimated number of adult Irish emigrants to Britain and Northern Ireland (Source: National Archives D/T 511582 Department of External Affairs Memorandum 30 August 1947.)**

	1941	1942	1943	1944	1945	Total
Women	3,272	14,448	19,003	5,890	10,609	53,222
Men	31,860	37,263	29,231	7,723	13,185	119,262
Total	35,132	51,711	48,234	13,613	23,794	172,484

Aside from some slack in 1944, probably attributable to travel restrictions prior to the Normandy landings, the flow as recorded above reached its highest point between 1941 and 1943, and the same high rate resumed in 1945. The male to female ratio was running at 268 to 100 (Connolly, 2000, p.125). Aside from military volunteers, conscription in the UK was now generating intensive recruitment activity to fill labour gaps previously filled by men.[7] Female immigration was very tightly controlled until 1946, when women once again dominated the emigration statistics to the UK.

There was a significant growth in the number of young women, aged sixteen to twenty four years of age emigrating, between 1943 to1945. Unemployment doubled for women between 1939 and 1943. However, emigration could offer rewards other than work. Working for a wage overseas could offer greater autonomy to women, especially those from the rural areas, where they were very likely to be working as unpaid labour for the family household. For some women, this could also mean being liberated from the possibility of marriage, quite likely arranged, to middle-aged bachelors newly inheriting the family farm. The drudgery of Irish pre-war, rural existence for women (and men) was not improved by the war. In addition to the possibilities of social change and advancement, wages were higher in wartime Britain and were continuing to rise. British wages rose from 16 *per cent* to 32 *per cent* of the national wage for men, and from eight *per cent* to three *per cent* for women (O'Grada, 1997, p.21). In Eire emergency orders held down wages which did not recover their pre-war levels until 1949 (*ibid*, p.17).

Chain migration was very influential in providing support mechanisms for family and neighbours. Emigrants returning on leave, or holiday, also influenced others. Connolly notes that failed emigrants were wont not to return because of the stigma attached if the returnee appeared empty-handed, while 'successful' returnees gave hope and status to their families.

The data summarised here by Connolly shows that the predominance of employment in domestic work was in decline throughout the war years. Other opportunities were arising in other sectors, though agriculture constantly appears the least popular option. For some, this marked upwards mobility, not least in nursing, a process assisted by the rapid growth of the nascent British Welfare State. By the end of the war, domestic service had declined by 60 *per cent*, and nursing had

risen by 14 *per cent*. Irish nurses, midwives, and those intending to train as such, were exempted from British wartime restrictions on Irish immigration (Daniels, 1993). Ryan (1990) noted that some 65 *per cent* of Irish nurses working in wartime Britain had been recruited in Ireland by British labour authorities, either through press advertising or Irish labour exchanges.

Irish male emigrants were predominately less skilled than their female counterparts, who were also more likely to travel alone. Travers (1995, p.164) notes that the increase in nursing training in the UK also reflects on their higher educational status. Inspectors from the Land Commission later reported that many farmers' daughters saw secondary education as an important catalyst in deciding to emigrate (*ibid*, p.164).

Fiánna Fail Government policy was particularly uneasy and ambiguous towards women emigrating, on a number of counts, despite the continued accommodations made for the tradition of emigration. It was also assumed that during what was euphemistically described as the 'Emergency', that migration to the UK would be a temporary measure. Connolly also notes that the Irish government was clearly alert to emigration as a safety valve for social and economic reasons, and indeed this had been a policy stance operating throughout the Economic War in the 1930s. Between 1939 and 1945, Irish registered unemployment fell by five *per cent* as the UK drew in further Irish labour. The return of remittances made its own financial impact.

Government passivity towards emigration, even quiet collaboration in it, reflected not just tolerance of a necessary evil, but acceptance of its necessity as a tool in economically restructuring Ireland. Politically, potential opposition towards Fiánna Fail and its programme of nationalist modernisation amongst the unemployed was effectively being exported abroad. However, at the same time foreign experiences were thought likely to contaminate the cultural and political outlooks of returnees who might not necessarily be found work in Eire, so potentially creating conditions for a social revolution which failed to take shape in 1922 (Mac Laughlin, 1997; Regan, 1999).

While the Irish Government was apparently willing to facilitate emigrant passage to the UK, it declined to provide any significant support to Irish workers living there. De Valera appeared sensitive to possible criticism of Ireland, as a neutral state,

aiding one side against another. State intervention at this level would also be an embarrassing public admission of the economic necessity of sending large numbers of Irish nationals to work abroad within the territory of a former enemy.

The Catholic Church was certainly willing to take action, possibly after some prompting from the Government (Delaney, 2000, p.67). The Irish Catholic Church had always been ambivalent on the question of migration, notably on the question of women; the language of many clergy was often racially couched around the threat to the physical and social reproduction of Ireland. In 1937, Archbishop Gilmartin preached to potential female emigrants to take advice from the clergy and Catholic agencies, or otherwise be "foolish girls who run terrible risks to soul and body" (Delaney, 2000, p.67). John Charles McQuaid, Archbishop of Dublin, made a more practical move in establishing the Emigrant Section of the Catholic Social Welfare Bureau in 1942 to monitor and support the moral and physical safety of young Irish women. At the opening of the agency, McQuaid proclaimed: "I have entrusted to you, as your chief activity in the beginning, the care of emigrants, especially women and girls" (Kelly & Nic Giolla Choille, 1995, p.169).

The goals of the Bureau were implemented by local parish priests, namely by putting emigrants in touch with other Catholics in the UK, establishing whether employment in the UK was suitable for Catholics, especially for women, and making arrangements for emigrants to fulfil their religious obligations. Priests were also expected to support and develop appropriate social welfare facilities. Other Catholic, voluntary organisations also mobilised in the UK and Ireland, at the behest of the Irish and British Catholic Churches, particularly the Legion of Mercy. Amongst other duties, Legion of Mercy volunteers travelled on trains to Dun Laoghaire, the departure point for boats to England, questioning possible migrants, particularly young women, and collecting information and addresses to be forwarded to local parish priests in the UK. They, in turn, were expected to report the safe arrival of identified emigrants (*ibid*, 1995, p.170), and to assist in the identification of suitable employment.

Ideal occupations for women were perceived to be in professions and vocations that would be consistent with the 'caring' social roles into which Irish girls and women had been socialised by the Catholic Church in Ireland, which played a major role in hospital care provision and controlled, State medical care (Yeates, 2004, p.85). So

nursing, midwifery, teaching and the religious orders distinctly appealed to an institution concerned to closely discipline those women stepping outside the private world of the home. Married women were shut out of public sector occupations from 1929 until 1973 (*ibid*, p.85). While the highest status was accorded to those who became nuns (Lanchester, 2007, p.42), nursing was also well regarded, with middle-class associations. Families were obliged to pay training fees, which restricted access to the profession in Ireland by those from poorer backgrounds.

The global network of the Church facilitated and sustained the organised emigration of both religious and secular nursing labour and its settlement into the host society, which gave rather less status to nursing. British women were more likely to perceive nursing as a poorly paid and unattractive option (Abel Smith, 1960). Irish nurses, however, saw working in the UK as attractive; it was relatively close in destination and cheap in terms of travel costs, there were similarities in culture and language, and employment was available for trained nurses or those taking up student training. The latter was waged and did not require training fees to be paid.

In the 1950s, Irish nurses clearly occupied a niche position in the British labour market; in 1951 22 *per cent* of Irish-born women in paid employment were in professional occupations, mainly nursing and midwifery (Yeates, 2004, p.87). Post-war Britain continued to be the most attractive destination for Irish emigrants. Connolly points up the 15-year hiatus in significant numbers of people migrating elsewhere, most notably the United States, which would have attenuated previous chain migration links. The UK, however, could offer plenty of support in this regard, as a direct consequence of wartime and post-war settlement by Irish emigrants. The expanding National Health Service continued to draw in more Irish nurses and doctors, as white- collar opportunities also grew elsewhere. One estimate suggested that over two- thirds of Irish medical school graduates had emigrated by 1966 (Delaney, 2002, p.14).

The permanent post-war settlement of thousands of Irish people was clearly a concrete rebuff to the austere and contradictory vision proffered by de Valera, of a self- sufficient Ireland, with as many people possible attached to the land, a policy that also endorsed the rural economy of independence, but which required the exclusion of non-inheriting sons and daughters (Travers, 1995, p.153).

The Commission on Emigration and Other Problems, established in 1948, confirmed that peacetime migration patterns had re-emerged; more women than men were migrating, and most were aged between 20 and 25 years. Aside from economic considerations, the Commission also heard evidence on the inferior social status of women in the Republic as a motivating factor in their decision to leave. Other than a restricted system of postponed marriage that threatened many women with the social obloquy of spinsterhood, inheritance effectively excluded women. Reproductive rights were also denied by constitutional prohibitions on abortion, divorce, and contraception (Jackson, 1984). Ireland was once again emerging from the war as a late developing, semi-peripheral economy, tied in to a *de facto* programme of emigration to the UK.

The 1958 expansionist economic programme of Lemass and Whitaker adopted a more aggressive State role, similar in some features to the Keynesian expansionist strategies of other Western European, capitalist economies (Hazelkorn, 1992, p.182). The encouragement of foreign capital and free trade led to a relative boom in the 1960s and marked a decisive move away from the protectionist isolationism of de Valera. For the first time in 100 years, the Irish census even recorded a slight net increase in immigration by the early 70s. This improvement in living standards was short-lived in face of a number of internal structural deficits, including a weak indigenous manufacturing base, the continuation of small-scale and inefficient agricultural enterprises, little exploitation of natural resources, and a weak infrastructure.

Problems were compounded by increased national debt, a fall in State revenues, rising unemployment and rising interest rates and inflation. Global rises in energy costs also added their impact, especially through the shock effects of oil sanctions from 1973 to 1974, and again in 1979. Demographic changes included sizeable internal migration from rural to urban areas. The population of Dublin now accounted for one third of the national total. An overall population increase put added pressure on the Irish labour market. However, over the following decade, the development of new, technological export-orientated sectors and the growth of financial services failed to provide matching employment opportunities (Hazelkorn, 1992, p.182). Ireland was now experiencing job-deficient growth (Kerby & Miller, 1985, p.69).

Agriculture continued to decline in output, and was more than matched by a parallel collapse in manufacturing; this was especially severe in Dublin, where manufacturing jobs fell by 36.7 *per cent* between 1961 and 1981. Despite the growth of the service sector, fewer people were at work in 1991 than in 1926 (Hazelkorn, 1992, p.183). Official unemployment was being progressively and more narrowly redefined; it is likely, therefore, that actual unemployment was undercounted.

Ireland now had a dual economy, with persistently high levels of unemployment and endemic poverty running side by side with booming economic indicators. The post- Lemass era has been characterised by neo-classical assumptions underpinning attempts by the Irish State to further align the economy with the global economic system. This was premised on increased foreign investment and joining free, international market zones. It also accommodated capital-intensive, export-orientated industrialisation and education being tied to industrial purposes. The State, partly through social partnership, would also hold down labour costs. This left the economy in a precarious position, with investment tied into branch line projects and multi-nationals able to export profits to core headquarters. In 1989, capital transfer totalled ten *per cent* of GNP.

Emigration saw at least one quarter of all Irish born people living outside of Ireland by 1991 (Walter *et al.*, 2002). Unlike their European counterparts, Irish women were as likely to emigrate as Irish men (See Table 2.3). These women were more likely to travel singly, without children, rather than in family groups and to be relatively young. (Kelly & Nic Giolle Choille, 1990).

Table 2.3: **Net migration from Ireland by gender 1936 to 2001, annual average (Sources: Walter et al. (2002); 1996 - 2001 data Yeates (2004))**

Intercensal period	Males	Females	Persons	No. of females per 1000 males
1936-1946	-11,258	-7,453	-18,711	662
1946-1951	-10,309	-14,075	=24,384	1,365
1951-1961	-21,786	-19,091	-40,877	876

Intercensal period	Males	Females	Persons	No. of females per 1000 males
1961-1971	-6,236	-7,215	-13,451	1,157
1971-1981	5,806	4,583	10,389	789
1981-1986	-8,283	-6,094	-14,377	736
1986-1991	-14,865	-11,969	-26,834	805
1991-1996	311	1,336	1,647	4,296
1996-2001	9,066	9,350	18,416	1,031

A feature of contemporary emigration from Ireland to the UK has been the growth in the proportion of skilled workers (Timur, 2000). What Yeats calls the 'nurse trade' was particularly able to draw on networks established during and after the war, a practice still persisting at the end of the 20th century. Individual hospitals formally and informally recruited using contacts between existing staff and their home areas (Yeates, 2004, p.86, Walter, 2001, p.180-1). This means that Irish women still work in large numbers in British nursing (Walter *et al.*, 2002; O'Connor & Goodwin (n.d)).

Ireland did not ever emulate the Philippines in adopting a formal policy of training nurses for export. Nevertheless, it was a *de facto* exporter for much of the second half of the 20th century (Yeates, 2004, p.86). Secondary analysis of the Beishon data will show continuity of this phenomenon. The trade, as previously described, was facilitated by ease of access, including costs of travel and right to settlement for Irish citizens. The core country could offer employment, a shared culture and language. These remain important features today. The international passport of a nursing qualification has also seen Irish nurses, alongside their British counterparts, moving further abroad, to the Gulf States, America, and the former white Dominion states, such as Canada and Australia. The EU has also become increasingly attractive to sojourners.

The peripheral economic status of Ireland with regard to international labour movements has also seen a dramatic change over the last two decades, with particular effects on internal demand for nursing labour. The economic downturn in the 1980s led to staffing cutbacks in the health sector; by the mid-80s, up to half of graduate intakes from schools of nursing were reported to be immigrating (Nowlan, 1986). By 1995, this pattern had reversed; improved economic conditions led to historic changes in Ireland's position as an emigrant nursery (see Table 2.3 above).

One in eight workers in Ireland now are foreign nationals. Fanning (2007) has noted the influx of another formerly excluded group - indigenous Irish women were making a significant contribution to the Republic of Ireland labour force in the 1990s, especially within the service sector. From 2000, Irish government policy actively sought to entice back skilled workers from abroad. After 2002, Government policy additionally began targeting non-EU nationals. Within the health care sector, the Philippines was actively tapped as a major reservoir for nursing labour. By 2002 it had become the third largest importer of Filipino nurses, after Saudi Arabia and the United Kingdom (Buchan *et al.*, 2003, p.50).

However, these workers are at risk of becoming the most likely to be disadvantaged and excluded from welfare provision, and more at risk of overt forms of discrimination, in a state that has struggled to face responsibilities as a newly-emerging, core economy and country of immigration. Fanning (2007) notes the consequences for a Filipina nurse "helping to fill labour gaps in the health service. Because she is not from the EU she is not entitled, for example to get any child benefit". The lack of a regulatory framework on potential discrimination for this class of workers is also reflected in the policy of the Department of Enterprise, Trade and Employment (DETE). Labour Inspectorate in not collecting data on complaints by, or on behalf of, migrant workers in Ireland. A more breathtaking policy move was Ireland's 2004 Constitutional Amendment, which explicitly removed birthright citizenship from any future Irish-born children of immigrant parents.[9] The entry visas of partners of non-EU nurses initially denied them access to employment, creating an enforced remittance economy, which was only overturned in 2004 when the Irish nurses' organisation protested about the possibility of ward closures as Filipina nurses left Ireland (Yeates, 2004).

The UK remains a niche area of employment for Irish nurses, though one with a somewhat longer history of minority ethnic recruitment and representation. The following section will explore some key the features of this international nursing labour market in a British context.

Minority ethnic representation within UK nursing

Nurses and midwives belonging to ethnic minority groups have a long history within the British National Health Service (NHS), which continues to remains the most substantial employer of health care personnel within the British Isles. The NHS has undergone several major organisational reforms since its inception in 1948.These changes have been generally accompanied by a greatly expanded workforce, which has repeatedly drawn on an overseas supply of labour to meet its workforce demands.

Abel-Smith (1960) provided a seminal account of the development of modern nursing in the UK; his comprehensive study claimed to map out the demographic features of the history of early 20th century British nursing. Useful details on sex, age, marital and educational status were extracted from a highly detailed analysis of primary statistical sources, including census returns from 1901 to 1951. This analysis plays a key part in supporting the assertion by Abel-Smith that claims to professionalisation were dogged by a shortage of recruits (Abel-Smith, 1960, p.253). This labour shortage was accentuated by wartime health service developments and the subsequent establishment of the National Health Service in 1948, which, according to Government estimates, would require an additional 48,000 nurses to meet expected service needs (*ibid*, p.227).

"The search for more nurses at the start of the NHS has to be seen against a background of major demographic changes" (*ibid*, p.210). The analysis of census returns from 1931 to 1951 showed that the traditional pool of labour of young single women in England and Wales had sharply declined. Furthermore, marriage was further reducing the period of full-time service. The number of women aged from 20 to 24 was now reduced from 74 *per cent* of the female adult population, to 52 *per cent* in 1951. This meant an overall decline in single women, from 5.4 million in 1931 to 4 million in 1951. The largest change occurred in women aged from 20 to 34, with 2.4 million women in 1931, in contrast to less than 1.4 million women in 1951. Full

employment had added a further structural change to the conditions for employment.

Health care reforms prompted a surge in numbers of nurse trainees, partly assisted by the development of enrolled nurse programmes. In 1938, there were 43,000 nurses in training, rising to 51,000 at the creation of the NHS (*ibid*, 1960, p.211). The accompanying increase in qualified nurses was achieved by the recruitment of men, many of whom had undertaken wartime paramedical training, and the creation of part-time posts, partly to retain married women, who were also entering full-time training in greater numbers. The workforce over this period of time had now risen from 154,000 to 225,000 nurses (*ibid*, 1960, p.212).

Yet paradoxically, as more highly educationally qualified women were entering nursing, Abel-Smith (1960) argued that his analysis of parental social class showed a decline in social esteem for the profession, as other career opportunities opened up. Nonetheless, nursing retained some attraction for the socially mobile, and as a means of escaping the family home. In addition, the occupation was attractive to those living in areas where suitable female employment was lacking.

Given this potential 'push pull' factor, Abel-Smith does not refer to a longstanding recruitment practice across mainland Britain, namely the organisation of hospital student nurse recruitment drives across the Republic of Ireland, a policy that continued unhindered, despite the so-called Economic War waged against the de Valera administration throughout the 1930s. Subsequent British wartime recruitment policy also specifically targeted Eire as a reserve army of labour, not least for the newly created emergency hospitals. The presence of Irish nurses in the UK is, however, referred to in discussion of the work of the Wood Committee[2] and cited by Abel-Smith. Wood was commissioned to examine the recruitment and

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[2] Ministry of Health Department of Health for Scotland & Ministry of Labour & National Health Service report of the working Party on the Recruitment and Training of Nurses HMSO 1947 (Chairman: Sir Robert Wood, KBE). Cited in Abel-Smith.

training of nurses for the needs of the newly planned National Health Service. His report in 1947 found that 12 *per cent* of the total hospital nursing staff was of Irish origin (Abel-Smith, 1960, p.215).

Abel-Smith acknowledges the opening of a 'third portal' to nursing by 1958 (*ibid*, p.248). Student numbers had steadily increased, by 75,000 additional training places compared to 1949. These numbers were achieved in part by cross-border migration, including additional recruitment from Eire, European refugees, and, for the first time, the Commonwealth and the colonial territories (*ibid*, p.222). The newly formed National Health Service was now explicitly recruiting minority ethnic groups beyond the traditional pool of labour supplied from Ireland. This 'marriage of convenience' operated through the 1960s and 1970s, reaching a peak in 1970 (Thomas & Morton-Williams, 1972).

The overall number of overseas nurses peaked in 1970. A secondary analysis of General Nurse Council statistics conducted by Akinsanya (1988) reported that by 1971 there were over 15,000 overseas student nurses, of whom 40 *per cent* were identified as West Indian, 29 *per cent* as Asian and 27 *per cent* as African There are few reliable statistical data for this period on the numbers of nurses born overseas. However, a study produced for the Briggs Committee in the early 1970s indicated that nurses beyond the British Isles formed nine *per cent* of the hospital nursing population (Morton-Williams & Berthould, 1971). Half of those sampled were reported as West Indian, another quarter were from Africa and a further quarter from Asia (Thomas & Morton-Williams, 1972). In 1980, the Policy Studies Institute identified an accompanying increase in medical personnel; a survey of 2,000 doctors established that 38 *per cent* were born overseas.

Moral panic and Government policy pandering to racist sentiment saw the introduction of the 1971 Immigration Act and the introduction of work permits. Recruitment from overseas became more arduous for individual nursing schools. By 1983, work permits were withdrawn altogether, which effectively closed direct overseas entry to British nurse training and NHS employment. This did not, however, close the door to second and third generation migrants now facing more limited opportunities in a shrinking job market.

Through the 1980s and into the 1990s, policy discussions on the nature of a multi-ethnic society focused more directly on issues around equity and access. Anecdotal and piecemeal evidence was beginning to emerge, evidence that indicated that black and Asian nurses were more likely to be recruited into the so called 'Cinderella' specialties of British nursing, notably geriatrics and mental illness, and that promotional opportunities would be more limited in comparison to their white colleagues. Akinsanya (1988) noted that discrimination was not an explicit item on government agendas. Successive Conservative administrations appeared initially more concerned with cutting back welfare provision, and indeed substantial elements of the party appeared either uncomfortable with, or even hostile to, the concept of a multi-cultural UK.

A series of studies added some weight to the concerns of Akinsanya and others that racism and discrimination were operating unchallenged in the Health Service (Baxter, 1988, p.8). In 1983, the Commission for Racial Equality (CRE) published a short report on ethnic minority staff that found that the large number of such staff employed was not *ipso facto* evidence of a lack of discrimination. The report identified cases of unlawful discrimination, and went on to pose questions about higher concentrations of black nurses within less prestigious specialties. Furthermore, the CRE report also emphasised that discrimination operated at levels beyond individual actions, pointing to systematic discrimination at an institutional level (CRE, 1983).

Baxter added qualitative details in interviews with 32 minority ethnic nurses, largely living and working in Manchester, who spoke of obstacles at all stages of their careers, from recruitment, through deployment to promotion. A common sense of isolation and hopelessness was partly attributed to the failure of nursing schools and professional organisations to represent their interests (Baxter, 1988). Akinsanya produced a further review in the late 1980s that additionally identified excessive numbers of ethnic minority nurses employed in second-level training and practice, over-representation in lower grades or 'Cinderella' specialisms, and lower numbers within higher management posts. Finally, Akinsanya reported the general lack of professional development opportunities, whilst white colleagues were clearly groomed for promotion.

A position paper by the King's Fund Equal Opportunities Task Force (Ellis, 1990) gave further support to these findings, but did not produce any additional empirical data. Nevertheless, it did draw attention to two CRE studies, the first published in 1987, which reported survey data on the under-representation of ethnic minority trainees in certain training schools, but not others. A key characteristic here was the status of the institutions concerned, the teaching hospitals, which appeared less welcoming to black potential students. The second report gave details of a CRE investigation in 1988, which found that although 29 *per cent* of applications for nursing promotion were from black applications, only eight *per cent* were successful.

The King's Fund also questioned why ethnic minority nurses continued to be under-represented in senior positions, as well as in the teaching hospitals and acute services more generally. Industrial tribunal cases were also beginning to be brought as ethnic minority nurses pointed to discrimination as a barrier in their attempts at career development. Finally, the policy paper also raised doubts about equity with regard to access to further training and career development opportunities. Selection did not appear to operate in an objective or transparent fashion. Alongside these aspects of discrimination, ethnic minority nurses found that racial abuse and harassment were not properly addressed, or even recognised by management (Virdee, 1995).

In response, professional regulatory and training bodies, such as the UKCC and the English National Board for Nurse Education, initiated attempts to monitor the ethnicity of registrants and students on training programmes (Gerrish *et al.*, 1996).

The Department of Health commissioned the Policy Studies Institute to examine how ethnic minority nurses fared from an equal opportunities perspective. 'Nursing in a Multi-Ethnic NHS' was a unique insight into the nursing careers and work experiences of NHS minority ethnic nurses (Beishon *et al.*, 1995). Sharon Beishon and her colleagues were initially able to show, through analysis of Labour Force Survey data from 1988 to 1990, that 6.3 *per cent* of female nurses from their sample were from ethnic minority groups, against 3.6 *per cent* of all white females in employment. The data were even more pronounced in the case of male nurses, where 14.7 *per cent* belonged to ethnic minority groups, against 3.9 *per cent* of all males in employment. Black and Asian ethnic minorities were, therefore, heavily

over- represented in nursing, as was the case for their Irish counterparts some 50 years before.

CONCLUSION

The implicit conceptualisation of race within this key study has effectively blocked interpretation of any data gathered on the career experiences of Irish nurses. Hickman and Walter have more broadly argued for the necessity of recovering the lost narratives of an Irish diaspora abroad (Hickman & Walter, 1997). Their own critique has suggested that the Irish in the UK continue to suffer discrimination and marginalisation. Understanding the experiences of Irish nurses training and working in the UK would make an important contribution to that debate. Nursing was, and remains, an important occupational choice for that émigré group.

This thesis will add substantially to the very limited existing literature on the presence of Irish nurses in British working life. It will specifically establish how this group of social actors have fared in terms of career specialisation and promotion. Data will also be provided on how this ethnic group has compared to other groups working in the National Health Service.

CHAPTER THREE
THE PROBLEMATIC OF IDENTITY

INTRODUCTION

This chapter will explore how doing social identity through social categorisation critically informs the epistemology of this thesis. The core problem here is whether identities can be intrinsically understood by social categorisation, a process that methodologically underpins the Beishon and the UKCC data sets explored respectively within the following analytic chapters. Identity matters not only in everyday encounters, but on wider stages, so understanding the workings of identity from a sociological perspective brings together what Jenkins (1995, p.3) has termed our 'public issues' and our 'private troubles'. Following Jenkins I will explore how social and individual identities are inextricably intertwined in framing understandings of difference. Delineating the subjects of this thesis in this manner also theoretically hinges on the apparent paradox of combining ideas of sameness and difference. In this regard some forms of mutual identity are understood to be interactive and mutually constitutive, rather than being merely additive, while other forms are mutually exclusive (Lawler, 2008, p.3).

But these latter 'unities', whether as members of a group, or category, "are in fact, constructed within the play of power relations and processes of exclusion, and are the result, not of a natural and inevitable or primordial totality, but of the naturalised, over-determined process of 'closure' (Hall, 1996, p.5). These 'relational identities' necessarily require what Hall has called the 'constitutive outside' of Western modernity, not only a division of labour, a global socio-economic order, but a self-identity constructed through its relation to the colonial other (Hall & Gieben, 1992), that is notions not only of other distinct categories that are other, opposing, and beyond the boundary, such as binaries of nationality, class or gender, but also more complex constructions of ethnicity and race that emerge through processes of affiliation, or exclusion. The chapter will move on to consider how nurses from a variety of Subaltern positions attempt to negotiate their positions and identities in the NHS through the relational habitus surrounding supervision, a critical stage with regard to managing self and career. Successfully doing identity here is a key

task in establishing position within the group, the analysis will discuss the implications with regard to ideological claims to autonomy, personal growth and the confessional nature of such power relationships. This will also be considered in light of theories of governance and struggles particularly marked by hegemonic constructions around gender, race and professional competence.

The previous discussion within Chapter Two has explored how Irish nurses working in the British health service carry a social identity/identities derived from socialisation and interactions within the conditions created by pre and post war patriarchal relations of the Irish state and church. These shaping influences with regard to identity are not only an intrinsic product of Irish society and culture, but also an outcome of the broader economic core periphery relations between a nominally independent Republic of Ireland and post colonial Britain. These are then conditions for diasporic identity formation, and secondary socialisation within the UK. The core periphery relations in the context of the new British welfare state and economic stagnation in post war Ireland create the conditions for a category, Irish nurses, to perform a variety of Subaltern identities shaped by gender, and ethnic perceptions of whiteness.

The chapter will revisit the tensions around nursing as a gendered occupation and the provision of labour to the NHS, its treatment of other categories of nurse, i.e. Black and Asian nurses and men. The case of the Irish as an acceptable 'other', or rather a Subaltern group successfully engaging with the hegemony of dominant formations, is partially based on shared 'culture' within groups, where boundaries are established to exclude others. This will be elaborated on in an analysis of the interaction order around built around competence and Gove mentality of the self. This will particularly explore identity formation as theorised in the work of Foucault, Hacking, and Rose on identity, discipline and governmentality and the contributions of Bourdieu on habitus.

The chapter will conclude on the possible implications of a Subaltern status for Irish nurses and the questions and methodology that need to be brought to bear on the secondary analyses within the following chapters. This discussion will contrast the theoretical assumptions of Gramsci against the celebratory perspective of Indian Subaltern cultural and historical studies. The data to be examined in the later analytical chapters will offer empirical evidence on whether advances in

occupational status for Irish nurses are at the expense of other minority groups, specifically the process of queuing as a racialised and gendered process excluding women and non white minority groups.

The focus of this chapter then will be on theorising identity, particularly the social identity of the subjects of this thesis, Irish people working as nurses in the British National Health Service. A sense of identity from this perspective emerges from the ways in which people relate to and shape the world around them. So a two way constructive process emerges between individuals and the work they do. Hence the experience of nursing affects the kind of person a particular nurse is, while the characteristics brought to that work will partially define the nature of that employment. A sociological view of workplace and identity is necessarily concerned with such things as gender, ethnicity, occupational role and status at the institutional level.

Theorising identity

Whereas other social sciences, including psychology and anthropology, emphasis the ability of people to construct meanings and actively create social structures within which they can work and live, sociology as a discipline has sought to understand the impact of structure in constraining or determining identity. Attempts to resolve this theoretical impasse, that is arguing for a more complex set of relationships that draw upon both elements of structure and agency, the internal and the external, in some form of dialectic or dynamic relationship, have emerged with the work of Berger and Luckmann who argued against allowing a "purely structural sociology … endemically in danger of reifying social phenomena" (Berger & Luckmann (1971, p.208). In turn Giddens (1984) Structuration theory, with its theoretical notion of 'duality of structure', rejects the reductionism of both action and structural accounts, albeit with a heavy emphasis towards reflexive agency:

> [b]ecause of the open 'openness' of social life today, the pluralisation of contexts of action and the diversity of 'authorities', lifestyle choice is increasingly important in the constitution of self-identity and daily activity. Reflexively organised life-planning, which normally presumes consideration of risks as filtered through contact with expert knowledge, becomes a central feature of the structuring of self-identity (Giddens, 1991, p.5).

Layder (1990) in turn emphasises that people shape the social institutions that they operate within and are in turn shaped by them. The capacity to shape roles is however a product of power, a property or in a Foucaudian sense, a relationship that is unevenly distributed. So this chapter will also later explore, through analysis of supervision, how nurse educationalists and nurse managers within their respective institutions act individually and collectively as an officer class, consciously distinguishing themselves from others further down the hierarchical relations of the occupation. As such, they are agents, both shaped and shaping the institutions within which they work and consequently develop their careers. Their formal status specifically allows them to play a more important role in the construction of health care institutions than those within the 'other ranks' of their respective nursing hierarchies.

To understand the problematic nature of the person in this context means exploring conceptualisation of the relationship between the individual and the social world of work. This discussion will specifically explore key institutions of work and related activity. Such socialisation affects both group and categorical identity formation.

Ethnicity and race

As previously argued both of these forms of identity, individual and social, draw on claims to similarity, however illusory that might be, as in subscription to an 'imagined' ethnic collectivity as conceived by Benedict Anderson (Anderson, 1987). Thus a nation is an 'imagined community':

> [r]egardless of the actual inequality and exploitation that may prevail in each, the nation is always conceived as a deep, horizontal comradeship. Ultimately it is this fraternity that makes it possible, over the past two centuries, for so many millions, not so much to kill, as willingly to die for such limited imaginings (Anderson, 1982, pp.6-7).

Such membership then requires serious investments in boundary setting and identifying difference in others beyond that boundary. As Jenkins (1995) argues, defining 'us' means defining 'them'. To say something about ourselves necessarily distinguishes our collectivity from that of the other. From a social perspective this is a point of view on difference and similarity. This is a dialectic of identification at the boundaries set between ourselves and others, the boundaries, despite our imaging, lack permanence. What Jenkins advances as a 'processual model of the social

construction of identity' has application at both the individual and social level (Jenkins, 1995, p.81). While racialised discourses depend on homogenising attributes and stereotyping, as Layder's domain theory argues, the role and relevance of race ideas will vary according to differing social domains. Sociological approaches must therefore be sensitive to such variations. Critical rereadings of Geertz on ethnicity and culture (1973, p.259), notably with reference to his key concept of 'primordial attachment', similarly challenge the determinism assumed to underpin ascribed ethnic identities. Jenkins (1997, p.45) notes the coercive features of ethnic ties, but concludes that the strength of these bonds will vary according to individual agency, social formation and historical era concerned.

To be ethnic was to be seen as 'other' or 'foreign', the description deriving from the Greek *ethnos*, or nation. Historically, ethnicity arises from a process of social differentiation within a population, eventually leading to that population dividing into two distinctive groups, or by an expansion of system boundaries that draw previously discrete groups into contact with each other (Eriksen, 2002, p.79). The intensity and range of such contacts leaped forward with the 'great discoveries' and consequent European colonisation from the 15th century onwards (Wolf, 1982).

> Many ethnic categorisations and ethnic hierarchies operating today can be traced to the intended or unintended results of European colonisation in North and South America, the Caribbean, Africa, South Asia, East Asia, Australia and the Pacific. (Eriksen, 2002, p.80)

Contemporary usage often preserves such excluding values attached to a concept that appears to conflate both religious and national identities. To be ethnic can still remain to be other, different and potentially marginalised. The social sciences have further elaborated ethnicity as a concept now incorporating any features by which people distinguish themselves from others. Race as a potentially competing social category has consequently been challenged and sometimes replaced by ethnicity in terms of differentiation through physical appearance and other social markers.

Race theory has a long and ignominious history within the biological and social sciences through attempts to impose racial taxonomies, a process fed especially by colonialism and eugenics theory (Gould, 1977, 1981). In brief, people were customarily divided into differing racial groupings which were held, implicitly or explicitly, to possess common biological characteristics not shared with other groups. Typically, difference was pinned on such physical traits as skin colour,

facial features, and body shape. Geneticists have labelled the physical form of an individual as their *phenotype*, which emerges from the environmental interaction with aspects of the inherited *genotype*, which are those inherited, genetic constituents of the individual concerned. Whilst phenotypic differences between human populations are self-evident, genetic research demonstrates that categorising such differences into races provides neither useful, nor accurate modelling of the underlying genotypic variation. Most genes arise identically in all human beings; of those that do not, that is *polymorphic* genes, a very small number are associated with phenotypic differences linked to conventional notions of race. At the same time, other *polymorphic* genes leap across 'racial' perceptions of boundaries, as for example in the genetic determination of blood types (Jones, 1981).

Hill (1989, p.26) challenges attempts to emphasis genetic difference between groups:

> The amount of variation within a racial group is considerably greater than the average genetic difference between races. Clearly the genes responsible for the morphological features that allow us to classify individuals into broad racial groupings are atypical and extremely unrepresentative of the true degree of interracial genetic difference.

From such observations Gould (1977, p.324) has questioned whether the human sciences should continue to reduce such variation to fixed units with formal labels, which must necessarily fail to illustrate a far more dynamic and continuous pattern. Biologists have now largely forsaken such cataloguing attempts in favour of more sophisticated, multivariate techniques for measuring genetic differences. In analysing racial patterns in health or socio-economic status, significance is more likely to be attached to the social meanings people attribute to phenotypic differences, rather than particular genetic traits. So, doubts can be raised about the reproducibility, comparability and universality of social identities that claim to be ethnic markers for particular collective genetic affinities. Indeed, most such classifications of social identity are likely to have limited external and internal validity, producing misleading information concerning the distribution of genetic variation and the relevance thereof to gene-gene and gene-environment interactions (Ellison & Rees Jones, 2002; Sankar & Cho, 2002).

Phenotypic differentiation, then, is an element of ethnicity, albeit a powerful one, in the UK, where, historically, ethnic distinction has been substantially driven by an ideology of race positing appearance, and especially skin colour, as a primary

characteristic of ethnicity. British 'four nations' history has also driven the interpretation of distinction around concepts of religion, language and territoriality. The slippery boundaries of ethnicity as a means of identity have also drawn in anthropological concerns around culture, premised on what Wallman (1986) has termed 'symbolic identifications', which include dress, diet, and kinship systems. As Wallman (p.229) argues, once it is apparent that ethnic relations hang on the social construction of difference, then phenotype "falls into place as one element in the repertoire of ethnic boundary markers".

So, those features that people might employ to emphasis race difference, or commonality, are essentially arbitrary. While factors such as language, phenotype and religion can signify important social differences to the people concerned, this does not lead necessarily to a conclusion that they should form ethnic markers with pronounced and fixed exclusionary meanings. Religious affiliation as an ethnic marker carries somewhat different meanings, for example, for Catholics in Belfast and those in Birmingham. Temporal changes in meaning and self-identification can also occur. For Gellner (1983), religious labels might also denote past ethnic differences, as in what was polyethnic Bosnia, where despite a common language, Bosnian Muslims distinguished themselves from Serbs and Croats. Since the latter were associated with *having been* [writers' italics] Orthodox or Catholic, whereas Bosnian Muslims "need not believe that Mohamed is his prophet, but you do need to have lost that faith" (p.71-72).

Attempts to subsume phenotype, or race, into an overarching concept of ethnicity have drawn objections that explanations for ethnic difference may still be couched in genetic terms, for example in relation to causal issues within epidemiology (Lock, 1994, Senior & Bophal, 1994). In addition such a usage for Gilroy (1987, 1990) and others would ignore those political and historical factors that would give concrete meaning to such markers. Thus, several writers continue to distinguish between ethnicity and race as a precarious discursive construction of identity (Gilroy, 1990, p.72).

Collective identities and categories

An individual sense of self, or selfhood, can be grasped fairly easily, not least because of its embodiment for example in terms of sex, even gender. A nurse

working in the NHS possesses the accoutrements of the trade, particularly where uniforms pertain and rituals of conduct shape their interactions with colleagues and patients. A social or collective membership is somewhat more slippery concept to grasp; to examine more closely. Is it feasible for example to claim Irish nursing as a category? Also, is this label appealing to ethnicity, nationality, or even race? In the first instance it is necessary to establish the meaning of collective. It would be an error to conceive such membership as based on insight of the members of the collectivity as to their shared identity, whether based on assumptions about gender, class, occupation or ethnicity. Membership from a sociological analytical perspective can draw on both the claims of the observer or the observed.

The thesis inherently depends on this conceptual distinction between group and category, and it particularly hangs on the idea of category possessing both nominal and real features with regard to identity (Jenkins, 1995, p.82). In emphasising distinctions between internal and external dialectical processes as posited by Barth (1969), Jenkins argues that this permits a "wider distinction to be drawn between *nominal identity* and the *virtual identity*: between the name and the *experience* of an identity [writers italics] (Jenkins, 2004, p.22). Nominal identities are those which are assumed by individuals in identifying themselves, while a virtual identity is the *experience* of that nominal identity. Two of my interviewees worked within the same casualty department and saw themselves as Irish, but their experiences were crucially mediated by others and their own perceptions of their class. One was acknowledged by colleagues to have the status of a 'medical wife', which also entailed her rejecting the 'fraternal' advances of her colleague, who had emerged from a poorer rural background. The latter found herself, to her discomfort, occasionally directed to work with "one of your lot"; Irish travellers.

So it is feasible for nominal identification to vary from context to context and to be associated with potentially numerous virtual identities (Jenkins, 2004). At the same time the methodological distinction between group and categorical identity formation permits sociological exploration beyond social psychological or anthropological investigation of social interaction. As Nadel (1951, p.28) posits, 'individuals in co-activity' at the differing level of groups and categories merely demand differing perspectives, though it is feasible at the individual level that those in co-activity may be unknown to each other as co-agents. The vital distinction here is that whilst group membership is determined by relationship amongst its

members, assignation to a category falls into the hands of the person defining such a category. So Marx may define, or rather dismiss the French peasantry as a bag of potatoes with regard to categorisation as a class, but the latter can still lay claims to group identity based on kinship.

This ontological move permits analysis of the social world for both theoretical inquiry and empirical examination. Yet in modelling social relations one must be alert to the risk of reification of such collectivities, which do not possess the embodied qualities of the individual, especially agency and substance. As previously suggested the boundaries of a plurality of persons clearly lack the physical integrity of the individual body, the delineated lines of a map cannot be precisely applied to a specified class, or category of people. So Bourdieu argues against replacing 'the reality of the model for that of the model of reality, thus imposing a misplaced precision on social reality. Furthermore, any such attempt to map reality always emerges from a point of view, a critique. Note for example the protest against the simplified black/white binary within British census assumptions about ethnicity (Walter, 1998).

As outlined above people produce group identities by relating to significant others and differentiating the group from others. Group identity is the product of such *collective internal definition*. Others may be excluded from membership, but relationships emerge with others by signifying their difference and creating relationships on that basis. So the process of categorisation is a broader, more generalised social activity, which is distinguished by what Jenkins terms *collective external definition*. Group identification may result from such categorisation, as illustrated by the Marxian concept of a 'class for itself', where class conflict and struggle do not automatically lead to unity and revolt, without the oppressed realising for themselves where their interests ultimately lie.

Again, assignment of such distinguishing characteristics to others may well be rejected by them, or not even be recognised by them. Nevertheless, it is often essential to the signifier in terms of their identity. Such everyday moves on categorisation, of us and others, create a sense of predictability in a complex social world where our knowledge is likely to be at least incomplete. A sense of uncertainty, or dissonance, is assuaged by our ability to title the unknown or the ill

understood with familiar labels, or categories, that permit us to know, or believe we know how to respond in potential interactions.

Governing individual and categorical identification

Such commonsense distinctions between internal and external collective identification are in turn mirrored by sociological concerns with group identification and social categorisation. But these are more than theoretical constructs within the sociological imagination. How people understand themselves and the social situation of others is imperative to sociological enquiry. This even applies at the level of the group which will find itself categorised by others, no matter what strategies it engages in to hide its criteria for membership from the categorising gaze of others. An important facet of such categorisation would be the consequences for those so categorised, even if they remained ignorant of such a collective identity assigned to them, or of the criteria on which it was based. This can be illustrated by classification procedures operated within the social sciences, which might be premised on claims for a concern for policies of redistribution, though the people to whom this label has been applied may not fully appreciate how they themselves might be allocated positions in this attempt to stratify social position. Nonetheless, such categories have some local grounding, in that some awareness exists amongst its members of such categorical frameworks.

The role of others in assigning such positions is not necessarily a liberating process. Foucault, Hacking and Rose have variously drawn attention to how such moves within the social sciences are not disinterested attempts to understand human and social relations, but actively contributing to the bureaucratic rationalising tendencies of the modern state in establishing disciplinary power over its objects. So Rose (1990, p.6) has illuminated how governmentality develops, government is dependent on knowledge. On the one hand, to govern a population one needs to isolate it as a sector of reality, identify certain characteristics and processes proper to it, to make its features notable, speakable writable, to account for them according to certain explanatory schemes. Government thus depends upon the production, circulation, organisation and authorisation of truths that incarnate what is to be governed, which make it thinkable, calculable, and practicable.

For a social category of that population to be known and understood, it requires to be defined. On the other hand governing a population requires information of a different kind. To measure and establish estimate human characteristics necessitates highlighting certain features of that population as a raw material of calculation, and requires data about them. Knowledge here is physically formed in through the recording of such phenomena as a birth, a death, a marriage, an illness, the number of persons living in this or hat house, their types of work, their diet, wealth or poverty. This constitutes material upon which political calculation can work. Calculation, that is to say, depends upon processes of *inscription* [Writer's italics] which translates the world into material traces: written reports, drawings, maps, charts and pre-eminently, numbers (Hacking, 1982). From this statistical governmentality, Hacking (1990) sees the implementation of powerful frameworks for establishing the normal, as an objectifying measure of difference, everyday, as well as what is acceptable, an ideal, 'our chosen destiny' (Hacking, 1990, p.169). This potentially excluding and disciplining process is considered later in relation to nursing supervision and Foucault on governmentality.

So the rise of statistics provides what Charles Taylor calls a "moral topography" (Taylor, 1989, p.111), a key distinguishing feature of the modern Western world, with its emphasis on assumptions about its strength and solidity in localisation and in our perception of the nature of our agency. This localisation for Taylor is neither permanent, nor universal, it is the function of a historically limited mode of self interpretation, dominant in the Western world, and possibly also limited in future time (Taylor, 1989, p.111).

But in the modern world the capacities of subjects become pertinent to and available for government in new ways. This includes the pursuit by government of socio-political ends such as education, cure, reform and punishment. The tools psychological assessment render subjectivity calculable, making people amenable to having things done to them, and doing things to themselves in the name of their subjective capacities (Rose, 1990). What Rose terms 'human technologies,' that is collections of forces, mechanisms and relationships, enable action from a centre of calculation upon the lives of men and women (Rose, 1990, pp.8-9). Hierarchical relations, from age, to educational qualifications and professional accreditation, position individuals in chains of allegiance and dependency. This empowers some to direct others and obliging others to obey. This is predicated on the ability of

people being able to collectively identify themselves, as well as others, in both terms of social categorisation and group identification. Both processes exist within a dialectic of collective identification.

Procedures of motivation vary, from moral injunctions, such as codes of conduct, to payment systems which direct workers to certain ends. Technologies of subjectivity exist for Rose symbiotically with what he calls 'techniques of the self'. "Through self –inspection, self-problematisation, self-monitoring, and confession, we evaluate ourselves according to the criteria provided for us by others" (Rose, 1990, pp.10-11). What Rose calls the 'government of the soul' depends on the subject aspiring to be a certain type of person, it also depends on the dissonance such techniques create within ourselves and our desire to conform to normative judgements of what we are and could become. This necessitates following the direction of experts on management of self. The features of such relationships in nursing will be explored later in this chapter with regard to confessional relationships and the role of the supervisor in establishing competence and professional development/career advancement.

The categorisation of individuals and populations by government through for example psychological assessments and censuses utilises the 'objective' procedures of the social sciences. People are then established as subjects of the state and objects of government through instruments provided by social science disciplines given to proclaiming their own independence, disinterest and scientific objectivity, as exemplified by the emergence of the clinical gaze (Foucault, 1973). But such categorising allows for the possibility of intervention within their lives, though this might not be recognised, or fully understood by those subject to this identification process with regard to consequences. This lack of recognition, in a new work place, for example, may lead us to suspect we have been negatively labelled in some subtle fashion. As Jenkins (1996) makes clear, the potential stigma of categorisation may be hidden from people, even systematically, despite its likely negative consequences on their moral careers, as for example through ascriptive inclusion or exclusion influencing recruitment choices by nurse managers maintaining organisational boundaries. The potential for ascriptive practices to operate in nurse recruitment and promotion will be returned to later in the chapter when queuing theory is considered.

Membership of social categories, unlike group membership, does not additionally imply relationships between members. Indeed, no relationship need exist between categoriser and the categorised. Such social relations that might be are solely dyadic, that is involving the categorised as individuals. On the other hand, relations between members of a category that include mutual recognition of that category and or its process lead in the direction of group identity. This could suggest the possibility of empowerment, a popular ideological expression in the within the discourse of nurse education, nursing does heavily concern itself with professional identity and its relationship to the patient. On the other hand, there is also the possibility of a 'club culture', which demands conformity, rather than clinical competence (Alaszewski & Brown, 2007). This would indicate that a less than emancipatory project is operating.

Again, categorisation may be more consequential to the signifier than the labelled. Also, while categorising others may assist in identifying oneself, this does not necessarily lead to explicit ideas about difference between the categoriser and the categorised. Neither does categorisation place expectations on the categorised towards the categorised. Nevertheless, the categorisation of others remains a potential resource in our own formation or construction of identity. The act of social categorisation creates then the possibility of group identification, though the opposite is not always true. Thus social categorisation reveals the impact of powerful outsiders on the construction or reification of ethnic groups, while group identification delimits shared experiences of cultural meaning, history and solidarity (Jenkins 1997, p.80). Classification for Foucault, is integral to the construction of disciplined subjects and a key characteristic of ethnicity for Jenkins. The ability to classify is not an objective process, but bound up within the workings of power, which in turn is tied into knowledge. "There is no power relationship without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations", the ways in which people can be known and understood are, in Foucaudian language, discourses.

Discourses that are concerned with the social production and reproduction of identity are not simply representations, or ways of speaking. Said (1991, p.10) saw that discourses are 'epistemological enforcers', regulating what might be talked or thought about. Such discourses draw on systematic shared knowledges. Hacking

(1986, p.30) also speaks of 'depth knowledge' shaped by history and culture; as set of rules discounting what is held to be false and declaring truths. Such knowledges, constitute ways of knowing, including categories of people, or subjects. The truths of such constructed identities are a product of social relations, truths or realities, which lie beyond superficial or false ideology.

These identities produce new knowledges and attendant subjects. Such subjects need to be understood in two ways. Foucault (1982, p.212) specified two meanings here, firstly, one is *subject* to another by control and dependence, as the patient might be to the nurse. Secondly, the self is tied to his own identity by a consciousness or self knowledge. The ability to be reflexive does not liberate, rather one is involved is socially engaged in power relations, in both cases the relationship involves subjugation and power over subjects. Aside from ascribing subject identity people take specific identities; this includes the emergence of experts, whose authority is derived in part by a claim to rational science from the political and social meanings attached to the category. In turn people are managed, and according to Foucault, they manage, or regulate themselves through 'technologies of the self', we constantly act upon ourselves to be a certain type of subject. This gaze also involves self scrutiny, so health and social workers reflect on their own possibilities for pathology. This then is how 'governmentality' is achieved, through attempts to normalise, rather than punish. So governmentality permits the management of populations through category and classification, which in turn produce subjectivities and identities created within those regimes of power/knowledge.

The 'psy complex' envisaged by Rose (1991) as a matrix of knowledges produces truths about the self and social relations to others. Such knowledges move from specialist fields to inform the practices of other caring occupations, such as nursing and social work (Rose, 1991, p.208). Despite the language of empowerment, education offers a psychotherapeutic culture trapping the subject in cycles of activity that promise autonomy, yet ironically the subject must follow the advise of experts to achieve 'government of the soul' (Rose, 1991, p.66).

This is a further feature of Foucaudian thought, in that power is exercised through the subject's desires to be a certain type of person, to achieve a particular identity. Regulatory, normalising power works here through the deployment of expertise

through state institutions whose "varying regulatory regimes are incorporated by social actors, so that their schema of understanding become means of self-understanding" (Lawler, 2007, p.77).

Validation of self understanding is achieved by social performance, though individuals can play an active part in fashioning these self-indicating performances. They are generally constrained to present images of themselves that can be socially supported in the context of a given status hierarchy. Thus the self is a social product in the sense that it depends upon validation awarded and withheld in accordance with the norms of a stratified society (Branaman, 1997). This is implemented through the notion of Goffman's *dramatic realisation*, which requires techniques of impression management. Performance is concerned not with the 'true' or 'false', it is fundamentally about seeming to be convincing, appearing competent in ones role and avoiding being 'discredited'(Goffman, 1990, p.245). This means engagement, or interaction, the performance of everyday ritual that "highlights the common official values of the society in which it occurs…in so far as the expressive bias of performances comes to be accepted as reality, then that which is accepted at the moment as reality will have some of the characteristics of a celebration" (Goffman, 1990, p.45). This is the basis of the interaction order for Goffman, to which actors will largely attempt to conform through 'framing' devices, over for example the display of gender and affirmation of gender identity (Goffman, 1977, p.324). The social features of gendered norms and gendered interactions are obscured by the doctrine of natural expression. The everyday posits 'the normal', and consequently implies what is different, abnormal, deviant and even pathological (Morgan, 2004, pp.37-38). As Goffman argued, the organisation of social identification is a subtle process, something that is not simply a formal title with a written code of conduct. Following Goffman and Bourdieu in term of the fluid conditions of interaction order, much is likely to be open to contingency, social action is often improvised. Further, people break certain rules, they act in apparently contradictory or incongruent ways. Yet at a local level, such indiscretions are tolerated as acceptable.

Institutionalising identity for Jenkins (1995, p.127) occurs through the establishment of patterns of behaviour over a period of time in particular contexts as the way things are done', this echoes Bourdieu's concern with habitus, collective habit is then a form of institutionalisation, and habit often emerges from individual expression of institutionalised patterns. Such social institutions normalise 'how

things are done', and are an integral part of the way the individual makes decisions and directs their attention and behaviour. Still, this is a two way process, as with identity, institutions are emergent products of what people do as well as being constitutive of what people do. Habitualisation helps the individual accommodate uncertainty through avoiding constant reassessment of interactions, even avoiding the need for predictability in many scenarios when habit creates a substantive and secure social environment that does not even require conscious reflection (Bourdieu, 1977; 1990).

Institutionalisation develops from sharing the above processes to the extent that a common history is acquired, people communicate in the same terms based on a shared sense of that they are performing in the same ways (Jenkins, p.128). Sanctions emerge, but the primary process of social control is established by the very existence of the social institution and the hegemony it imposes, 'the way things are' excludes the possibility of thinking otherwise.

The reality of social institutions is maintained by social reproduction of institutionalised practices which give the actor a sense of "objectivated social reality" (Bergman and Luckmann, 1967, p.84), despite their existence depending on ourselves believing them to be concrete entities outside of ourselves. Their importance in ordering social life depends on their continual legitimation for successive generations. 'Axiomatic legitimation' emerges from a constant round of shared experiences, canonised meanings, which coalesce in "the thoroughgoing and interpenetrating institutionalisation of social life (Jenkins, 1983, p.7).

Legitimisation of institutional projects is threatened by constituencies, especially Subaltern collectivities, offering alternative constructions. For Berger and Luckmann this moves beyond values to claims about knowledge (1967, pp.110-146). Such collective points of view provide in a sense a symbolic universe that accounts for individual and collective consistency and continuity. Jenkins argues for a more fractured social world built from a complex, and sometimes conflicting, interplay of greater or lesser symbolic universes. Of equal importance is the materiality of the social world, the social glue that helps keep institutions 'hanging together'. "Symbolisation is always embodied in then materiality of practices, their products, and three dimensional space" (Jenkins, 1995, p.132). In drawing upon Berger and Luckmann's account of institutionalisation Jenkins offers a range of possibilities

with regard to considering how institutionalisation operates as a process. Specifically, with the emphasis upon identification, identity as process, then ethnic identifications are institutionalised. This also applies to particular locally specific gender identifications, even towards temporary internet groups and the most loosely knit friendship group.

This is important in that claims to social structure are most obviously represented by social institutions, which are themselves ideal typifications of continuing processes of institutionalisation.

Berger and Luckmann (1967, pp.71-72) also see habitualisation as preceding institutionalisation, through narrowing choices the individual is freed from the stress of constant decision making, though habitualised actions retain their meaningful character within routines that, in themselves, are implemented without reflection. They become embedded in everyday behaviour and assumptions. This routinisation also becomes taken for granted, as Bourdieu observes habitualisation creates social security, a familiar grasp of 'the way things are', and importantly this understanding may not be easily given conscious attention, much less change (Bourdieu, 1997; 1990). Understanding of these differing matrixes of knowledges demands cultural understanding, or competence in the presentation of self. Habitus is critically important in the presentation of self in this respect, as a corpus of dispositions embodied in the individual and generating practices that develop in improvised interactions contained within Bourdieu's notion of field. Lawler draws attention to the *relationality* of habitus with regard to the theorisation of field [her italics] (Lawler, 2008, p.131). Habitus can only be made sense of within the circumstances of local contexts, or rather fields, that is following Bourdieu, networks, or configurations of objective relations between positions (Bourdieu & Wacquant, 2002, p.97). Broader categories, such as class, race and gender are all socially marked and divided, but the social nature of habitus means relations to each other are also hierarchical. As Bourdieu argues, following Goffman, some people are constructed as normal and others may be decreed as pathological. Additionally, there well be "habitus clash as well as class conflict". For Bourdieu, habitus gives the power of judgement to some over others, whether implicitly or explicitly, that judgement of difference is not without material or other consequences for the judged (Lawler, 2007, p.131). This of course would depend on the point of view taken by the observer assigning identity, power relationships

determine who might assign such labels. Some can pass judgement on others, either implicitly or explicitly, through classification or examination. This typically proceeds from vetting interviews, or more informal conversations in practice, or educational settings, such as tutorials or seminars.

Interviewing is important within nursing across a variety of contexts at the organisational level. People create organisations for the purpose of identity projects, whether to provide acquired identities, or to engage in ascription. Note for example the Council of Deans, which has no legal or formal administrative status, but proffers 'expert' advice to Government and academic bodies on health care higher education. Interviewing and other screening devices are important mechanisms within social organisations, whether as informal or ritualised processes, they are critically dependent on the ability of the actors concerned in articulating competence. As Jenkins notes, it is only rivalled by the committee as a bureaucratic social encounter (Jenkins, 1986, pp.128-129; Jenkins, 1996, p.151). Within the 'caring' professions, this tool has special application in selecting and 'mentoring' suitable candidates who are expected to be self actualising, the interview is deployed as part of the techniques of the self proposed by Foucault (1986, p.29). The implications of this confessional discourse are further examined in later discussion of the supervision interview.

However, this process is undertaken, at the group or categorical level, judgement can be made to count through marginalisation and exclusion. Such large scale categorisation at even the nominal level bears down on the individual virtual identity in the conditions of their life. This is especially the case through the practices of institutions. Nursing clearly operates within this sociological conception of organisation as summarised by Jenkins. Organisations are organised and task focused collectivities, and they have group characteristics. They are also organised on networks of formally differentiated membership positions, allocating specifically different positions, or rather identities, to members (Jenkins, 1996, p.25). Membership is subject to formal classification and the organisation claims for rationality in the operation of its procedures. But the make up and distribution of positions in these organisations opens potential for conflict and discrimination, so nursing operates socially in organisations which are marked by the outcomes of political relationships and struggles. This involves the systematic production and reproduction of collective and individual identities. The previous chapters have

drawn attention here to losers in this struggle over identity, and particularly through the racialised and gendered classification of populations. The more ambiguous position of the Irish will be considered below from the concept of affiliation within the perspective of Subaltern identity.

As suggested previously, organisations are, "… first and foremost, groups" (Jenkins, 1996, p.153). Organisational memberships therefore constitute a substantive element of individual identities. In turn, members exclude others, those non-members deemed not to possess the characteristics of membership. This still leaves room for exclusion within the hierarchical relations of the organisation. Again, the literature has previously demonstrated an array of tactics to marginalise those members who are not quite 'one of us'. This process of internal identification simultaneously determines the status of individual members, say on the basis, for example, cultural competency. But these organisations are at the same time shaped by the organisational categories established for members and non members. This is the dominant theme of recruitment and advancement. Beishon and others have particularly drawn attention to the way individuals could be groomed or neglected with regard to professional development, itself a key strategy for advancement and promotion.

If we proceed with the conceptualisation of organisations as groups, that is that they possess a reflexive membership, in the sense that they know the group and that they themselves belong to it, then this also recognises the dialectic that exists around their positionality. Mutuality and reciprocity within organisations is built up by hierarchies of authority and control, which can potentially subjugate the less acceptable membership, while seemingly offering them an organisational identity that draws on the status, or other social meanings attached to the organisation for the outside world. This leaves the individual with a sense of dissonance, discounted because of their ethnic identity for example, while invited to share the approbation offered to a caring profession.

Identity is consequential and organisational identity is consequential in terms of material and symbolic benefits, aside from the necessarily uneven distribution of benefits with a hierarchical group, organisations direct behaviour of members, through for example contracts, codes of conduct and impose collective routines,

though clinical and administrative procedures. One activity particularly combining these characteristics, namely supervision, will be further analysed below.

Such practices also contribute to the management of organisational identity in the public domain. Social space, both symbolic and physical, is heavily intruded upon by buildings, artefacts and other visible identifications of organisations. Interaction also raises public and individual awareness of such collectives allocating resources, or penalties to non members. These processes beg questions for sociology on how organisations might classify other collectives, and move on to identify embodied individuals to determine allocation of resources to them. What are the consequences of these distribution strategies?

Although procedural correctness is a key feature of bureaucratic organisation, this still permits both formal and informal allocation. The interview, in its various forms, lies at the centre of allocation of resources. As a ritualised encounter as discussed above, the interviewee performs, that is engages in presentation of self, while the interviewer categorises. This oral form, is especially important with regard to the criterion of acceptability, and as such is preferred over tests for suitability (Cohen, 1985, p.183; Giddens, 1990, pp.27-29). It runs hand in hand with two other features, or modes, of categorisation and allocation; discretion and stereotyping.

Discretion is a discrete form of power in allocation that offers context specific and flexible responses to demand and supply issues and the complexity of individual differentiation. As such discretion permits a reflexive reinterpretation of apparently fixed rules, however, the risk of discriminatory practices is self evident. At the same time managers still cling to the simplicities of stereotyping in categorical classification. The literature can supply ample evidence of the cumulative impact of employers using recruitment stereotypes with regard to race, ethnicity, gender and class. Again, this topic will be returned later in the chapter with regard to the consequences in the form of queuing and the rewards of successful affiliation in the face of potential exclusion.

Gender and queuing

The previous literature review of this thesis has offered empirical evidence of occupational segregation by gender by positive correlation of salaries and grade seniority with proportion of men in the occupation. Women have historically

replaced men in feminised occupations (Williams, 1995). Reskin and Roos (1990) theory of queuing argues that white men are favoured by potential employers, whose capitalist practices are also shaped by patriarchal assumptions. Queuing can be conceived as an imaginary device, a managerial response to a shortage of favoured candidates, white males. This preferred category would usually be selected in preference to other categories of potential worker. They are placed at the front as a discriminatory practice. The presence of women and other minority workers in higher grades of nursing, albeit statistically under-represented, as demonstrated by both the Beishon and UKCC datasets, shows this does not operate in all circumstances. Aside from legal requirements to adhere to equality standards, nurse managers are more subtly concerned with 'acceptability' and 'suitability' interacting as selection criteria.

The possibilities for subtle discrimination abound in the determination of criteria for acceptability, or rather, 'who you are.' Managers are likely to wish to select 'one of us', someone who is likely to 'fit in' to the local networks and relationships of the organisation. Given the history of nursing in Britain discussed elsewhere in this thesis this seems likely to run the risk of being exercised from racialised and gendered perspectives. But in both recruitment and promotional practices rationalisation may well operate in either direction, as a mental defence mechanism, in supplying a defence for either rejecting an unsuitable candidate, because they are black and/or a woman, or alternatively opting for them despite their apparently unacceptable status (Silverman & Jones, 1976).

Suitability, as in 'what you are' in the sense of achieved or acquired characteristics, typically competencies, or expressed interests, are more likely to be taken into account when promotion, rather than membership of the organisation is being applied for. Beishon found evidence of professional development opportunities being unequally distributed on racial lines. My own interviewees were aware of grooming practices, appointment to committees, and funded training that would clearly help develop profiles in terms of suitability, or employability indicators. But access to such opportunities can also depend on access to acceptability criteria.

Again, women and minority ethnic candidates can achieve acceptance to pre-registration places, especially where competition is low, and the threshold of suitability is low. Entry gates narrow with the possibility of competition for

relatively scarce specialities, higher grades or training in relation to those areas of practice. Again this is demonstrated within the literature reviewed and the secondary analyses of empirical data.

White male candidates who would have filled these front row places have turned to better employment in other occupations. Their empty positions allow white women and other minority ethnic candidates positioned behind them to be shuffled forward for potential inspection and selection, albeit as less desirable categories. These other categories necessarily include both white women and minority ethnic men and women. The latter are in turn forced into this job queue due to exclusion from occupational opportunities elsewhere.

This does not bring gratitude from the organisation or the host society in general. As Beezmohun observed of her mothers post colonial status as an immigrant and nurse, her particular post colonial history did not provide "… racial equality, but accusations of stealing jobs no one else wanted any way" (Beezmohan, 1996, p.331). Colour racialises people, by ranking them lower down hierarchically with material and social consequences (Lee, 1999, p.280). This produces real gains for white people, especially men. They benefit from what Roediger (1991, p.12), following W.E.B. Dubois, has termed the "wages" of whiteness. In effect white male workers can vote with their feet with regard to their occupational choices.

Alternatively, Williams found that American men entering feminised occupations, like nursing, were beneficiaries of societal assumptions of their masculine identity. The recruitment of men on masculine terms reproduced gender hierarchies within feminised professions such as nursing (Williams, 1995, p.162). Employers selected on the stereotypical criteria discussed earlier in the chapter. Even men of minority ethnic background appear to have benefited from this process, as demonstrated by the Beishon data.

Williams concludes that integrating men into 'women's professions' such as nursing, reduces occupational segregation, but at the risk of displacing women from more desirable positions within the profession. Men in such positions also symbolically occupy extremely contradictory positions in terms of the gender order. On the one hand, their position challenges stereotypical assumptions about

gendered work; on the other hand, they are beneficiaries of a system they ostensibly appear to challenge. Williams argues that:

> [b]ecause of the higher value placed on men by the larger society , men extract advantages within these occupations. Men enter these professions carrying their gender privilege with them, and consequently they 'rise to the top', out earning their female colleagues and reproducing the same gender hierarchies that characterise other professions (Williams, 1995, p.177).

Organisations are then deeply gendered, jobs are effectively designed for men and women, assumptions about gender and work are embedded within job descriptions, hierarchies and organisational practices. Individual workers also bring in values and expectations that are socially reproduced with regard to gender. This was noted by Williams with regard to way men actively responded to boundary heightening in predominately women's professions. This effectively overturns token theory, which argues all numerical minorities are disadvantaged. The assumed qualities of masculinity override such positioning, as the organisation, and men themselves reproduce and accentuate their difference as a resource, one that brings prestige and advantage. Williams argues that minority men in women's work actively redefine their work and recast their participation in this work as consistent with hegemonic masculinity (Williams, 1995, p.183). Securing a masculine gender identity propels men up varying career ladders, no matter how feminised the occupation. Managers, including some women, continue to subscribe to masculine values with regard to senior positions. The assumption here of masculinity is a binary position that subjugates the feminine; masculinity emerges from dialectic interplay between the organisational structure and the needs and desires of men. Habitus varies the context of such relations, and Williams highlights the work of Simnel on 'contexts of social interaction' (Williams, 1995, p.181), yet the literature points to the consistent ascendancy of men, whatever the context of their employment.

A theoretical problem with regard to exclusion lies around the ontological status of gender assumptions around category. Gender is a main primary analytical category in feminist writing and politics, yet for Goldenberg the problem of theorising women lies in social constructionist accounts essentialising and thus excluding significant groups of women (Goldenberg, 2007, p.140). Empirical fieldwork has revealed enormous variety in women's experiences, especially cross cultural analyses. Reducing such a multiplicity of experiences and attributes into one or even

several shared underlying features necessarily excludes the marginalised, whether poor, working class, minority ethnic or lesbian. As argued previously categorisation emerges from a point of view. As Spellman (1988) argued, the act of categorising is also an act reflecting the interests and priorities of the categoriser, the distinctions made through categorisation matter. Yet generalisation is important in giving explanatory power and permitting political organisation and action.

Bradley's (1993) typology of three forms of entry into women's work; takeover, invasion and infiltration lacks such explanatory power. Bagilhole and Cross alternatively argue from the findings of an exploratory study for deeper and broader empirical studies to replace the infiltration concept and its accompanying ideas of agency, motivation and intention, with a theory accommodating structural consequences. In the mean time empirical analyses of such as Labour Force Survey (2004) cited by Chan shows gendering of employment, with women predominately involved in caring and other service work, this continues to be a persistent feature of the division of labour in Britain. From such analyses Anker is able to point to occupational sex segregation as 'one of the most important and enduring aspects of labour markets around the world' (Anker, 1998, p.3).

A Subaltern perspective

Subaltern theory offers a potentially fruitful critical perspective on social identity. This cultural studies and political history project was inspired by the seminal work of E.P. Thompson, whose 'History from Below' project made a widespread impact on radical historians wanting to emulate his work within an Indian context. This response reflected a number of factors within post colonial Indian politics and society. This specifically found its voice in the new and expanding universities of India, where 'History from Below' was timely in challenging the prevailing orthodoxy, a suffocating mix of Stalinist and Nationalist ideology dominating historical studies, particularly of the colonial period. In broad terms nationalists viewed the anti-colonial struggle in terms of a 'unitary movement' under the leadership of the Gandhian Congress, whereas orthodox Communist historians, such as Bipan Chandra, had widened the parameters of 'acceptable nationalism' to include 'revolutionary terrorists' and the left. Nevertheless, both nationalists and communists shared the assumption that the mass of Indians were drawn into to

political action by Gandhi and the elite cadres of the Indian National Congress Party (Sivaramakrishnan,1995).

However, the impact of 'History from Below' collided in the Indian academy with another import from the west, the critiques of post-structuralism and post-modernism. This collision produced a new and specifically Indian synthesis; the Subaltern Studies group, its namesake journal first appeared in 1982, edited by Ranajit Guha. The term *Subaltern* was taken from Gramsci. In his *Prison Notebooks* Subaltern groups were conceived as diverse oppressed groupings, subjugated by the state and its dominant class allies (Gramsci, 1970). The Marxist class based perspective of Gramsci had moved away from the historical determinism and materialism of Marxist orthodoxy, his praxis allowed examination of cultural relations as opposed to the imposition of an all embracing theory of the economic substructure (Crotty, 1998, pp.124-125). This in turn was expanded by the Subaltern Studies collective, who initially enlisted trade unionists, the proletariat and peasant insurgents, to include a more diverse range of oppressed groups, including women, and tribal people (Graham, 1996, p.365).

Subaltern studies sought to recover the struggles of the poor and the outcast from what they critiqued as the 'condescension of posterity' and the grip of 'official' left intellectuals. The collective focussed on peasant and tribal struggles, with little later work being done on urban movements, with the notable exception of Dipesh Chakrabarty's study of the jute mill workers of Calcutta (Chakrabarty, 1984). Their analyses were distinguished by arguments that these struggles were not the product of what they termed 'elite nationalism', which they critiqued as a form of 'bourgeois' nationalism. Indeed, these insurgent groups were independent of the Congress movement, more radicalised and at times in direct conflict with Congress precepts. Gyan Pandy (1982) for example demonstrated convincingly, in a study of the 1921-22 peasant struggle in Awadh, how Congress, had opposed the peasants were targeting Indian landlords, who Congress wished to recruit into their pan-Indian alliance against the British.

Furthermore, Subaltern analysis argued that such movements from below were subordinate to an elite nationalist project. When they wrote of combating 'grand narratives', it was the 'grand narrative' of anti-colonial nationalism they were targeting. This was an important theme within their argument, that essentially the

'nationalist leadership' had attempted to use 'highly controlled' struggles of the Indian masses in order to confront and then replace their colonial masters. So the Congress party was effectively achieving hegemony for its elite leadership as a new dominant class formation. But the collective's project had an even more ambitious aim: they wished to reconstruct peasant consciousness itself, and to demonstrate its autonomy from elite nationalist thought.

Over time however, the Subalterns began to shift their theoretical perspective under the influence of post-modernism and 'post-colonial studies'. The central theme of the group's work became not the hijacking of popular struggles in the interests of an aspiring Indian bourgeoisie, nor the reconstruction of Subaltern consciousness, but the argument that the whole 'nationalist' project was fundamentally flawed. In the name of 'progress' and 'modernity', the nationalists, after 1947, had imposed an oppressive centralising state on the 'fragments' that comprise Indian society, an overly homogenising ideology that sustains Subaltern status over a multiplicity of subjugated classes and groups. It is in this context that 'community' began to replace 'Subaltern' as the focus of the collective's work. 'Community' was now privileged as the key source of resistance to the new hegemonic power. Critics have argued that this has led to a celebration of local traditions for their own sake. The celebration of these fragments has produced a counter critique, one which points to pre-colonial orders that subjugated other groups on the assumption of identity differences of ethnic, class and gender. This includes the observation that in Indian society communities are not simply centres of resistance to an intrusive and oppressive state, but also sources of oppression themselves, in this case with regard to class, gender and caste.

Nevertheless, Graham (1996, p.366) cites and credits Spivak (1985) with opening the project to feminist and ethnic critiques of the dominant. Graham in turn argues that this novel reading of the Subaltern with regard to gender can be applied to cultural and political interrogations of the historical and contemporary position of women in Irish society. Their identity has been subjugated as a category, by their effective exclusion from the economic and social life of the state. The structural conditions and consequences for a gendered diaspora have previously been explored in Chapter Two. Graham argues that the category of 'Irish' must be reconsidered from a Subaltern perspective, to explore the processes that attempt to bind what Irish women may be, and challenge the social and legal sanctions invoked to contain

those on the margins. The consequences of this historical categorisation have effectively expunged women from participating in the world of work and politics. This is not uncontested territory, resistance has critically highlighted how gender is understood in Ireland. As Smyth (1993) argued, a debate looms, a debate without resolution over the positioning of gender within Irish societies, which has prioritised sexuality and reproduction, social and sexual. Women here can be said to constitute a Subaltern category, though a sense of solidarity splinters women on the basis of other loyalties and affiliations.

The concept of the 'Subaltern' has two significant origins, Gramsci (1971, p.52) referred to the Subaltern as a label, or category, for those groupings in Italian society oppressed by the state, and their allies, the dominant classes of capitalism, the church and landlordism. This Marxist critique recognised that such groups were diverse, indeed even 'fragmented and episodic'. An inherent contradiction of the Subaltern was their *affiliation* to 'dominant political formations'. Again, such groupings cannot unite until they become, what Gramsci specifies, a "State". This unlikely liberation scenario is necessarily obstructed by the dominance of the ruling elites, or classes. However, the emancipatory aims of Subaltern groupings for "autonomy, unity and dominance" help define their Subaltern status and collective identity.

The Gramscian concept of hegemony also plays its part, Subaltern groups are, in these terms in conflict, counter-hegemonic, struggling to overturn, even replace the dominant ideology. This is a struggle not only concerned with toppling, or subverting the dominant class, but a strategy to overturn and replace 'the dominant'. The category of Subaltern is for Gramsci a disparate collection of groups only united by a shared experience of oppression. Yet their struggle against their allotted social or political position, a feature of categorisation, demonstrates their resistance to the status applied, or enforced on them. They move to 'rise' from their status by 'active or passive affiliation' to dominant formations, which they hope will 'influence the programmes of these formations [and] to press claims of their own (Gramsci, 1971, p.52). Conservative patriarchal nationalist movements can be characterised in this way, whether through the land war in Ireland, or the preservation of caste systems in India.

But the term 'Subaltern' was appropriated as a histigraphic project that sought, as Guha claimed, to write 'the politics of the people' (Guha, 1982, p.7), namely the colonial resistance of Indian nationalists, which was effectively ignored, or brushed aside, by dominant hegemonic discourses of British Empire. The concept of the Subaltern was theoretically expanded beyond Gramsci's Marxist view of a class based conflict. This opening was led by Spivak (1985), who consciously drove forward a revisionist feminist critique which opened the door to other oppressed and marginalised groups beyond the socio-economic classes or formations seen by Gramsci (Graham, 1996, p.365). So a literature focused on peasant insurgency, working class and trade union struggle now enveloped ethnic and feminist accounts of the 'dominant'. Spivak and others have established the Subalternity of women in post-colonial discourses, particularly within the cultural studies literature, that posit a set of experiences shaped by nationalism, colonialism, and post-colonialism (Spivak 1988, 1993a, Donaldson 1992).

A further distinguishing feature of the Subaltern studies project was its theorisation, and condemnation, of post colonial India as an 'ideological product of British rule in India (Guha 1982b, p.1). This particularly applies to the apparatus of the state and its ideological assertion of national identity. Nationalism in this political project, acting hegomonically in Gramsci's terms, through a necessary rebuttal of colonialism, effectively denies and suppresses a multiplicity of Subaltern classes and groups, thus maintaining their pre-colonial Subaltern status.

The idea that struggle also did not involve complicity is a central feature of Gramsci and his observation of Subaltern groupings 'actively' or even 'passively' participating, within the structures of the dominant classes and the state. This is the process of affiliation, albeit undertaken with varying degrees of success. But an alternative tendency in contemporary Subaltern studies has been the effective valorisation of oppressed groups by colonial formations. The category of the Subaltern is read through the lens of an ethics of post-colonial critique claiming to speak for its victims and celebrating unsung heroes (and heroines), and martyrs. Their rewritten utopian histories are in effect bleached of any stain of collusion or collaboration. This denies an important processual quality of Gramscian Subaltern theory, the concept of affiliation as mentioned above, and also the heterogeneous nature of the groups concerned.

To apply Subaltern critique to questions of diaspora, gender, nationality in Ireland can risk gliding over contemporary and historical social and cultural relations of a deeply hierarchical nature embedded within the institutions of Irish society and state. Nevertheless, a Subaltern critique necessarily challenges relationships between nationality, class and gender and race. These are questions increasingly asked and confronting Irish society (Graham, 1996, p.366). Ideologies that inform unionist and nationalist discourses in Ireland meld gender within social constructions of family and society that have pronounced patriarchal meanings (Meaney, 1991, p.17). Feminist critiques give considerable emphasis to how the metaphors and cultural discourses of Irish politics and religion exhibit controlling mechanisms over the status and role of women, this critique is shared by Irish writers and a broader stream of post colonial feminist thought. This dominant discourse reaches out to women, claiming to represent them while also denying to them their citizenship. Thus Kandiyoti perceives discourses of difference hanging on concepts of nation, gender interests are subsumed to terms of reference set by nationalist discourse. Gender is in effect affiliated as a Subaltern category, following Gramsci, to a dominant post colonial formation that is patriarchal (Kandiyoti, 1993, p.380).

This is illuminated by Radharkrishnan (1992, p.78) who argues that the politics of nationalism cut out any claims to discourse, by "other and different temporalities", the ideology of nationalist politics creates the normative mode of the political. Irish nationalism, as expressed through the compact of de Valera with the Catholic Church was borne out of the agenda of basically a conservative revolution, whose leadership invoked 'folk roots', returning to a pre-colonial golden age located in the rural west (Delaney, 2000). Indeed, the state and the Church promoted an 'ideology of the rural' despite limited modernisation. An ancient and authentic west evoked in travel writing, and especially in paintings of the Irish cottage landscape. National identity was not only embodied in but maintained through cottage landscape imagery by means of what Michael Billig terms banal nationalism, that is the daily inculcation of nationhood by means of an array of barely-noticed signs. The cottage landscape, constantly reproduced and taken for granted daily recalled citizens to their heritage (Cusack, 2001, p.222).

A serious problem with Subaltern studies has been moves towards the celebration of nationalism as a unifying force, a uniting ideology subversive of all authority

(Coulter, 1993, p.54). This nostalgic glossing of history neglects the proper examination of social realities, the consequences for those Subaltern groups who were not empowered by the overthrow of the dominant formation of the British State. This has a special resonance concerning the hegemonic forces politically and socially subjugating women in 'post-colonial' Ireland.

Spivak has attacked this homogenising narrative which empties the experience, indeed the very category of women of any meaning. Spivak (1993a, p.79) notes that the "… colonised Subaltern is always irretrievably heterogeneous". This return to Gramscian theory acknowledges that a variety of collective Subaltern identities might collide as well as collaborate with each other and dominant formations in pursuit of their own goals. In an Irish context this would give recognition to the exclusion of women as a consistent policy of successive nationalist regimes, rather than just an unfortunate by product of colonialism. The particular danger for Graham (1996, p.370) lies in the risk of accepting, or "…rehearsing the idioms and rejuvenating the discourses of an essentialist Irishness which is always oppressed, and yet is itself oppressive of the heterogeneity with which it is confronted". Acknowledging the complexities of relationships produced by affiliation allows the possibility of understanding a wider notion of the post colonial status of Ireland and the gendered diasporas it has produced.

A Subaltern commentary on diaspora would usefully draw on the productive division Paul Gilroy established between ontological and strategic essentialism in his seminal The Black Atlantic. This division opposes nationalist and ethnically absolute, unitary approaches to culture and identity with a more pluralistic and complex representation of particularity seen as internally divided by class, sexuality, gender, age, ethnicity, economics, and political consciousness. This means constantly weighting the claims of a unified national identity against other contrasting varieties of subjectivity and identification (Gilroy, 2003, p 49).

Subaltern groups seeking advancement within the terms of a dominant discourse of nursing practice must convincingly demonstrate their competence within the field and its particular habitus established by their 'expert' supervisors. An uncontrived front and the true self is revealed via the trait of spontaneity (idealised interaction allowing the individual to present a desired face). This notion, spontaneity in performance, links Goffman's opus of work theorising identity and interaction

order (Goffman, 1983), through presentation of self and the routines and rituals of interaction and framing (Goffman, 1969, 1975) to macro-sociological entities such as organisations in which specific enterprise and social values are being implemented by management ideologies adopted within nursing. Such values include those embodied in

- Professional codes of practice

- Total quality management

- Investors in people

- Business process re-engineering

- Learning organisation schemes

These define required, role-based social interaction which affirm an organisational ideal or "truth". They drive organisational performance and the organisation-bound individual is socialised into the organisation and internalises its values from which they express their spontaneous freedom in actions which reflect the "truth". Processes of social hegemony, through its affect on consciousness, promote Gramsci's "common sense", 'this is the way to go' and the consequent assimilation of doctrinal bases of culture.

- Large sections of the population give their "spontaneous" consent to directions imposed by dominant groups e.g. intellectuals and agents.

- "Idealised" performances are defined via social pressure

- The norms, mores, and laws to which face, line and stigma apply are established.

- The link between the macro-level of social institutions and the micro-level of face-to-face interaction can be seen through the interview, act of supervision.

Establishing boundaries and control through competency in confession

Western nursing, within Britain and the United States, has consciously blended particular constructions of spirituality, confession and control to establish its

occupational identity. Its occupational socialisation from the Nineteenth century drew on explicit assumptions that nursing should be a calling, a vocation for women, and so subject to the disciplines imposed by contemporary religious orders on their novices (Glaser, 1966). This quasi-religious apprenticeship model was frequently referred to through narratives that alluded to self sacrifice and unconditional service, while specialisation of role and status echoed previous moves made by medicine in cloaking, or enclosing itself beyond the understanding of the lay world (Gramsci, 1970). The novice to expert association also traditionally assumed acceptance of a moral authority exercised by its formal leadership. Such group loyalty reconfigures how people see the world around them, including arrogance towards the outside lay world. A further feature of nursing educational relationships was the importance of localism and its conventions in the face of cosmopolitan challenges to ontology and epistemology.

The transformation from novice to practice 'expert' was cloaked through instruction initially validated by medicine, and then increasingly, an evolving hierarchy of nurses promoted to teach and administer nursing (Abel-Smith, 1968; Strauss, 1966), who in turn developed and promoted models of nursing. These models drew on ontological positions within the human sciences, notably humanistic educational theory, including the key work of Rogers. The educational process also deliberately borrowed from a range of Christian religious orders prominent in European nursing care in the Nineteenth century. This evolving process demanded an ethic of self examination shared with a confessor figure and other members of the order. Vocation here was often implied to mean a divine calling, rather than a more prosaic technical training towards a particular work career.

The medical profession still imposed their control over the work and even the sexuality of their colleagues (Davies, 1980). Yet the drive for self-regulation has remained a core tenet of professions and professionalising occupations such as nursing. More broadly, attention has been drawn to the increasing significance of 'technologies of the self' inside post-modern regimes of governance (Foucault 1988a). These technologies of the self 'permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being. They therefore transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality' (Foucault, 1988a, p.18). Through various forms of self-

disclosure an obligation is established for people 'to speak the truth about themselves' (Bury, 1998). Both policing of the self and the public declaration of oneself as "fit for purpose" through the management, for example, of a healthy lifestyle and presentation of a healthy body signify responsible (controlled) citizenship (Petersen and Lupton, 1996).

Such concerns, it can be argued, have become heightened within late modern cultures. These cultures are said to be increasingly characterised by 'individualisation' and 'risk' (Beck 1992, Beck and Beck-Gernsheim, 1996) as a result of detraditionalisation, deindustrialisation and a consequent disembedding of individual identities from their more stable modernist categories, such as gender or sexuality. The resulting 'risk cultures' (Lash and Urry, 1994) demand reflexive, self monitoring individuals capable of constructing their own identities and biographies (Beck, 1992) under the guidance of expert knowledges. In this way, risk serves as a form of governance (Castel, 1992), as individuals continually find themselves in a process of balancing risk and opportunity.

Michel Foucault's insights into identity and the importance of 'care of the self' and 'surveillance of the self' to post-modern systems of social order and control are significant in identifying nursing as 'a form of confessional discourse' (Banks, 1998) and in viewing 'reflective practice' and 'clinical supervision' as 'technologies' which function both as 'modes of surveillance' and as 'confessional practices' (Gilbert, 2001). In this way, 'clinical supervision' can be understood as part of a process of 'governance'; what Foucault (1988a) has defined as the 'conduct of conduct' or ''art' for acting on the actions of individuals, taken either single or collectively, so as to shape, guide, correct and modify ways in which they conduct themselves (Burchell, 1996).

A belt and braces approach is detectable in the literature for this new command and (self)-control culture. Professional self-regulation is initially to be encouraged and if necessary, subsumed within a renewed complex of 'disciplinary' mechanisms. For example, new regulatory bodies in which 'lay' voices are to be heard. This appeal to the "lay public" is a significant device for monitoring professional standards/quality, a process to be partially upheld by the reinvention of "matron", or rather modern matron, supposedly a reassuring figure to the lay public.

Yet in learning this catechism nursing practitioners and local nurse managers remain socialised by local procedure, and informal rule (Melia, 1987). At the same time they are drawing on allocatory decision making (Jenkins, 1996, p.162), where judgements draw on moral rationing, who should get what. This produces ambiguity, a dualism for nursing persists of the everyday and curriculum driven claims to knowledge. So tensions exist between current appeals to the lay perspective as an independent/external device for monitoring professional practice, for example, New Labour attitudes to the National Health Service (NHS), and professional claims to expert knowledge and the exclusion/boundary setting these involve. This is possibly reconstruction in the 'regime of truth', that is in 'the types of discourse which [society] accepts and makes function as true' (Foucault, 1980, p.131). The hegemony of professionally-based expertise is challenged by the granting of voice and authority to lay knowledge in the arena of health discourse secured through political imperative. 'The long-term issue is whether these changes [in professional jurisdictions, established privileges and the state-profession relationship] also threaten professionalism as the dominant means of institutionalising expert services' (Johnson, 1993, p.152).

Carpenter (1978) pointed up not only an occupational split within nursing between teaching and practice but drew attention to a further group, nursing administrators, or managers. This group has turned towards New Management theory as a self-validating tool for their own leadership claims. This managerial discourse freely employs religious metaphors around transformation and vision, as a means to secure control for this elite group in imposing their vocational interpretation of nursing (Clarke and Newman, 1997).

Nursing is therefore beset by competing ideologies of professional identity. Within nursing practice this confusion of ideas is traditionally fended off by internally reciting the 'principles', or sacred canons of professional identity (Strauss, 1963). Reflection becomes a useful tool here in curriculum defence of these canons of identity/knowledge. The confessional act is a central construct operating on the premise that knowledge is revealed as parables-powerful and enlightening. These parables appeal to local knowledge and relationships, drawing in effect on anecdotes to illustrate desired and undesirable practice. This appeal to local knowledge and relationships serves another function in reducing anxiety concerning uncertainty in practice, or performance, and enabling practitioners to

reject or down play other sources of knowledge. Established practitioners can claim role competence through approbation of their local peers.

Unsurprisingly, such localism depends on knowing 'who's who' and being known within this network of work, a habitus which is unexpressed, or rather not formalised. Despite current attempts to persuade or impose the development of evidence based practice, (DOH 1997, DOH 1998, DOH 2000) a cosmopolitan ideal, local nursing hierarchies sustain and reinforce authority resting on established local orders. This poses problems for outsiders seeking to negotiate their way into the habitus established there. So mentor roles and clinical supervision in nursing are often hierarchically imposed, negotiation may often be impractical if a nurse wished to reject a supervisory relationship with a senior team colleague. Rather bizarrely, nurse consultants may find themselves in such scenarios where more senior nursing colleagues assume clinical supervisory positions over them. Yet these mentors or supervisors do not maintain their own practice.

Clinical governance, latched onto another emergent discourse, evidence based practice, emerges as a bureaucratic control device, finding out what people do, whilst driving responsibility and blame back to practitioners but sold as empowering them. This hangs on the assumption that there is a best practice, however much clinical practice is not measurable. So promotion note Jenkins on acceptable occurs through local knowledge and previous local experience.

Interestingly, the corollary suggests that the led need to be disciplined in to acceptance of this *fuhrerdemokratsie*. Reinvention of the matron role as the Modern Matron is not just a populist gesture by New Labour but also a clear rejection of professional claims to individual autonomy of practice and self-management. It is worth noting the survival of this title and role in more conservative institutions where nursing operates, namely the private sector and the armed forces.

The reinvention of matron places individual self-surveillance of 'fitness for purpose', and its public display through the requirement to maintain a portfolio of practice, in the 'gaze' of a renewed and reinvigorated disciplinary structure. This signifies a move to increased central regulation of individual accountability and responsibility. Great pride has been taken in the construction of this curriculum project despite its lack of connection with socialisation of practice, not least

concerning the parent child transactional relationships policed by educators, whilst claiming participation in a transformative curriculum (Freire, 1966, p.4). A world of practice and appropriate roles is constructed here according to documentation (Atkinson and Coffey, 1997). British nurse educationalists have also eagerly borrowed from American nursing theory a resistance towards rational enquiry and an alternative appeal to intuition (Benner, 1984). Nurse educationalists in particular embraced Schon (1983), with the claim that 'reflective practice' can either substitute or add to scientific knowledge as a source of professional knowledge.

The ideological claims of a transcultural universal nursing therefore burst with internal contradictions. Many nursings are possible not one as its practice is differently 'constructed' in a vast array of socially and culturally diverse sites, situations and encounters. The illusion of nursing knowledge, there's not much to know, and the denial of the contribution of cognate disciplines and borrowed collections of knowledge, mean that educational curricula swing quickly in response to external rather than professional demands.

So those concerned with nursing instruction and confession lean towards narratives, the 'horror story', a tale of woe for either the learner or the patient, which is now to be shaped in to diary disclosures and case histories 'evidencing' learning, a rhetoric of theoretical agendas pay lip service, note continual reference to application of practice. Nurses therefore depend on informal processes of socialisation from which exemplars are drawn. These stories draw upon the narrative devices of characters, action and plot, the latter drives the story, picking up broader strands of cultural narrative and symbols familiar to the narrator and audience. A critical feature of this interaction and interpretation lies in what Ricouer termed 'emplotment', this requires a shared cultural understanding between speaker and listener, the latter must interpret the place of particular events, ordering them to explain the moral compass of the account, or rather the point of the account (Ricouer, 1980).

Identity is produced by such autobiographical accounts, moreover, the social identity of the nurse is produced by such acts of interpretation and reinterpretation. Power, with regard to interpretation, swings towards the expert figure, who is encouraged to judge the speculative materials produced by the student. Diaries and portfolios allow students to demonstrate a 'reflective' style, which would include statements about their own ability to empathise with the patient, and admissions

concerning their ability to demonstrate self-awareness. These tasks draw upon reinterpretations of the literature on counselling and communication. These resources also provide 'expert' narratives that assist the nurse in constituting their own narrative identity.

There are two significant groups of actors, educationalists and managers, struggling for control of the role of expert in this potential arena of conflict. Consequently nursing has difficulty in accepting new discourses because these preceding dominant discourses lock them out. For both these groups the confessional act is therefore a powerful social act, and a required ritual, which expects voluntary submission by the student/preceptee, a public acknowledgement of limitations, for example through disclosure of the diary, or other portfolio work. In return an appropriate nursing authority promises to validate personal growth, or absolution and salvation, on the part of the student. Note here the self-disciplinary consequences discussed above.

But the validation of personal growth is only possible if this growth conforms to an approved direction. The humanist ideal of education facilitating individual personal development remains an impossible fiction when the educational process is driven by professional requirements. Learning opportunities must be identified which will enable the novice's individual growth and development, albeit in the direction required to satisfy the requirements of professional registration, rather than meeting the potentially unique learning needs of each and every student nurse. This inability of nurse education to facilitate individual development needs is not a question of capacity so much as a feature of professionalisation.

Far from seeking to facilitate personal development and empowerment, nurse education has traditionally sought to secure the individual novice's professional development with predetermined competencies. As Foucault remarks concerning the way in which subjects' actively constitute themselves through 'practices of self': 'these practices are nevertheless not something that the individual invents by himself. They are patterns that he finds in his culture and which are proposed, suggested and imposed on him by his culture, his society and his social group' (Foucault, 1988b, p.11).

Nursing, and other professions therefore occupy a significant position in the 'apparatus of governmentality', in the 'directing' of 'free will' (Higgs, 1998) and the 'shaping' of 'the self-regulating capacity of subjectivity among citizens' (Johnson, 1993). Through this apparatus self-regulating subjects are reproduced and the governing of a liberal, democratic state is secured. In this sense nursing both assists in the construction of the self-caring patient/client, through for example through the construction of the subject of health education discourse, and in the construction of the "appropriate" nurse, that is the reflective practitioner.

The ease with which nursing apprentices and experts embrace the concept of the 'reflective practitioner' stands as testimony to the presence of a mode of power, the operation of which does not rely on the domination of the individual through institutionalised and disciplinary regimes, but rather through engaging with the person. This is the dominion of 'pastoral power' (Foucault, 1982), of a power which seeks to express itself 'in the immediate inter-actional and discursive contact between individuals. Power under conditions of post-modernity is not 'seized' or 'exercised' but is 'productive' and 'constitutive' of social relationships' (Bury, 1998, p.15). Such an engaging, interacting, talking mode of power resonates throughout post-modern mechanisms for recognising and constructing the self. In both the public and private worlds the individual bows to the sovereignty of the 'entrepreneurial self', 'the self who is expected to live life in a prudent, calculating way, and to be ever-vigilant of risks' (Petersen and Lupton, 1996, p xiii) and the force of individualism as social control is felt, as 'we are obliged to be individuals of a certain sort' (Rose, 1997, p.237).

Key to this sense of individual identity is faith in the fixed nature of that identity, an identity which far from being viewed by the individual practitioner and the profession as fluid, fragmented and constructed through discursive practices (such as those of 'clinical supervision' and 'reflective practice') believes itself to exist in a state of discursive innocence. The authentic self is seen to exist prior to and outside of the confessional encounters of 'supervision' and 'reflection'. The 'inevitably fragmented self' of a subjectivity which is 'dynamic and contextual rather than static' (Lupton, 1997, p.106) is denied. Indeed, a condition for both 'supervision' and 'reflection' is the assumption that persons exist as unitary subjects ready equipped to declare the degree of their 'professional fitness' through personal reflection on their experience.

Actors may fail to recognise that their social 'identity' is fabricated through the process of reflection and therefore could always be constructed differently at different times and in different places. The 'self-assessment' involved in confessional encounters is social and context specific in nature. Identity shifts and changes with context and situation, and is dependant on these and other discursive practices, rather than on any sense of authentic personal identity standing outside of the play of force and power that the confessional relationship signifies.

Late modern cultures 'risk' cultures (Lash and Urry, 1994) that have witnessed the breakdown of traditional institutions and identities and that are driven by neo-liberal imperatives of self monitoring and responsibility are increasingly characterised by the 'governance of individuals' through a process of individualisation of responsibility (Beck and Beck-Gernsheim, 1996). This process serves not only as a disciplinary mechanism (Foucault, 1978), but a means of actively constructing and constituting the subject in complex ways, with reference to diverse discourses. Such ideas resist the notion of an authentic, pre-discursive self, and rather posit the fluid and pluralistic nature (sic) of identities in late modern cultures. In the confessional that is the nursing supervision, the speaking process itself has a key role to play in constructing the subject in line with expert discourses.

The mechanisms of power at work are thus rarely unidirectional, but part of a complex cycle of power/ knowledge that works upon an active, speaking subject, to actually construct the subject itself. In this way, the speaking subject is implicated in the process of their own subjection, as they simultaneously become the speaker and the subject of the statement. This is played out as the supervisee confesses their actions, both good and bad, positive and negative as part of an active process of constructing the self with reference to the 'expert' feedback and guidance of the clinical or educational supervisor. The individual nurse is thus active in their own governance through the inculcation of expert discourses on theory and practice. Such processes of surveillance invite individuals to govern themselves; observing and monitoring their own behaviour through the operation of disciplinary power (Nettleton, 1997). As Foucault (1978) notes:

> The confession is a ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and

appreciates it, and intervenes in order to judge, punish, forgive, console and reconcile...a ritual in which the expression alone, independently of it's external consequences, produces extrinsic modifications in the person who articulates it..' (pp.61-62).

Within such a process the subject is thus fluid and dynamic and open to diverse constructions, the outcome of a confessional relationship with an 'interlocutor' and the product of power/ knowledge; and thus the antithesis of a pre-discursive, stable self. As noted above, clinical supervision represent such a strategy of the governance of individualisation, or 'governmentality' by acting as a 'technology of the self' (Foucault, 1988a), that, in interactions with technologies of power and domination serves to actively construct the individual through a process of self scrutiny and confession to the expert. As Foucault (1978) has noted, the confessional act, in which the pupil discloses all to the master, serves as a source of discriminatory power, whereby the subject is actively constructed with reference to expert knowledge, drawn from dominant discourses, and propagated through the figure of the master.

In this way, technologies of the self such as the confessional serve as bridge between technologies of domination and the subject, as they serve to actively construct a subject inline with dominant discourses, a subject constructed to meet the needs of societies and institutions. Such technologies thus become a means of exercising the bio power (Foucault, 1978) that Foucault's later work has documented, through a process of governmentality that induces, through introspection and confession, a conformity to expert knowledge, yet also an active engagement in such processes of subjection. In this way, the knowing, speaking subject becomes the object of their own subjection through a process of reification of expert knowledges. This act of engagement leads to subjugation of the subject, but also effectively excludes those others who are incompetent in interpreting their responses to existing dominant discourses.

CONCLUSION

Social identity is consequential, being reciprocally entailed with allocation of resources and exclusion. Further, "It is in the consistency over time and across organisations of (stereo)typifications of identification and patterns of allocation that a social structure-an organised pattern of relationships between stable collective

identities and allocation – can be discerned" (Jenkins, 1996, p.169). This consequentiality is key in understanding identity, over and beyond internalisation. The imposition of social identity does not require acceptance, or even awareness by the recipient. Crucially however, that allocated category will generate experiences for the individual or group so labelled. Society imposes that category as a social reality. In what ever way the subject is constructed, the consequences are real, in terms of discrimination and reward.

Organisational membership is also a resource when a job interview takes place. Both successful candidate and interviewer can be viewed a co-members of a professional team, but this shared status is only nominal when job distinction gives higher virtual status to the interviewer. The non-member in turn is stigmatised, forced in to work of lower status. Thus organisations not only produce services or products, they produce identities (Foucault, Jenkins, pp.155-156).

The apparent rationality of nursing organisations as bureaucracies, and their consequential formal demands on actors in terms of social and cognitive competences is undermined by resistance, incompetence and what Jenkins terms the 'irrational' dimensions of social life, including symbolism, myth, notions of fate or luck, sexuality, religious or other ideologies, kinship and ethnic attachments and emotions, Jenkins(1996, p.173). Supervision, as a tool of self governance, was unpacked as a power relationship, the analysis showed how such dimensions might easily shape moral and material careers. So, organisations are more than rational bureaucratic devices, history and ritual help shape social identities, through maintaining boundaries and recruiting and disciplining its membership.

Irish nurses in the British health service, and elsewhere, continue to work within an occupation that is hierarchically divided on gender and class lines; their respective positions historically separated on the rungs of an occupational ladder derived from the domestic ideology of Victorian professionalisation (Cohen, 1998, p.139). It therefore feasible, and indeed necessary, to explore the realities of inequality and stratification for this category of workers in the modern National Health Service in comparison to other minority ethnic groups. This also means examining their place, within this nominal category of Irish, and distinguishing the aforesaid consequences, or 'virtualities', of that category of whiteness.[4] White identity, as a social category, requires interrogation from a more comprehensive, or nuanced

analysis of differences within the lives of those living under that tag and the possibilities inherent for Subaltern identity. So gender, nationality, ethnicity and occupational class will be operational concepts here. The following chapter will address the methodology and methods employed for the questions raised by this thesis.

CHAPTER FOUR
METHODOLOGY AND METHODS

INTRODUCTION

The research undertaken for this thesis followed an empirical design, or what Creswell (1995, p.177) has termed a 'dominant-less dominant' study. The major component comprised an exploration by secondary analysis of the available quantitative data.

Triangulation at this methodological level offers completeness, abductive inspiration and confirmation (Bryman, 1988, p.131; Risjord, Moloney & Dunbar, 2006, p.341). The logic of triangulation, therefore, corroborates findings, so quantitative mapping allows selection of comparative groups for in-depth qualitative interviewing, during which past events, such as job histories can be explored. Nevertheless, the cardinal findings were assumed to be extracted from the quantitative data.

Triangulation methods have been strongly advocated as a way of doing social research (Bryman, 2003; Denzin, 1970; Gilbert, 1993). Triangulation broadly refers to looking at the research question from several viewpoints and methodologically accommodates empirical positions with regard to measurement, meaning and exploration. In its best known form, data triangulation, various combinations of quantitative data collection are combined to explore the research question, following Denzin (1970).

Bryman *et al.* (2003) claim convergent validity from such multi-method approaches and this has been my intention, so that doing triangulation becomes a series of steps and these steps are integrated with the researcher's changing conceptual map of the terrain.

Triangulation does not just validate or strengthen data sets. It also offers ways to enrich data analysis methodologies. In other words the map *changes* rather than the map getting *more perfect* within a single, narrow perspective. Triangulation is not

primarily about accurate or unbiased measurement. It is also about learning (Olsen, 2004, p.136).

Olsen argues that triangulation should not be considered a division of labour among social scientists; the researcher must be epistemologically pluralist: "In other words the point is not just to have multiple data types, but rather to have multiple types of in-depth experience. One result of this argument is that instead of triangulation acting as an empiricist re-confirming practice, it becomes instead a dialectical practice" (Olsen, 2002, p.2).

Contradictory findings generated from the analysis of quantitative data have also been explored through qualitative methods, for example the views of white police recruits on halting immigration and policing a multiracial society (Fielding & Fielding, 1986, pp.146-147). The quantitative data examined here permits the exploitation of standardised data collection and analysis techniques, through secondary analysis, from differing perspectives with regard to sample frames and claims to representation. This is especially pertinent to the problematic of social identity; particularly contested concepts around ethnicity.

Methodology of secondary analysis

Secondary analysis, that is the analysis of existing data, as opposed to data collected specifically for the study at hand, is an important aspect of contemporary social research. Historically, within the social sciences, seminal studies have drawn upon secondary analyses, notably the classic works of Durkheim and Booth (Hakim, 1982, p.3). Secondary analysis essentially draws on survey techniques to illuminate the past, but unlike experiment it engages empirically with the world as it is (Byrne, 2002, p.62).

While secondary analysis seeks to generate additional or indeed different conclusions to the original researchers, many data sets are now constructed with a view to further analysis, for example, population censuses, continuous multi-purpose surveys and, to varying degrees, ad hoc studies. Aside from well recognised savings in time and funding, this method can reduce the reporting burden on the target population (Sayer, 2000, p.99). Nurses working in the UK are increasingly recruited or sampled to a variety of projects attempting to understand their roles, performance and motivation. This burden has increased with the growth

of auditing of educational and clinical activities, for which survey techniques are heavily employed. Over sampling the same population is known to reduce response rates.

I was freed from the extensive negotiations now increasingly associated with gaining access to participants distributed across many different sites of employment. Such obstacles within the health service have always included gatekeepers, in the form of line managers concerned with risk management, restricting access to staff and patients. There are now additional potential hurdles posed by reformed NHS ethics committees and health service research governance personnel (Samanata, *et al.*, 2005). Researchers have *inter alia* reported hostility towards and ignorance of specific research methods, particularly qualitative methods and inconsistencies between committees dealing with multi-site applications (Hannigan *et al.*, 2003, p.687). NHS Local Research Ethics Committees (LRECs) have been also accused of excessively policing social researchers (Dingwall, 2006).

The most substantial element of the data reviewed within the thesis can be characterised as *micro data,* which is data based on the responses of individual cases (Byrne, 2002, 57). However, some aggregate data, which is summarised material from published statistics or tables, supplements this exploration. Within Hakim's typology of government and non- government sources (Hakim, 1982, p.6), this thesis has been able to explore data from two key sources:

- The UKCC Register for Nursing, Midwifery and Health Visiting, which comprise an anonymised dataset extracted from administrative records.

- The Department of Health funded Policy Studies Institute (PSI) study conducted by Beishon *et al.* (1995), an ad hoc survey that examined data collected from an ethic minority group previously unreported on this scale.

Secondary analysis employing survey techniques has well recognised limitations (De Vaus, 2002, p.99), a topic comprehensively reviewed by Dale *et al.* (1988, p.47). The level of analysis is constrained by the design intentions of the original data collectors. Yet critically understanding the conceptual and operational issues can also open up new ways of exploring the data in understanding, for example, occupational distribution. In this case, by looking beyond the conventional view of

Beishon towards ethnicity as a category informed by questions race, of skin colour, I explored the data from a different perspective, and indeed a differing conception of ethnicity and race (Dale *et al.* 1988, p.54). As a result, I discovered the existence of a substantial unpublished subset of Irish born nurses within the Beishon dataset through checking country of birth frequency counts. This in turn led to an eventually successful request to the UKCC for access to their registration files.

This process should not, therefore, be dismissed as data mining (Byrne, 2003), or data dredging (Dale *et al.* p.29). At the same time serendipity played a part, for example in mapping out settlement patterns in across the UK for Catholic and Protestant nurses. The postcode data here were originally requested as a variable to make sense of minority ethnic settlement across the UK.

Not all of the data available to me were readily comparable across data sets, particularly given the rather more limited aims of UKCC Council (See Chapter Six for further discussion of UKCC policy on ethnic monitoring). Some cross-sectional features of the Beishon and UKCC datasets did however permit a more limited exploration of potential time series data, for example, the number of Irish born nurse registrants annually entering the register. Cross tabulation of Beishon data also gave some indication of how many Irish nurses enter NHS employment in England annually.

Scope for additional in-depth analysis varied depending on the nature and quality of the original data. For example, the UKCC dataset contained far fewer variables in comparison to the Beishon study, which was designed to produce richer and more varied data on career development. The latter also provided more sensitive information on questions of racial discrimination, albeit only in relation to black and Asian nurses. The accumulation of data on gender, ethnicity and religious affiliation within the above datasets means that, in design terms, they are driven to greater or lesser degrees by policies of public disclosure, in that they claim to offer greater understanding of potential discrimination within these categories (Pawson, 2004). I recognised the potential for attending to important but previously neglected issues in analysing available data, which would maximise the potential of the primary data sources.

Dale *et al.* (1988, p.48) warned against complacency concerning the quality of governmental surveys.[3] I was, to some extent, dependent on the integrity of the organisations producing the original data. However, it was possible to undertake some verification procedures. First, the overall quality of the original data needed to be assessed. For example, data entry problems with the UKCC data set required me to undertake data cleaning, in particular in relation to the postcode entries. Second, a check for the extent of missing data relevant to the secondary analysis but not relevant to the original study was undertaken. For example, it was important to check the extent of non-responses to questions about ethnic identity and nationality, as high levels of non-response to such questions might have had an impact on the validity of the findings of the current study. These variables are discussed in further detail in within the analytic chapters on Beishon and the UKCC data sets.

Clearly, as a secondary analyst I was not part of the original research team and, therefore, understanding how the data was originally collected was a major consideration. With regard to the Beishon study, I discussed the feasibility of undertaking a replication study with the then Head of Research at PSI, Richard Berthoud. He was very supportive and offered an anonymised copy of the original Beishon data set. PSI also agreed to supply a complete dataset from the original study, to allow comparisons with the replication study and to permit further secondary analysis. This was a generous act not always repeated by other research organisations or professional bodies. As Homan (1991, p.90) observes, data should be made available to fellow professionals as a principle of intellectual integrity, this not only allows for re-interpretation of findings, it is making a commitment to the conduct of an open debate, which of itself is healthy and desirable for the intellectual community concerned and in the wider public interest.

My replication project involved four local NHS trusts within Durham and Teesside. This funded evaluation exercise familiarised me with fieldwork issues facing the

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[3] To the credit of Bertoud and his colleagues, 'Irish born' data was not aggregated with British White cases within the primary dataset, thus enabling this secondary analysis to proceed. The foresight shown here by the PSI researchers was part of an admirable commitment to sharing data with a broader research community.

original research team, primarily negotiating access to research sites, establishing an accurate sample frame and encouraging an adequate response rate for the distribution of questionnaires. The replication study also involved me gathering primary qualitative data, in the form of some fifty interviews on white British, Irish and other minority ethnic groups working as nurses and midwives in Teesside and Durham. Additional interviews were conducted in London, Ireland, the United Arab Emirates and Australia.

The secondary analysis initially involved a descriptive analysis of the existing data to establish whether sufficient cases were present for a white Irish category. Secondary analysis requires access to original datasets where possible, in order to re-examine the data with the new focus in mind (Dale *et al.*, 1988). I wished to ascertain whether there were sufficient cases within the variables available to permit multivariate analysis. The replication project was, therefore, an invaluable field exercise in enabling me to understand how the original research team implemented their study design. I was also able to interview and consult with two of the primary researchers in order to assess the quality of the original work and to contextualise the material. Sharon Beishon, as the lead researcher for the original PSI study was especially accommodating in meeting with me to discuss the background issues underpinning the design and implementation of the survey.

Since I was operating in an independent capacity, there was little formal constraint on publication of findings, or indeed a formal contractual agreement, other than acknowledgement of the support provided by the primary researchers and data archive managers. This is highly unusual, especially with regard to membership information data obtained from professional organisations such as the UKCC, which jealously guard such material. There were, however, extensive discussions around preserving anonymity, in particular with regard to postcode data.

As to the reporting of original and secondary data analyses, it is important that the study design, methods and issues involved are fully described, given the large scale and complexity of the secondary analyses undertaken here, particularly the employment of multivariate procedures. The chapters addressing each of the secondary analyses, therefore, include detailed descriptions of the original Beishon study and the data collection procedures employed by PSI and the UKCC, together with a description of the processes involved in categorising and summarising the

data for the secondary analysis, as well as an account of how methodological and ethical considerations were addressed.

Informed consent, following faculty procedures can be sought for interviews, this was clearly not possible for the quantitative secondary analyses. This does pose questions about how was consent obtained from subjects contributing personal data to the original study. Where sensitive data is involved, informed consent cannot be presumed. Given that it is usually not feasible to seek additional consent, a professional judgement has been made about whether re-use of the data could violate the contract made between subjects and the primary researchers.

Growing interest in re-using data make it imperative that researchers in general now consider obtaining consent which covers the possibility of secondary analysis as well as the research in hand; this is consistent with professional guidelines on ethical practice (British Sociological Association, 1996). Anonymised datasets are of particular value here.

The Beishon survey and the UKCC register provide unique details on the careers of Irish nurses working within the United Kingdom, for whom little published material otherwise exists, the two analyses provide descriptive evidence for the employment characteristics of this group.

With regard to sample frames, the UKCC dataset can be considered a complete population census that is an attempt to enumerate *all* qualified nurses practicing within the UK, unlike the Beishon study, which nevertheless obtained 14,330 cases, a response rate of sixty two *per cent* from a sampling fraction of one in three, based on a target population estimate of over 75,000 nurses on permanent contracts working in the English NHS.

Descriptive data

Sampling is not a particularly relevant issue with regard to such large data sets, which clearly facilitate summarising and exploration of data for potential patterns (Byrne, 2002, p.97). Secondary analysis of the Beishon and UKCC datasets necessarily throws up a great deal of baseline data in the form of descriptive statistics.

Taken together these datasets, or archive data, provide a substantial amount of demographic detail on Irish nurses working in UK. Descriptive statistics are given here in the form of frequency counts, percentages, measures of central tendency, particularly means, and variability, or spread of values of variables, primarily ranges and standard deviations. Cross tabulation and tables were also extensively employed. Correlations were also sought.

Modelling causality

The largely non parametric levels of measurement for variables within the two major data sets analysed here, namely Beishon and UKCC, allows for the employment of logistic regression, the cardinal inferential procedure applied to the quantitative data within this thesis. This multivariate method of analysis permits the description of relationships between categorical variables; that is variables which are nominal, or ordinal but discrete.

Logistic regression also allows testing for predictive models and is, therefore, particularly pertinent as an inferential statistical procedure working with two or more independent variables. This permits a predictive model with regard to career progression for Irish nurses. The theoretical assumptions of social category were critically considered in detail within Chapter Three. Operational issues around categorisation are further addressed within the following two chapters analysing the above data sets.

A major aspect of this design rests on the assumption that membership of the categories of the Y variable is independent; therefore, logistic regression is inappropriate for paired or repeated measure designs (De Vaus, 2002, p.387). Another working assumption here lies in the relatively low numbers of categories to be considered; otherwise the data could be treated as interval. Since non-parametric levels of data are being analysed there are no assumptions required with linearity and normality, whilst dichotomous variables are permitted.

Dependent variables are assumed to be single in number and discrete, with two or more categories, indeed logistic regression more readily copes with two or more categories in comparison to linear regression, a companion test for parametric data. Finally, the relationship between X and Y is assumed to be non-linear.

The construction of a multivariate contingency table precedes investigation of the relationship between the variables. All the tabulated variables are treated as independent variables, while the dependent variables arise as the number of cases within each cell of the contingency table. So the emerging linear model allows cell frequencies to be predicted, thus the better the model, the closer the predicted, or expected frequency will be to the observed frequency. The natural logs of the cell frequencies are utilised in building the linear model, hence its name (Calder & Sapsford, 2006, p.237). Logistic regression requires larger samples than those used for linear regression if hypothesis testing is being undertaken, (De Vaus, 2002, p.386). Aldrich and Nelson (1984) recommend at least 50 cases per predictor variable.

The data may be presented as raw figures, percentages, proportions, or odds ratios. The power of such techniques permits the construction of a model which specifies which effects should be significant (Sapsford, 2007, p.206). It is not only worth knowing how well the model fits the model, but how individual predictors, such as ethnicity, contribute to the overall the fit. The Wald statistic performs a similar function to the *t*-statistic in linear regression, the value of the regression coefficient (*b*) being divided its associated standard error (SE).

The Wald statistic, therefore, indicates if the *b* coefficient is significantly different for a predictor from zero. If this is the case then it can be assumed that that predictor has made a significant contribution to the prediction of the outcome (*Y*) (Field, 2005, p. 224). Caution needs to be exercised with the application of this formula, given the propensity of a large regression coefficient to inflate the standard error, which in turn results in an underestimated Wald statistic (Menard, 2002). Such inflation of SE would lead to a Type II error, a false negative result arising from the probability of rejecting a predictor being significant, when the predictor actually has made a statistically significant contribution to the model.

A more important reported value from employing logistic regression is the value of exp *b (EXP(B)* as reported in SPSS output tables, exp *b* is similar to the *b*-coefficient in logistic regression, but does not require a logarithmic transformation. When the predictor variable is categorical exp *b* becomes easier to explain. Logistic regression here employs odds that are the probability of an event occurring being divided by the probability of it not occurring. To calculate the change in odds resulting from a

unit change in the predictor, odds for the event occurring and odds for the event not occurring must be calculated. Finally the proportionate change in those two odds must be calculated.

As with multiple regression there is more than one method option. Forced entry in multiple regression is replicated by the 'enter' method in logistic regression (Field, 2005, p.224-227). Menard (p.63) notes the stepwise method has value in both prediction and exploration capabilities. A more detailed discussion and justification of the selected method using the entry method is offered in the following chapter considering the secondary analysis of the Beishon data set.

Modelling uncertainty

But statistical modelling within the social sciences is problematic in establishing causality (Cox, 1992). This is simply that with observational data, as opposed to experimental data, the potential number of models consistent with the data will be large, especially whence non-linear data, such as the square of age, or the log of income is included (Elliot, 2005, pp.110-111). Any model must, therefore, be putative in face of the possibility of other potential rivals.

Discussion of methodology and results of the secondary analysis were subsequently presented as conference papers at the BSA Medical Sociology conference in 1998 and two international nursing conferences in 2005.

In conclusion I have, therefore, sought to employ a "combination of methods" within quantitative methods, to move towards a realistic account and explanation of the social phenomena surrounding Irish nursing careers in the NHS. I would now reconsider the methodological approach to this data, particularly the Beishon data, given a recent introduction to developments around Qualitative Comparative Analysis (QCA). QCA allows for the possibility of exploring for multiple 'prime implicants'.

As Byrne observes the most parsimonious representation of cause may involve more than one. The procedure, therefore, offers opportunities for understanding how "a particular outcome might result from different combinations of conditions and that single factors might combine with different other factors to produce different outcomes.

In other words, by recognising interaction the procedure recognises contingency and complexity" (Byrne, 2002, p.155). Time constraints prevent further analysis at this point; however, it is my intention to employ this procedure at a later date in post-doctoral studies on questions around Irish identity and experience.

CHAPTER FIVE

IRISH NURSING CAREERS: MAKING SENSE OF THE BEISHON EVIDENCE

INTRODUCTION

This chapter will explore career progression and access to clinical specialities for Irish nurses in the National Health Service, through secondary analysis of a substantial and unique dataset drawn from a cross-sectional survey conducted by the Policy Studies Institute (PSI). The findings will be contrasted with the experiences of other minority ethnic groups reported by Beishon *et al*. (1995).

Nursing in a MultiEthnic NHS was published in 1995 by the PSI as a consequence of a project commissioned by the Department of Health between 1992 and 1994. The only large scale study of its kind to date, its findings make a significant contribution to a growing critique of racial discrimination, for both health care workers and those receiving and affected by their services. The report offers data suggesting that ethnic minorities appear over-represented in nursing. Its detailed analysis of equal opportunity issues within NHS nursing showed a complex picture, in terms of over- and under- representation at different steps of the career ladder within different specialities. This project formed part of a wider PSI enquiry into equal opportunities in British society.

The Beishon study merits further analytical attention for a number of reasons, not least because its methodological stance implies an essentialist, binary conception of racism derived from colour. The categories, as utilised by Beishon, raise further questions about the meanings of ethnic identity, and which particular discourse appears to have primacy in theoretical analysis, policy formation and implementation. Aside from the equal opportunities agenda of PSI, it would also be worth identifying how any 'independent' research is affected by category constructs and survey methods developed by Government agencies, notably through the fieldwork of the Office for National Statistics, and its predecessors. Ethnic 'groups' may be convenient catchall categories for quantitative data collection, as well as theoretically driven constructs.

These findings will be discussed in the light of a secondary analysis by the author focusing on 'Irishness', based on birth in Ireland. The essentialist limitations of this latter category will also be taken into account.

An outline of the Beishon study, its aims, methods and findings

The Beishon research design was intended to provide a comprehensive analysis of the training opportunities, appraisal procedures and general experiences of ethnic minority nurses and midwives. Such experiences were interpreted in the light of NHS reorganisation and the general career development of nurses and midwives generally. The study claims to cover the extent to which employers have clearly defined equal opportunities criteria, and the extent to which such policies work in the environment of the internal market.

A number of key research questions were posited by the researchers. Labour force data suggested relatively high, ethnic minority representation in nursing. The researchers wished to explore claims that this was being mirrored by under-representation in higher, clinical grades. Other key areas for investigation included the allegation that occupational segregation might be operating, in that ethnic minority nurses were thought to be particularly concentrated in particular 'Cinderella' specialities, such as mental illness, learning disabilities and elderly care. These specialities traditionally had poorer status within the profession and were thought likely to be factors in strategically limiting access to promotion and further career development for minority ethnic nurses. The researchers also wished to confirm whether black and Asian nurses were, as previously claimed, concentrated disproportionately in enrolled nurse posts, which were effectively dead-end appointments, only registered nurses could apply for promotion to higher clinical grades (Akinsanya, 1988). Finally, the researchers examined whether appraisal and promotional procedures showed signs of institutional discrimination against ethnic minority staff.

The methods of enquiry were twofold. First, a large-scale, postal questionnaire was aimed at nursing staff working for 123 NHS employers; second, six NHS Trusts were selected for more detailed case studies. This involved 156 interviews with nursing staff, nurse managers and personnel representatives. Questions for nurses were developed from seven broad themes around the topic of equal opportunities.

The managers were questioned more prescriptively, following a topic guide listing 19 primary questions, each of which was accompanied by optional questions. Beishon termed these as 'informal', depth interviews, lasting between 40 and 60 minutes, though the interviews were highly structured given the policy questions being posed.

There is insufficient space to explore all of the key findings here; nevertheless, the author will draw out some conclusions from a secondary analysis of the survey data (see Beishon *et al.* (1995, pp.19-32) for a detailed description of gaining access, and sampling issues, including stratification). Despite the apparent 'belt and braces' approach to Beishon's survey design, the informing theoretical framework and subsequent analysis were conventionally restricted to discrimination on the basis of colour. Whether this was the perspective of the researchers or the research sponsors is unknown, yet its effect is to exclude other potential categories for examination. Specifically, the experience of Irish nurses is only cursorily alluded to in Beishon's discussion of the interview data. Irishness or related self-concepts are otherwise lost in the all-encompassing category of 'whiteness'. Mac an Ghaill (1999, p.65) has argued that British theorists have too readily accepted American race relations as an appropriate model for the politics and social relations of the British nation-state. What is ignored, or underplayed, are the peculiarities of a society with a specific class formation and reproduction, which has developed in the context of a wider history of European colonialism and imperialism.

Recycling other constructs - Government surveys

The possibility of recovering data on this subject has not been totally lost when consideration is given to the methodology underpinning the postal questionnaire. Here, categorisation of ethnic identity was addressed beyond the constructs derived from skin colour, expressly through country of birth and ethnic self-identity. Beishon had opted for the categories employed for the 1991 Census, which was beginning to extend, if rather awkwardly, the potential range of definitions reflecting different conceptions of ethnic identity (Aspinall, 1997). This, then, potentially complicated Beishon's attempt to operationalise a satisfactory category based on race.

Aside from the difficulties in conceptualising ethnic identity, Beishon faced further problems familiar to any researchers attempting to gather empirical data on ethnic relations in Britain. The development of ethnicity statistics has traditionally depended on demographic information derived from the Decennial Census. Until 1971, the only question relevant to ethnicity was nationality, when the 1971 Census additionally asked for country of birth and mother and father's country of birth.

While this substantially identified post-war migrants, their descendants could only identify themselves as 'British' (though this did incidentally allow subsequent analysis of an Irish second generation (Walter *et al.* (2005)). The need for a question on ethnicity was a major challenge to a methodology concerned with designing and measuring objective questions in search of social facts (Leech, 1989). This was and remains a contentious issue between those policy makers demanding collection of data and the concerns of potential respondents. Indeed, the 1981 Census, despite pilot projects, opted only to ask a question on birthplace (Daykin, 1986).

Demographic researchers appeared to have two options: extend the 1971 approach by asking the country of birth of parents/grandparents/great-grandparents; or abandon a direct focus on migration and construct an acceptable ethnic taxonomy from which individuals could indicate their preferred identity. Neither option was regarded as satisfactory; arbitrary choices were still required for the appropriate demarcation of either geographic areas or ethnic categories. Country of birth appeared a simpler descriptor than ethnicity. Respondent bias was certainly not allowed, yet value judgements were required about geographic aggregation and allocation when parents' places of birth were not congruent. Acknowledgement of ethnicity, rather than migration, recognised not only the existence of structural social forces leading to the reproduction of social differences beyond the migrant generation to its indigenous offspring, but also challenged potentially racist constructions of an 'alien threat' (Ahmad & Sheldon, 1992; Nanton, 1992; Ohri, 1988).

Ultimately no 'gold standard' existed by which their validity could be measured. Nevertheless, self-reporting ethnicity from a pre-defined list appeared to be the predominant method adopted in official British statistics from 1979 onwards (Smaje, 1995, p.20). The *Labour Force Survey*, the *National Dwelling and Household Survey* and the *General Household Survey* now included ethnic group questions (see Table 5.1).

Table 5.1: **Ethnic origin in the Labour Force Survey <u>and</u> General Household Survey**

To which of the groups listed do you consider you belong?
White
West Indian or Guyanese
Indian
Pakistani
Bangladeshi
Chinese
African
Arab

However, of these surveys the 1991 Census was claimed by Haskey (1996) to be the most accurate and complete dataset available for the study of the minority ethnic populations in Britain (Table 5.2).

Table 5.2: **1991 Census question category responses on 'ethnic group'**

Ethnic group - please tick the appropriate box.
White
Black - Caribbean
Black - African
Black - Other
Indian

Ethnic group - please tick the appropriate box.
Pakistani
Bangladeshi
Chinese
Any other Ethnic Group (please describe)
If the person is descended from more than one ethnic or racial group, tick the group to which the person considers he/she belongs, or tick the 'Any other ethnic group' box and describe the person's ancestry in the space provided.

The Government Statistical Service attempted to harmonise questions posed in relation to social surveys (ONS, 1995). Further work in preparation for the 2001 Census addressed more sensitively operationalised concepts of ethnicity, whilst retaining what they called 'harmonised' inputs and outputs. The 1991 Census and some other surveys asked further questions of those who described themselves as of 'mixed', 'other' or 'black – other' categories. This information was subsequently used to reallocate respondents to named categories of single ethnic origin (Teague, 1993).

In recognition of this conflation of categories, respondents were now to be allowed to assign themselves to a ninth category "none of these", in place of "any other ethnic group", but without giving any further description. This had been justified on the grounds that such detail was unnecessary, because of the small sub-samples likely to be generated, or because for specific surveys such hybrid categories would not a topic of central interest. The issue remained so contentious that the Government Statistical Service was forced to concede the possibility of more amendments, depending on the outcome of further research before the 2001 Census. Both the harmonised question and the output categories therefore remained under review (Roberts, 1996). Any analyses in the meantime would be obliged to speculate about the nature of an artifice called 'none of these'.

The United Kingdom Central Council for Nursing and Midwifery, in line with the Government policy of the time, attempted to survey all current registered nurses in the United Kingdom. Ethnic coding categories were extracted from the Office of National Statistics proposals for the 2001 Census (see Table 5.3). This initiative, however, was not conducted in the spirit of 'joined up' Government policy, individual NHS Trusts persisted in gathering employee and patient data utilising the 1991 Census categories offered in the NHS *Data Standards Manual* published in April, 1999 (NHS Information Authority, 1999).

Categorising Irish nurses

The creation of a more discrete category for Irish nurses was also problematic. Irish respondents could be identified by the place of birth question. But analysts of the 'Irish- born' population faced two specific problems with regard to the 1991 Census. First, there was a serious issue of under-enumeration. Though no specific correction figures have been calculated for Irish non-respondents, conclusions may be drawn from other estimates. Young white men, between the ages of 20and 29, were under-enumerated by 10 *per cent*, with an even higher proportion for black Caribbeans, at 14 *per cent* within the age band 20 to 24, and 16 *per cent* for those aged between 25 and 29. The figures were even higher for those living in the inner cities. In Inner London, for example, 22 *per cent* were thought to be missing (OPCS, 1994). Since London has been the prime destination for young Irish men since the 1980s, this serious under-enumeration should be borne in mind. Although the correction factor calculated for young women was much lower (OPCS, 1994), Irish women are likely to conform to the behaviours of their male compatriots, and therefore suffer a similar under-enumeration (Walter, 1989). Second, despite representations from Irish interest groups, the category 'Irish' was not included in the new ethnic question for 1991. The OPCS did, however, compromise by making use of an additional column, 'born in Ireland' in a number of the subsequently published tables.

Table 5.3: **Source: UKCC letter to applicants to the professional register. N.B. These data were being collated from 1999 onwards to monitor UKCC Equal Opportunities Policy, a process supported by CRE.**

UKCC Ethnic Monitoring Form (Extract)

What is your ethnic group?

Choose <u>one</u> section from (a) to (e) then tick the appropriate box to indicate your cultural background.

(a) White

British

Irish

Any other White background

(b) Mixed

White and Black Caribbean

White and Black African

White and Asian

(c) Asian or Black British

Indian

Pakistani

Bangladeshi

Any other Asian background

UKCC Ethnic Monitoring Form (Extract)
(e) Chinese or other ethnic group
Chinese
Any other group

This, however, raised further problems when birthplace alone was utilised as a measure of representation. That black and Asian respondents were only being distinguished demographically as first wave immigrants had been an early criticism of the validity of birthplace as an ethnic identifier. This partly led to the inclusion of an ethnicity question for self-identification by themselves and succeeding generations.

Though a clear presumption was made about the primacy of colour in determining ethnicity, the 1991 Census invited all 'white' groups to tick the first category, 'white', subsequently overriding any second choice. Those that also attempted to write 'Irish' in the 'other white' category were disqualified from doing so, and allotted to the 'white' category (Haskey, 1996). In the Irish case, the inclusion of only one generation, by place of birth, in subsequent statistical analyses makes numerical comparisons misleading, given that black and Asian second and third generations are counted in.

Hence, Irish descendants are denied the opportunity to identify as anything but 'white', and not surprisingly perhaps there is no general study of the Irish in Britain which carries comprehensive detail on the second and third generations of Irish descent (Holmes, 1991, p.1; Walter, B. *et al.*, 2002). Again, Beishon respondents were implicitly directed in the same way, by the question order, only 15 respondents identifying their ethnic status as 'Irish'. Beishon largely ignored the place of birth question as an ethnic identifier for analysis.

As mentioned above, the recording of parents' birthplace in the 1971 Census did allow the possibility of tracing second generation Irish people through the OPCS Longitudinal Survey (LS), though the one *per cent* sample utilised by the LS limits subdivision of the data. Similar problems affected other large datasets, including

the Labour Force Survey and the General Household Survey, the latter only yielding 400 Irish-born individuals (Pearson *et al.,* 1991). A further problem, also acknowledged by Beishon, though only in relation to black and Asian groups, was the use of area sampling frames. These rapidly reduce the accuracy of statistics on spatially clustered populations such as the Irish in Britain. Such effects would produce under-representation, both of the total Irish population, and of the specific characteristics of those in larger areas of settlement such as London (Ratcliffe, 1996). Further problems with self-identity also arose with the amalgamation of data relating to people born in the Irish Republic and Northern Ireland. [4]

The Beishon nurses

How representative, then, were the respondents interviewed and surveyed by Beishon? Also, how representative are those respondents born in Ireland of post-war migrants coming to Britain? In the absence of accurate and consistent data relating to ethnic minorities employed by National Health Service employers, the researchers resorted to Census statistics delineating resident, ethnic minority populations within local authority boundaries (Beishon *et al.,* 1995, p.25). NHS employers falling within these areas were then subdivided according to their respective high, medium, or low ethnic minority concentrations determined by Beishon (Table 5.4). So, Beishon was able to over- sample those minority groups considered important to the purposes of the study, a common process in order to obtain enough responses from the target groups.

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[4] This is a bizarre aggregation in the face of the recent conflict. Aside from the political and cultural implications, it is worth noting that the socio-economic characteristics of the Northern Irish-born population are often intermediate between those of Great Britain and the Irish Republic. The consequence of adding them together would obscure important differences between the three populations (Walter, 1996). Furthermore, disparities between the two increasingly distinctive religious communities in Northern Ireland have resulted in a unique equal opportunities policy in the United Kingdom, namely one of positive discrimination, as a consequence of the enactment in 1989 of the US 'MacBride' Principles (Sheehan, 1995 p.74). Under American Congressional pressure, the British Government has effectively conceded that discrimination against Northern Irish Catholics has parallels with the experience of African Americans, after the failure of previous legislation modelled on a weakly-enforced equal opportunities agenda for the remainder of the United Kingdom.

Table5.4: **NHS Employers categorised by ethnic minority concentration. (Source: Beishon, 1995)**

Number of Employers*	Ethnic Minority Concentration
27	High
37	Medium
29	Low

* N=91 as two employers withdrew prior to survey distribution

The interview sample drew on data calculated from the 1988-1990 *Labour Force Survey* to respectively establish the appropriate ethnic minority population and ethnic minority nursing workforce sizes in each region. Black and Asian nurses were identified in the highest concentrations in four English regions: South East, West Midlands, North West, and the East Midlands.

While 54 *per cent* of the total black and Asian population were resident in the South East, Beishon found that over 60 *per cent* of all black and Asian nurses were working there. Concentrations were highest in the Greater London area, with 28 *per cent* of all nurses being of ethnic minority origin. To reflect both the distribution of the total ethnic minority population and the ethnic minority nursing population, three employers were selected from the South East, including Greater London, and one each from the remaining regions. The actual employer within each region was identified utilising a more detailed analysis of ethnic minority populations at Metropolitan County and District level (Haskey, 1991).

Deliberate over-sampling was used to obtain a statistically significant number of black and Asian respondents. According to Beishon 1,630 fell into this category, to avoid bias in the subsequent analysis different weights were accorded to the responses of nurses from different employer layers (see Beishon, 1995, p.28).

Though Beishon did not target Irish nurses, a substantial sub-set was subsequently identified by the author in a secondary analysis of the dataset (see Table 5.5). At a regional level the 'Irish born in Britain', according to the 1991 Census, have shown a change in settlement patterns compared to their 19th century predecessors in the

first great wave of migration to Britain. Traditional establishment in Scotland and the North West has given way in the post-war period to an increasingly clustered population in the South East, constituting 31 *per cent* of the whole Irish born population. A slight, though declining, over-representation is evident in the East Midlands, while the declining population in the North West almost proportionately equals that of the total population (Owen, 1995).

It is important to emphasise, with the exception of lower percentages in Yorkshire and Humberside, and higher percentages of Irish born in North West England, the Irish born in England show a similar pattern of settlement at the regional level to other ethnic minorities. This is especially true of those originating from Eire (Hickman & Walter, 1997, p.26). Mapping at the finer scale of districts also confirms the above regional patterns, with distinctive clusters of Eire-born people in Greater London, and the urban conurbations of Manchester, Birmingham and Luton (Owen, 1995).

Table 5.5: **Total number of respondents as categorised by Beishon et al. (1995) including an additional 'Born in Ireland/Eire' category identified by the author. (Source: Beishon, 1995)**.

Category of respondent	Asian respondents	Black respondents	Irish respondents (by place of birth)	All other White respondents
Total	603	892	629	11,107

The Irish sample obtained by Beishon, therefore, appears as reasonably representative as their black and Asian counterparts. The sampling procedure was acknowledged by Beishon to be not totally unsatisfactory. It certainly presumes that the local population coincides with that from which NHS employers draw their labour. How local is local? Higher concentrations of ethnic minority groups are to be found in inner city areas blighted by socio-economic decline (Fielding & Halford, 1993; Harridan, 1992). A growing body of research has pointed up their experience of poorer provision of housing and welfare services, alongside unequal access to the

job market (Wilpert, 1989; Brown, 2000, p.1048; Ramji, 2005, p.3). Teaching hospitals have historically been centred in such areas of social deprivation, though discriminatory employment practice in nursing and medicine is a recognised phenomenon of these institutions (Davies, 1995).

Furthermore, nursing, with its professional claims, carries social aspirations. Many nurses, though working in such local services, might well be commuting to work from more affluent areas (Cooke, 1989, Urry, 1990, p.189). A study by the Manufacturing, Science and Finance Union found that Department of Health statistics on non-medical, NHS staff for 1996 showed incomplete data collection processes and widespread failure to recruit from local, ethnic minority populations.

Nevertheless, a substantial number of black and Asian respondents were successfully trawled by Beishon and her colleagues. A number of explanations can be offered for this phenomenon. Beishon included unqualified staff in her definition of nursing, these grades are traditionally drawn from the local job market, and indeed the sample shows black over-representation amongst A and B grades. These were grades filled by nursing assistants, auxiliaries and other workers not possessing an enrolled or registered nursing qualification. Since Beishon also deliberately targeted employers within the larger urban conurbations, especially London, this over representation of black and Asian respondents appears hardly surprising (Atkins *et al*. 1996).

A secondary analysis by the author identified a further 614 nurses within the sample who declared themselves 'born in Ireland/Eire'. Comparatively fewer Irish nurses were working in this category, indicating that rather more opted, and were accepted, for training, though ENB data are not yet available to confirm this. However, Beishon did not survey staff employed on temporary contracts, or those working on a bank, or agency basis. These workers would have included no doubt sourjoners. Traditionally, many Australians and New Zealanders register for this purpose, as well as others seeking more flexible work arrangements. But those attempting to find permanent posts would also find themselves forced into this type of employment. Furthermore, temporary contracts are commonplace for newly-qualified staff, lasting between three and six months. Some staff can find themselves on such contracts for two years under current employment legislation. This allows considerable room for discriminatory practice.

Aside from the local labour supply, the National Health Service has always traditionally drawn on Britain's former colonies to fulfil its labour demands. Secondary analysis of question 80, cross-tabulated with the 'country of birth' question, shows a significant proportion of black and Asian Nurses to be first generation migrants. Consequentially, this group is a demographically ageing one, compared to their white colleagues. The reliability of these data is confirmed by findings from successive Department of Health reports and UKCC registration data (Beishon, 1995; Carpenter, 1997).

These respondents appear to be part of that post-war generation seeking asylum, or work, such processes being dictated by the socio-economic and political conditions of former colonies and the labour demands of their former imperial master. The average age of the Irish sub-sample falls between their younger, white colleagues, and that of the black and Asian groups.

This confirms other data indicating that Irish women, not men, are still being recruited in significant numbers to train. Comparative analysis of UKCC data for that period suggests that less than one-tenth of those were already qualified, having previously trained in Ireland. Yet even this last group, according to UKCC analyses, significantly outnumber qualified nurses seeking registration to work from the Caribbean and the 'New Commonwealth' (UKCC, 1996).

Buchan (1995, p.29) also notes that the number of nurses from these countries registering to work in this country with the UKCC had fallen significantly. Irish nurses trained in Eire also dominate the inflow of qualified nurses seeking work from within the European Community (see Table 5.6).

Table5.6: **Number of persons verified and documents issued by the Council under European Community Directives for General Nursing and Midwifery 1995 - 1996 (Source: Statistical Analysis of the Council Professional Register, 1 April to 31 March 1996, UKKC, December 1996)**

Member state	Persons	General nurses	Adult nurses	Midwives	Total
Austria	4	4	0	0	4
Belgium	2	2	0	0	2
Denmark	6	5	1	1	7
Finland	0	0	0	0	0
France	22	20	1	5	26
Germany	9	8	0	2	10
Greece	3	2	0	1	3
Iceland	0	0	0	0	0
Ireland	600	449	107	79	635
Italy	5	5	0	0	0
Luxembourg	0	0	0	0	0
Netherlands	20	15	0	8	8
Norway	4	4	0	0	0
Portugal	8	8	0	0	0
Spain	25	23	0	4	4

Member state	Persons	General nurses	Adult nurses	Midwives	Total
Sweden	3	3	0	0	0
Total	711	548	109	100	699

A striking feature of recent Irish migration has been its youth and its focus on South East England. Irish women were even more strongly attracted to this region than men. In 1991, 66.1 *per cent* of all arrivals were located there (ONS Census 1991, Ethnic Group and Country of Birth Tables). Irish-born women outnumber men in Greater London, 115,865 to 98,362 respectively. This is again reflected in the secondary analysis of the Beishon data, where a substantial sub-group was aged below 30 years. They were also overwhelmingly female, across all grades and specialities. In contrast, black and Asian nurses were significantly older, their average age being around 45 years, with a greater proportion of men. Other white nurses were, on average, 40 years old and female in 90 *per cent* of cases responding.

Given that the NHS could be expected to be a significant local employer for black communities for the reasons outlined above, why were younger black people not entering nursing? Analyses of NHS employment statistics for 1994 and 1995 showed a similar pattern emerging not only in nursing, but also in medicine and the professions allied to medicine (Carpenter, 1997).

Black workers, unionists and anti-racist groups allege racism at various levels. The Runnymede Trust has drawn particular attention to poor representation by black and ethnic minorities amongst quangos and public bodies administering public expenditure and services. Health Authorities and NHS Trusts form a significant proportion of over 1,300 non-departmental public bodies (Amin & Richardson, 1994, p.22). Of the 534 chairs of Health Authorities and Trusts, only four were of ethnic minority background in 1993 (NAHA/King's Fund Centre, 1993).

The situation of Irish nurses, according to the Beishon data is somewhat different. In the absence of much historical data, the Beishon study suggests a continuing flow of young Irish people into nursing in this country, whether as trainees or qualified nurses. Little is know of this latter group.

Applications for registration to practice within the UK gives a clue to those interested in working in the United Kingdom, but these data do not necessarily mean they pursued or successfully obtained work, either in the NHS, or with other nurse employers. Irish nurses registering with the UKCC to practice accounted for 67 *per cent* of all European State entrants via European Union Directives in 1993-4. UKCC records show this figure to remain fairly consistent over this period (UKCC, 1997).

These data also suggested that Britain's former colonies continued to remain a more significant labour resource for qualified nurses than Europe, despite freedom of movement within the European Union, EU entrants only represented under one-fifth of all nurses from abroad.

However, former 'white' Dominion nurses predominated amongst those Commonwealth nurses seeking to practice in the United Kingdom. In 1995-6 for example, nearly 2,000 Australians and New Zealanders sought first time registration to practice, a valid decision for two years. The Beishon sample included only a small portion of such applicants, possibly because many of them were only seeking temporary work; Beishon's sample frame included only those working under a permanent contract.

It is worth noting that UKCC annual statistical analyses did not include data on the numbers of unsuccessful applications by country. The UKCC 1996 Report only supplied data on successful applicants granted a 'decision' to practice for two years, in the first instance, before reapplication (see Table 5.7 below). Aside from a stricter enforcement of immigration restrictions from Government, overseas applicants might have faced barriers from within the UKCC, but there is no way of knowing this since the criteria for giving a 'decision' are not in the public domain.

Table 5.7: **Number of decisions given to overseas applicants by their country of origin. (Source: UKCC, 1996)**

Country	Decisions	Country	Decisions	Country	Decisions
Algeria	1	Iran	23	Portugal	1
Argentina	1	Iraq	1	Russia	3

Country	Decisions	Country	Decisions	Country	Decisions
Australia	1,360	Ireland	146	Saudi Arabia	16
Bangladesh	5	Israel	13	Seychelles	2
Belgium	1	Japan	10	Sierra Leone	38
Benin	1	Lithuania	1	Singapore	13
Brazil	3	Malawi	7	Sweden	12
Brunei	15	Malaysia	12	Switzerland	21
Cameroon	2	Malta	17	Taiwan	2
Canada	95	Nepal	6	Tanzania	17
Colombia	1	Netherlands	18	Thailand	4
Croatia	4	New Zealand	580	Turkey	14
Cyprus	3	Nigeria	584	Uganda	18
Czechoslovakia	6	Norway	15	USA	131
Egypt	2	Oman	18	West Indies	52
Ethiopia	16	Pacific Islands	1	Jordan	4
Finland	22	Somalia	6	Kenya	24

Country	Decisions	Country	Decisions	Country	Decisions
France	2	South Africa	266	Korea	4
Hong Kong	80	Sudan	6	Yugoslavia	14
Hungary	3	Pakistan	49	Zaire	3
Iceland	1	Philippines	108	Zambia	41
India	57	Poland	30	Zimbabwe	37
Total	4,218				

Question 80 asked respondents, "*[i]f you were not born in the United Kingdom*, how old were you when you moved to Britain?" [italics added by author] This qualifying question, through cross-tabulation of the sub-set identifying those as 'born in Ireland', permitted identification of Irish adults seeking work, as opposed to those brought over as children. There are some problems with validity of the data here, given an 'eyeball' analysis of the raw figures entered. It appears possible that some respondents supplied the year of their entry to the United Kingdom, rather than their chronological age. Several respondents otherwise would have been working into their 70s, clearly beyond the official age of retirement in the NHS. The Beishon Irish-born nurses also tended to fall into two distinctive age groups, reflecting the second and third waves of migrants discussed above. Nevertheless, the data do show the majority, over four-fifths, commenced pre-registration training in Britain.

Iganski *et al.* (1998) have subsequently analysed anonymised data on 54,194 applicants to pre-registration nurse and midwifery training between 1993 and 1996. Their findings, using the 1991 Census categories, plus an 'Irish' category, also show data for 'overseas' status. They report that 80.9 *per cent* of Irish applicants were resident overseas in 1995/-6 (Iganski, *et al.*,1998, p.27).

While Beishon sought to identify many of the traditional overseas recruitment areas utilised by the Health Service, the researchers failed to acknowledge the diversity of internal, national populations. Scots, Welsh and Northern Irish respondents would find themselves compelled to label themselves as British (see Table 5.8). The difficulty for some in answering this question has been obliquely referred to by the ONS, where apparently Northern Irish-accented respondents indicated Eire nationality (Haskey, 1996).

Clearly, the boundaries of the nation state do not offer a reasonable conceptualisation of national identity. Hall, Gilroy and others argue that back experience in Britain has created a more complex notion, than that of 'black Briton', which is more than a reaction to imposed colonial status (Gilroy, 1987, Yuval- Davis, 1999). The likelihood of such a label being taken up by those who might constitute themselves as Asian is doubtful; Madood and others point to the greater significance of Indian or Pakistani origin, regional affiliations and religion, even amongst the majority of second generation settlers (Madood, 1994b). This is tacitly acknowledged by the Beishon survey design in coding and reporting categories.

Table 5.8: **Place/area of birth. (Source: Beishon, 1995, p.148 codes)**

United Kingdom and N. Ireland	1
Eire/Irish Republic	2
Caribbean	
West Indies/Guyana	3
Indian Sub-Continent	
India	4
Pakistan	5
Bangladesh	6
Sri Lanka	7

Table 5.8: Place/area of birth. Source: Beishon, 1995, p.148 Codes.

African Continent	
Africa	8
Mauritius	9
Asia	
Philippines	10
Hong Kong	11
Singapore	12
China	13
Vietnam	14
Malaysia	15
Australasia	
New Zealand	16
Australia	17
Other country (please specify and tick box)	18

To be born in a particular country may grant political citizenship, but not necessarily a sense of political or social affiliation, as in the case of many Northern Irish Catholics, and to some degree their Ulster Protestant neighbours, amongst whom can be distinguished a social identity beyond Britishness.[3] Indeed, the formal titular distinction of Northern Ireland, from the United Kingdom, suggests more

than a geographical device. It could be argued that the contested nature of citizenship here has been discretely acknowledged (see Table 5.8).

The later, qualifying question on ethnic identity appears to offer a richer range of alternatives, but the order of the categories offered again encourages respondents to identify themselves on the basis of colour (see Table 5.9). Only black and Asian respondents are permitted a further choice of regional identification, or hybrid identity, for example, Asian Caribbean. The possibility of Irishness is not explicitly allowed for, and not surprisingly, few respondents identify themselves as Irish when initially checking listed options and opting for the first, closest category apparently based on colour.

The secondary analysis did show a very small number of Irish-born nurses identifying themselves as black, or Asian - 15 in all. Though statistically insignificant here, these respondents would be interesting subjects for further study around Grossberg's notion of the outsider negotiating 'in process' cultural identity (Grossberg, 1996). None of these respondents answered questions on personal discrimination when Irish-born cases were filtered on the above questions. The 'born in Ireland' respondents have been treated as a discrete category for the purposes of comparison with other white nurses and the black and Asian categories derived by Beishon. While not totally satisfactory, this is not just a pragmatic manoeuvre to unearth interesting data. Though many 'born in Ireland' respondents identified themselves as 'white', Irishness as a self-identifier was not offered as an alternative, ethnic tag. Yet Irish people have tenaciously clung to cultural signifiers differentiating them from the English, many seeing themselves as part of an imagined community (Hickman & Walter, 1997, p.22).

Table 5.9: **Question 81: Ethnic origin. (Source: Beishon, 1995)**

Would you describe your ethnic origins as: (Please tick ALL that apply)	
White	25
Black Caribbean	26
Indian Caribbean	27

Would you describe your ethnic origins as: (Please tick ALL that apply)	
Black African	28
Black other	29-34
Indian	35
Pakistani	36
Bangladeshi	37
Chinese	38
Other (please specify and tick box)	39-44

The postal questionnaire and the case studies produced some polarisation of opinion amongst black, Asian and white nurses in the Beishon study, in apparent perception and understanding of equal opportunities issues. Whilst all groups acknowledged the presence of racism in the NHS, white nurses tended to deny having personally observed such incidents, or to play down their significance for those involved (Beishon, 1995, p.203). Given the claims made by Irish writers about racism as an English colonial phenomena (Porter, 1993), and the consequent solidarity felt for other subaltern groups, one might expect to discern different responses from Irish nurses to this issue.

Five specific questions were posed by Beishon, covering personal discrimination in relation to obtaining jobs, promotion, training, and their experience of discrimination from patients and staff. The data suggest strongly that Irish nurses did not see themselves as disadvantaged in the NHS job market due to 'racial' discrimination. Over 95.4 *per cent* were "never refused a job for reasons to do with your race or colour". Similar responses were elicited for questions relating to promotion and training. Possibly respondents here were influenced by the wording of the questionnaire, and the specific questions here which referred to *race* or *colour*. If Irish nurses construct themselves as 'white', as well as Irish, they might well see themselves as not stigmatised by a process associated with being 'non-white'.

Subaltern groups may identify, or 'affiliate' with oppressors, rather than other oppressed groups (Graham, 1996). In terms of competition for work, where three or more distinctive, ethnic groups are competing, 'queuing' has been identified as a process of selective discrimination by employers in the United States (Reskin & Roos, 1990). Irish nurses might therefore also experience favour on the basis of a perceived white identity, if a similar process is taking place in Britain. This argument could be supported by the similar promotion grades achieved by Irish and other white nurses in the sample, in contrast to Asian and especially black nurses.

Alternatively, Irish nurses were more likely concede that racism was present in the NHS, and that they had witnessed it within their own workplace. This suggests sensitivity beyond the homogenising critiques of traditional, anti-racist discourse. Yet many did not respond to the question on who might suffer bias regarding specific issues, like access to further training; 56 *per cent* chose not to answer. Irish interviewees usually tended, like their English counterparts, not to see discrimination within their own workplace. A number of explanations could be speculated on, since the inadequacies of survey method do not allow insights into that experience. How this experience might be better understood requires further research utilising an array of methodologies that allow the reader to hear the voices of those subjects lost in the frequency counts of social survey.

Multivariate analysis

Multivariate analysis offers an opportunity to build on the descriptive results discussed above. Multivariate statistical procedures can be used to examine simultaneous associations between ethnicity and career progression, the dependent variable (DV), and other independent variables (IV) that might also be hypothesised as explanatory factors, such as, for example, sex, age, and qualifications. Potentially confounding variables can also be eliminated (Smaje, 1996, p.92).

In relation to the Irish category identified within the Beishon survey, the author was permitted access to the original dataset, and this has allowed replication of the logistic regression procedure utilised in the original study. Specifically, logistic regression permits usage of dichotomous variables, that is where an 'either/or' response is given. This procedure predicts the probability, or odds, that a person has

a given characteristic based on a combination of independent or predictor variables (Hosmer & Lemshow, 1989, pvii).

Predictor variables may be dichotomous, for example, male/female, or continuous, for example, age. This permits the combined measurement of factors normally subject to different levels of measurement and associated parametric and non-parametric tests. Most importantly, logistic regression allows a whole range of variables to be held constant to allow an estimate of the influence of one particular variable.

The author has attempted to model the phenomenon that white, Irish nurses seem to be more successful, that is that they reach higher grades than other minority ethnic groups. Logistic regression estimates whether this is a chance association, or whether there is some form of association between success and white, Irish nurses. Logistic regression will allow the author to:

1) Derive and identify those elements or characteristics that are common to this group of nurses, and the effect these characteristics have on attaining higher grades;

2) Predict, given a specific set of characteristics, the likelihood of a white, Irish nurse being successful or not and

3) Determine how well this model reflects other reported data on this phenomenon.

The models and procedure are outlined here as follows: the model being tested is that white Irish who are successful, the dependent variable (DV), would be dependent upon the following variables extracted from the Beishon dataset: age, qualifications, number of breaks in service, sex, level of education, sector, time in service and specialisms. These are the independent variables (IVs). Formally, the null hypothesis (H_o) would be that there is no relationship between the DV and the IVs. Any relationship that is found would be purely due to chance and is therefore random. The alternative hypothesis (H_1) is that white, Irish nurses who reach grade E and above are influenced by the above independent variables, and that such a relationship is not due to chance or random happenings. The E grade, as mentioned

previously, was on the first rung of the promotional ladder for a staff nurse. Newly-qualified nurses were appointed at the basic grade of D.

The original Beishon data were recoded to identify white Irish nurses only, and those who satisfied the criteria of being successful in their careers. Success is defined in terms of those nurses who had reached grade E or above. Those that were successful were coded as 1, while those who were not were coded as 0. Given that each case in the survey can be either successful, reaching Grade E or above, or not successful, only attaining a grade D or lower, this question lends itself to the use of logistic regression, since the dependent variable can only take on a value of 1 or 0. Ordinary multiple regression could not be used because the dependent variable is not ratio or interval in nature, but nominal.

As with multiple regression, there are a number of methods that could be employed to run the logistic regression analysis. For the purposes of this study, two different methods were selected. First, the *enter* method was used. This was selected on common sense assumptions, and consultation with senior nursing colleagues, regarding which independent variables would be most likely to produce success.

This is in keeping with logistic regression methodology, in that instead of *least squares* being used to produce the resultant equation and analysis, logistic regression uses *likelihood* estimates. This is simply a way of assessing goodness of fit of a model by looking at how likely the results are, given the data being examined. For example, if a coin was to be flipped and the results noted and summarised, then it would soon be identified that that the outcome of either a head or tail is one or the other. In addition, the frequency of either a head or tail would also be noted. By throwing three or four coins, it would be possible to make some form of prediction as to what would most likely occur. Within the logistic regression procedure, the computer programme employs *iteration*, that is it guesses until it cannot improve on its last guess. This is fundamentally the same as the coin-throwing procedure described above.

As an alternative, a second analysis using *stepwise* methodology was also run, accepting the statistical criteria for the introduction and withdrawal of the variables as *per* SPSS defaults. These settings are universally accepted by statisticians as being acceptable steps to produce an analytical procedure that has validity, and upholds

the robustness of the method. This method takes complete control of the subsequent analysis, and the output produced is based entirely upon statistical procedures and criteria. In essence, it removes any influence the researcher may have over the analysis.

The results of both methods are very similar:

Table 5.10: **Independent variables used in each method of logistic regression.**

Method – Enter	**Method – Stepwise**
Time in	Time in
Specialisms	Specialisms
Qualifications	Qualifications
Education level	
Age	
Number of breaks	
Sector	
Sex	

However, in relation to the independent variables, as Table 5.10 demonstrates above, the stepwise method did not enter into the analysis of the variables of education level, age, number of breaks, sector and sex. This is attributable to their failure to reach the statistical criteria for inclusion. The question now moves on to which method needs to be utilised. The *enter* method was selected for all of the following discussion. This allows presentation of a total picture of the precise nature of the model. If a purist statistical position were adopted, then valuable information about the variables not included would have been lost in following a *stepwise* approach. In addition to the information gained, it is argued that not including all the variables is essentially undermining the reasons for which research is undertaken.

Any research within the regression environment essentially seeks to answer three fundamental questions:

1) Is there a relationship between the dependent and independent variables?

2) What is the precise nature of this relationship?

3) What predictions can be made given that a relationship exits and its form is known?

The following interpretation of results is offered in light of the findings generated by SPSS, using the logistic regression statistical procedure.

Interpretation of results

-2Log Likelihood = 768.01138

If the IVs explain the DV totally, this figure would be 0; the closer to zero, the more appropriate the model. Clearly it is not, but this is the only the first guess. H_1 cannot be rejected, or a Type I error could be made. After nine 'guesses' the programme gives the -2 log likelihood of 344.278. This figure has been reduced from the first attempt. It is still not 0, that is the perfect model, and so the independent variables (IVs) do not completely account for the dependent variable (DV) entirely. The goodness of fit figure (582.496) indicates in another way how well the proposed model fits the data. It essentially looks at the probability of each case having a specific attribute, compared to not having that specific attribute. This figure must be read in conjunction with chi-square and significance results.

Chi-square and significance

The model, block and step procedures are all the same. This is because there is only one model and block of variables to analyse. It is important to check the significance figure. The analysis suggests that the null hypothesis (H_o) can be rejected, and there is, then, evidence for a relationship not merely based on chance. Variables are interacting to produce an association and effect between the IVs and the DV. It is also possible to compute an R-square and adjusted co-efficient from the data results below:

R-square (log reg) = model chi-square/initial-2 log likelihood = 423.733/768.01138 = 0.5517 or 55.17 per cent

Adjusted R-square (log reg) = model chi--squaresquare-2k/initial-2 log likelihood = 423.733- (2x5) /768.01138 = 0.5387 or 53.87 per cent

The R-square computation is similar to the Cox and Snell figure, and represents the amount of variation that can be expected by the IVs. The adjusted R-square takes into account the number of IVs (k in the equation above). There are other factors that could be brought into the model to strengthen the results. Such further analysis might demonstrate the precise nature of the IVs that yield a successful, white Irish nurse. However, by bringing other factors into the model, the co-efficient calculate is increased, irrespective of whether or not it is meaningful. To counteract his problem, the adjusted R-square has been calculated, and it is slightly lower than the R-square, and similar to the Cox and Snell results. This also indicates that more IVs need to be introduced to improve the strength of the findings.

With regard to the classification table, there is no statistically acceptable procedure for interpretation. In essence, the table attempts to perform a chi-square, that is, to attempt to predict white, Irish successful nurses from its observations of the IVs. The overall figure of 87.69 *per cent* gives an indication of how well it can perform here. This figure represents the diagonal upper left to lower right. Given that the author would seek to predict white, Irish successful nurses all the time, this means that the figure should be 100 *per cent*. Nevertheless, 87 *per cent* is very good, but given the lack of a set statistical procedure, caution should be exercised in interpreting this result and any consequent claims. With regard to the variables in the equation, apart from their individual use, they can collectively be utilised to create the probability of a person with various values of the IVs becoming a successful white, Irish nurse.

B – It is worth noting how the DV changes as the IVs change in log odds terms. A positive figure increases the odds, whilst a negative figure decreases the odds. From the analysis, 'qualification' seems to increase the odds of being successful, while ironically 'education' decreases these odds. Note also the individual co-efficients given to qualifications, *i.e.* quals 5 would appear to have a bigger effect on the DV

than, say quals. 2. SE – Simply the standard error, which is of little use, merely allowing us to calculate the limits in terms of standard deviations for each IV.

Wald – replacing the *t* test in normal regression analysis (it is a problem, though not here, that when the Wald value increases too far, it moves away from the normal distribution and consequently violates one of the central assumptions of parametric testing). The df and significance figures relate to the Wald. Assuming this problem and merely concentrating on the significance figures, then at $p<0.05$, age and qualification seem to be the only significant variables.

R, as the partial correlation, between an IV and the DV, after controlling for all other DVs. This can be used to produce a table of the IVs which are having the greatest affect. In this analysis, qualifications would seem to be the most important IV, yet with a value of 0.3, the relationship would be deemed to be weak.

Finally, Exp (b) looks at how the odds of an event happening, that is a white, Irish successful nurse, will change by adding the IV. Anything above 1 increases the odds. From the actual size of the figure, we can construct a table which lists the IV with the greatest effect, to the IV with the lowest effect. From the analysis, these are age, time, the number of breaks on service. Q10 and quals all increase the odds of becoming a white, Irish successful nurse. Clearly, qualifications 1 to 5 have a very big impact. Qual 5 has the largest impact of all.

CONCLUSION

This analysis reveals that Irish nurses are continuing to play a distinct role within the British National Health Service in England and Wales. The baseline data here reveal that substantial numbers of Irish nurses continue to work in the NHS, indeed they form the largest minority ethnic group, if black Caribbean and black African nurses are disaggregated as an ethnic group. Furthermore, the descriptive data reveal a number of particular features with regard to demographic characteristics, such as age, employment history, and clinical speciality which distinguish them from white and non-white colleagues.

They are on average significantly younger than their Asian and black colleagues. They show significantly greater career mobility than their white colleagues, but like

them, they are more highly represented within the specialist and general acute posts of medicine and surgery, rather than the Cinderella services of elderly care, psychiatry and learning disabilities. They are also well represented within community and midwifery, again in sharp contrast to their non-white minority colleagues. Finally, the multivariate analysis indicates a pattern of career success in comparison to other minority ethnic groups. These loglinear regression findings also clearly show the impact of gender on the likelihood of promotion. Irish men are more likely to be promoted with regard to clinical posts in comparison to women, and nurses from other minority backgrounds.

CHAPTER SIX

A SECONDARY ANALYSIS OF DATA FROM THE UKCC REGISTER

INTRODUCTION

This chapter considers an anonymised dataset derived from registration files maintained by the United Kingdom Council for Nursing, Midwifery and Health Visiting (UKCC). The dataset provides a limited range of variables describing training and demographic characteristics for 931,278 nurses, midwives and health visitors registered to practice within the United Kingdom and Northern Ireland up to April 2002. Unless otherwise stated, all registrants will hereafter be generically referred to as nurses. These categories therefore supply a large-scale, if somewhat incomplete, jigsaw of the demographic and professional details of nurses registered to practice with the UKCC. Further limitations are imposed by missing values, either for complete categories, or for specific cases. The impact and management of these missing data will be discussed further in relation to missing values for individual variables, and the cumulative loss of cases from grouping variables (De Vaus, 2002).

Despite the limited number of categories provided, the target population data do offer a potential sample frame to test the validity claims of the Beishon survey. Some categories between the two datasets provide like for like comparison, so it is further possible, like Beishon, to scrutinise 'Irish' nurses by recoding country of birth details. Ethnic categorisation for the purposes of statistical analysis and policy development is a hazardous exercise, subject to a number of potential methodological pitfalls (Ahmad & Sheldon, 1991; Gerrish, 2000,; Smaje, 1995). To operationalise Irish identity, or rather identities, is especially problematic (Connolly, 2003; Walter, 2001). For further discussion of the methodological defence for this ethnic coding, see the Methods Chapter, analysis of the problematic of categorising identity has also been addressed within Chapter Four.

Other categories obtained from this dataset give access to data not covered by Beishon. Professional registration data will reveal some details on labour mobility

amongst different ethnic groups, and some insights into patterns of training across different specialities. Recoding of other categories also provides further descriptive details of the population, and opportunities for cross-sectional analysis. It is also worthwhile noting that the compulsory nature of this index of nursing has revealed an even greater number of 'Irish' nurses recorded on the UKCC Register in comparison to the numbers recovered from the Beishon dataset.

Historical background

The United Kingdom Council for Nursing, Midwifery and Health Visiting (UKCC) and its four constituent National Boards held statutory responsibility for nurse training and registration to practice from 1979 (HMSO, 1979). Prior to the establishment of the UKCC by Act of Parliament, nine differing professional bodies regulated training and standards for differing occupational groups, including midwifery and health visiting, across and within different UK countries (Davies & Beech, 2000).

The UKCC was disbanded as a professional regulator in April 2002 (Nursing and Midwifery Council Order, 2001). Disciplinary and other regulatory functions for nursing were transferred to a successor body, the Nursing and Midwifery Council (NMC). The Bristol Inquiry, though focusing on the work of the General Medical Council, had raised specific questions about bullying and 'club culture' within the NHS, it also fundamentally attacked the efficacy of self-regulation by the health care professions in Britain. The UKCC had considerable difficulty in refuting allegations that, in its pursuit of other professional goals, it had lost sight of its primary function as a public defence agency. UKCC reform followed significant criticism of its organisational performance, particularly in relation to public safety issues and clinical training (Garbett, 1998; Norman, 2002). Broader ideological goals regarding professional development, particularly control of training, were substantially undermined by the movement of nurse education into the universities from the early 1990s (UKCC, 1998). The subsequent development of contractual partnerships between these institutions and health service providers effectively cut out the validating role of the National Boards.

Accurate maintenance of the Register within these operating conditions posed fundamental difficulties for both the UKCC and the NMC. The following

examination of this dataset will reveal how successfully the Register was managed under the stewardship of the UKCC.

The UKCC dataset

The dataset supplied by the UKCC Information Service contains 931,278 cases, of which 634,442 cases represent 'active' registrants, that is, nurses who have paid their registration fee, which is required once every three years. 'Active' status suggests that the individual concerned is practising in some capacity, or is intending to seek employment relevant to their registration. 'Lapsed' cases represent historical data for those nurses who have not renewed their registration. This will include the deceased, those who have retired and nurses making temporary or permanent breaks from the profession. UKCC policy had been to retain lapsed records for up to ten years in the event of former registrants wishing to renew registration to practice. It is worth noting that the Register is effectively a three-yearly Census of nurses maintaining the right to practice nursing in the United Kingdom.

The analysis of data specifically addressed active registrants. However, it was thought that there might be some value in examining other, lapsed entrants for purposes of historical context. This is especially likely to be true in relation to minority ethnic representation within different parts of the Register and declared areas of employment.

The dataset contained thirty variables, which supplied demographic and professional details for each individual entry (see variable names listed in Table 6.1). These were examined in turn, before cross-tabulation and application of filters to identify further descriptive statistics. Statistical procedures were applied through an SPSS PC package. Recoding of the existing variables allowed creation of additional variables, which permitted closer analyses of specific sub-groups. Design characteristics of the primary variables and their data contents were individually explored. These will be described below before further cross-sectional analysis is undertaken of their data contents. The chapter concludes with analysis of the data retrieved for UKCC Irish nurses and their non-Irish counterparts.

Table 6.1: **UKCC dataset variable names.**

Reference number	Qualification 3
Sex	National Board training
Date of birth	Registration to practise date
Active/lapsed	Qualification 4
Postcode	National Board training
Ethnic origin	Registration to practise date
Nationality	Qualification 5
Birth country	National Board training
Home country	Registration to practise date
Type of employment	Qualification 6
Qualification 1	National Board training
National Board training	Registration to practise date
Registration to practise date	Qualification 7
Qualification 2	National Board training
National Board training	Registration to practise date
Registration to practise date	

Reference number

The reference number individually identifies separate cases but does not include all coding items associated with the original Personal Identity Number (PIN). The total number of individual cases within the dataset numbers 931, 278. A PIN would be allocated to new student nurses entering training with UKCC National Boards and qualified overseas nurses seeking registration to practice within Britain and Northern Ireland.

The PIN included a registration string code for nurses that trained in Eire and British National Boards. The last digit contained a character code for one of the four British Boards, and for the purposes of this analysis the lack of this variable is a serious shortcoming. Coding was only supplied for UKCC Boards within the National Board training variable. However, cross-tabulation of relevant Beishon data variables showed that less than 20 *per cent* of Irish respondents working in England had trained in Eire (See Chapter Five).

Sex

Sex as a nominal categorical variable appears to be one of the most reliable and completely recorded categories. A frequency count, for all lapsed and active cases, shows only two missing case values for this question from 931,276 cases recorded by the UKCC (See Table 6.2). Overall, the count indicates that men continue to constitute less than one in ten of all UKCC registered nurses (9.6 *per cent*). This compares to 11 *per cent* of the NHS workforce. This latter data would include unqualified staff (Beishon, 1995, p.147). For active cases only, which totalled 634,348 valid entries, 10.8 *per cent* were male and 89.8 *per cent* were female. One case was not coded.

Table 6.2: **Sex frequency count for all UKCC cases.**

Sex	Frequency	Per cent	Valid per cent	Cumulative per cent
Female	841,729	0.0	0.0	0.0
Male	89,547	90.4	90.4	90.4
Total	931,278	9.6	9.6	100.0

Date of birth

Frequency counting for active members shows 94 missing cases for the total of 634,442 active entries. Mean = 42.6 years, SD = 10.3. Three entries suggest data entry errors, or the less likely possibility that the UKCC registered three under-age entrants. Student and pupil nurses were unable to commence training until they reached their 18 birthday; this was subsequently reduced to 17 ½ in 1988. The proportion of cases ranging from 21 years to 60 years was 95.4 *per cent*. A further 27,580 cases are recorded between the ages of 61 to 70 (4.3 *per cent*). Two outlier cases are listed as active registrants between the ages of 91 and 100.

Retirement for NHS female employees remains at 60 years, whilst men are required to continue working until 65 years. Nurses are able to retire earlier, at 55 years, some groups with 'Mental Health Officer' status, usually those employed as Enrolled or Registered Mental Nurses, or Enrolled or Registered Mental Handicap Nurses, are able to seek an earlier retirement date according to particular Whitley Council conditions of employment. The formula is calculated according to years of service.

Active and lapsed status

Registrants may have either active or lapsed status, dependent on payment of the tri-annual registration fee. The frequency count for this variable (Table 1) shows 634,442 (68.1*per cent*) registrants to have paid their fees within the last three years. A further 296,836 registrants (31.9 *per cent*) have not continued to pay fees. Tri-annual payment of fees enabled the UKCC, and its successor, the Nursing and Midwifery

Council (NMC), to make an important professional claim, that the list was a valid, or 'live' Registry of practitioners. Previous registration lists were plagued by ghost entries, as people died, retired or discontinued nursing for other reasons. Comparison of means for a recoded date of birth category - age at 2002 - for both active and lapsed cases gives some weight to the argument that the Register is a reasonably reliable measure of nurses practising within the UK (mean active age = 42.6, SD = 10.3, mean lapsed age = 52.4, SD = 12).

National Health Service employers routinely check professional registration of staff as an audit measure. Recent clinical governance policy has placed greater managerial focus on this task (UKCC, 1999a, NMC, 2003). However, UKCC and NMC reports on disciplinary cases suggest that the private sector is less likely to police this process with the same rigour. The professional and lay press have reported a number of cases where nurses, who had been suspended, or even struck off, were found continuing to work (Smith & Macintosh, 2007, p.2213).

Postcode

This dataset also contains area postcode data. This potentially useful variable for analysis required considerable cleaning. 'Eyeballing' of the data revealed a considerable number of apparent errors, possibly attributable to data entry staff. It may also be possible that coding requirements confuse registrants, when they are completing Registry application forms. A frequency count for this category shows 1.5 *per cent* of active cases to have missing values. Other entries clearly represent suffix elements of the postcode data relating to street addresses. Nonetheless, cross-tabulation shows apparent geographical clusters in relation to country of birth, for example, those nurses born in Eire. Findings from these data are addressed further below.

Ethnic origin

Four of the demographic variables refer directly to the ethnic and national identity of the registrant. The first and apparently most problematic, from an operational perspective, is labelled 'Ethnic Origin'. An initial decision by the UKCC to collect such data was made in 1990. Approval for the coding arrangements was sought from the Commission for Racial Equality and followed the methodology pursued

for the 1991 Census. The codes were later amended in line with the 16 revised categories developed for the 2001 Census. These are listed below, with UKCC frequency counts for all active cases (See Table 6.3). Missing cases totalled 216, 456, or 34.1 *per cent*, for all active cases.

Table 6.3: UKCC frequency counts for 2001 Census ethnic origin categories

	Frequency	Per cent	Valid per cent	Cumulative per cent
(a) White				
British	177,455	28.0	82.0	82.0
Irish	10,057	1.6	4.6	86.6
Any other White background	6,072	1.0	2.8	89.4
(b) Mixed				
White and Black Caribbean	408	0.1	0.2	89.6
White and Black African	202	0.0	0.1	89.7
White and Asian	361	0.1	0.2	89.9
Any other mixed background	646	0.1	0.3	90.2
(c) Asian or Black British				
Indian	1,883	0.3	0.9	91.1
Pakistani	246	0.0	0.1	91.2
Bangladeshi	330	0.1	0.2	91.3

	Frequency	Per cent	Valid per cent	Cumulative per cent
Any other Asian background	3,530	0.6	1.6	92.9
(d) Black or Black British				
Caribbean	5,087	0.8	2.4	95.3
African	5,411	0.9	2.5	97.8
Any other Black background	412	0.1	0.2	98.0
(e) Chinese or other ethnic group				
Chinese	2,947	0.5	1.4	99.3
Any other group	924	0.1	0.4	99.8
Declined to reply	485	0.1	0.2	100.0
Total valid cases	21,645	34.1	100.0	
Missing System	417,986	65.9		
Total	634,442	100.0		

A cross-tabulated results summary between active and lapsed cases shows 700,398 cases to be missing from the summary data (75.2 *per cent*). There were 230,880 cases for which ethnic origin was identified (24.8 *per cent*), 542 were coded '99', that is 'Declined to Notify', which suggests that these entries were either impossible to decipher, or spoiled. Within the active category for those that gave ethnic identity,

the largest sub-group identified themselves as 'White British' - 177,455 of all such cases (81.9 *per cent*). Active 'White Irish' cases totalled 10,057 (4.7 *per cent*).

The 'Other White' sub-category produced 6,072 cases. 'Mixed' ethnic attribution was self-identified by 1,917 respondents. Cross-tabulation with the 'nationality' variable shows a mixture of overseas registrants, mainly from the European Community, the Commonwealth, especially Australia, and the United States. Such 'overseas' data were annually reported by the UKCC, and this statistical measure continues to be reported on by the NMC.

Coding ethnicity

For those registrants born within the United Kingdom, self-determining ethnic origin appears to have been a potentially confusing decision, and echoes problems elsewhere associated with attempts to operationalise ethnicity as a quantifiable construct (Smaje, 1995). Like many other public sector agencies and quangos, the UKCC found itself in considerable difficulties when challenged to provide accurate, ethnic profile data regarding entry and progress within the nursing professions (Foolchand, 2000). Previous Registry records had required details of nationality and country of birth; this had been substantially driven by Governmental policy interest in the workforce output of the British National Boards and the impact of overseas recruitment within and outside European Community member states.

Unlike its predecessors, the newly established UKCC was now at least partially driven by the novel policy demands of its own Council membership and other external policy drivers beyond traditional Government workforce planning for NHS shortages. Council membership now included a substantial number of elected members, many of whom were sponsored by trades unions and professional associations clearly concerned with developing an equal opportunities agenda (Davies & Beech, 2000). There was also additional pressure from a new Government administration. 'New Labour' was interested in the effects of social exclusion, specifically attaching a higher profile to questions of race and social justice. This was particularly focused around the emerging debate from the Macpherson Report, which was pointing up institutional racism in British society, specifically within public bodies and agencies (Solomos, 1999).

After further consultation with the Commission for Racial Equality (CRE), Council determined that from September 2000 new registrants would be requested to submit a response concerning ethnic origin (see Table 6.3 above). Existing registrants were individually surveyed by postal questionnaire that year, in order to build up a profile for the UKCC Register. These data had not been previously obtained. An accompanying UKCC Council letter advised registered nurses of the Council "commitment to valuing the diversity that is present in the professions we regulate, the society in which we operate and the people we employ" (UKCC Ethnic Monitoring Form, 2000).

Rather more confusingly the same letter promised a strategy for valuing and managing diversity and ensuring equality of opportunity across all UKCC operations, if accurate information on ethnicity of respondents could be recorded. Questions can also be asked of the subsequent assertion by the writer that ethnic origin categories specified on the form were "not about nationality, place of birth or citizenship. It is about colour and broad ethnic group". The actual categories listed were based on the 2001 Census, which for the first time included a sub-category for Irish within the broader White category. Respondents were also advised of the contingent nature of ethnicity coding "it is possible that the categories may change".

Potential respondents were also promised that this **"information is strictly confidential and will not be used to identify the ethnicity of individual registrants** [bold lettering in original]". This assurance may have comforted some potential respondents, but poor returns still required a reminder letter with a second questionnaire later that year. The then UKCC Director of Information claimed an overall 30 *per cent* response rate when interviewed by the author, though he indicated that CRE were unhappy about proceeding with any analysis of these returns. Frequency counting of the current dataset showed just over 34 *per cent* of active cases to have given ethnic origin details. There is a well known phenomenon amongst white respondents, who do not regard themselves as possessing an 'ethnic' identity, opting not to answer questions on this topic. White interviewees confirmed to the author that questions of ethnicity were seen by them to be closely connected to issues of race, or colour. Ethnicity was not something pertaining to them.

Frequency counting for lapsed registrants showed an even greater number of errors compared against active cases. These might result from either keyboard mistakes by

data entry staff at the UKCC, or omissions and errors by applicants when completing registration application forms. The improvement in the quality of data collection here suggested a renewed effort by the UKCC to gather a more reliable overview of ethnic status for UKCC practitioners. Recoding of the ethnic identity variable to collapse sub-categories allowed comparison with the Beishon data. Six codes were created for 'shortened ethnic origin' as employed by Beishon (See Table 6.4 below).

Table 6.4: Shortened ethnic origin of NHS nursing staff.

Ethnic code	Beishon per cent	UKCC active cases per cent	UKCC all cases per cent
White	83.5	89.4	89.6
Asian	2.4	2.8	2.7
Black	4.3	5.0	5.0
Other	1.6	2.5	2.5
Not stated	7.5	0.2	0.2

Comparison of UKCC active cases against UCCC all active and lapsed cases, for shortened ethnic origin, shows little apparent difference in distribution across all groups (See Table 6.4). Approximately similar percentages emerge for UKCC registrants and the Beishon sample. White nurses remain the largest sub-group for both UKCC and Beishon samples.

Beishon (1995, p.145) found the greatest number of non-responders to questions of ethnic origin to be from the UK. A similar picture emerges from cross-tabulation of the UKCC data. However, cross-tabulation of variables for 'nationality' with 'recoded ethnicity' for all UKCC cases produced only 10.6 *per cent* for valid cases. The same result was produced from filtering active cases only. The same filter analysis applied to variables for 'birth country' and 'recoded ethnic groups' produced a slightly improved result - 16.5 *per cent* valid cases (See Table 6.5). Of

these 7,2831 entries, 7,1051 United Kingdom and Northern Irish respondents self-identified themselves as of White ethnic origin (97.6 *per cent*).

For those within the 'born in Ireland' sub-category, 1,880 cases (2.6 *per cent* of valid cases), a very high majority self identified their ethnic origin as White. Only ten of these registrants gave other responses. These responses tally very closely with the self-attributed ethnic origin of Irish Beishon nurses.

Table 6.5: Cross-tabulated 'birth country' with 'recoded ethnic groups for active cases'

	White	Mixed	Asian	Black	Other	Declined to notify	Total
Britain	106	0	0	2	0	0	108
England	49,688	300	314	779	61	106	51,248
Scotland	11,228	30	81	5	6	18	11,368
Ireland	1,870	3	5	0	1	1	1,880
Northern Ireland	0	3	8	1	0	9	21
Wales	0	14	8	10	6	8	46
Channel Islands	62	1	0	0	0	0	63
Total	71,051	351	416	797	74	142	72,831

Nationality

This category contains 155, four-digit codes for nationality types, including a system default code, 9999. Frequency counting for all lapsed and active cases showed 658,231 cases to be missing (70.7 *per cent*), of valid cases total 273,074 (29.3 *per cent*). This shows a low response rate from registrants. A frequency count of active cases only shows a slightly improved response rate, 221,051 (34.8 *per cent* of active cases). UKCC nationality codes permitted respondents to identify themselves as: British,

English, Scottish, Welsh, Northern Irish or Channel Islander. A separate category was allocated for 'Irish'. This may have left some room for potential confusion, or disputation, by registrants, particularly those uncertain whether nationality referred to their British, or UK, home nation identity. Some Northern Irish respondents may have wished to refute 'British' or 'Northern Irish' as a satisfactory descriptor..

Asking respondents to identify their 'Home Country' category also appears to be problematic for operational purposes. Yet active registrants, 381,257 (60.1 *per cent*) supplied a statistically valid entry. However, of these entries, 2,373 (0.4 *per cent*) were recorded as 9999 codes. This suggests problems when attempting data entry for this category. Closer examination of the frequency count for individual UK countries values, and individual case entries, suggests that respondents might be confused. This category might be perceived to refer to a number of differing theoretical and operational concepts. Interviewees offered a wide array of differing justifications in explanation of their own responses, these most commonly included perception of ethnic identity, nationality, country of current residence, domicile, or where a permanent home address might be given.

The frequency count for the category of 'Country of Birth' produced a high response rate for all cases, 424,473 (45.6 *per cent*). A further improvement was shown when this category was filtered for active cases only. Valid entries here showed 344,486 respondents gave their country of birth (54.3 *per cent*).

Birth country for all active and lapsed cases contained the largest number of entries (45.6 *per cent* of valid cases) compared against nationality (29.3 *per cent*) and ethnic origin (24.8 *per cent*). However, home country contained an even higher rate of valid entries (50.8 *per cent*).

Employment

Respondents were required to identify one of eighteen options (See Table 6.6). 336,014 (36.1 *per cent*) of the cases were missing from the summary. This includes data from both lapsed and active registrants. Data entered for lapsed registrants showed only 19.5 *per cent* had type of employment identified. Active registrants who specified type of employment totalled 537,320, or 84.7 *per cent* of all active registrants. A further six unlabelled codes were revealed by a frequency count. Military employers are not listed.

Table 6.6: UKCC employer types.

NHS Trust Mental Health	Independent Practice
Private Hospital	NHS Trust Acute
NHS Primary Care	Practising outside UK
Nursing Home	FHSA
NHS, NHS Trust or DMU	Not currently practising
Industry	General Practitioner
NHS Other	Other
Nursing Agency	Occupational Health
Educational Institution	Local Authority

This nominal variable identifies a range of public sector and commercial employers. Of these, at least seven are identifiable as NHS organisations, or services employing NHS nursing staff. Overall, the National Health Service remains the largest overall employer of registered nurses in the UK. Yet a secondary market is apparent in the numbers of nurses working within nursing homes and as agency nurses, Black and Asian nurses, unlike their Irish counterparts, are excessively represented within these sectors.

Unfiltered cross-tabulation of employer type, with the recoded ethnic variable, showed 199,981 valid entries for both lapsed and active cases (21.5 *per cent*). A filter for lapsed cases showed only 8,263 valid entries (2.8 *per cent*). A more complete record appears to have been attempted for active registrants - filtering for these cases showed 191,549 valid entries (30.2 *per cent*). For all ethnic groups, the National Health Service remains the major employer.

Aside from possible data entry problems at the UKCC, it is also possible that some missing cases may be attributable to confusion by registrants regarding the range of employer types. A number of NHS reorganisation initiatives have led to title

changes for constituent organisations, as well as the creation of new bodies and the dissolution of others. Timetables for transfer arrangements meant that shadow organisations were functioning alongside the original structures. It is also worthwhile noting that the Beishon data demonstrated that minority ethnic nurses were more likely to hold multiple jobs within different organisations. The author's own survey, of nurses working within four North East of England trusts, found some respondents to be employed in two different posts by the same organisation.

Professional training

The remaining variables identify professional training. The data supplied within this dataset are closely related, and fall in to three, broad types of sub-category: Registered qualification, National Training Board, qualification registration date. UKCC coding arrangements for the date categories necessitated recoding categories. This also permitted date banding for analysis and reporting purposes.

The UKCC permitted registration to 15 separate parts of the Register. Parts of the register were specified for Health Visitors, Midwives, and four fields of practice for Registered and Enrolled Nurses:

- General Nursing

- Mental Nursing

- Mental Handicap

- Sick Children

Enrolled nurses were again divided into parts according to whether training was undertaken in England and Wales, or Scotland and Northern Ireland. For enrolled nurses in Scotland and Northern Ireland, no distinction was made regarding field of practice. Part 9 of the Register was reserved for Registered Fever Nurses.

The database potentially allowed for up to seven professional practice qualifications to be submitted. These would be recorded in accordance with the current practice declared by the registrant, rather than the chronological order in which they were obtained. A frequency count demonstrates no entries after first, second and third qualifications, for either lapsed or active registrants. This appears to have been an

undeclared policy practice by the UKCC and its successor, the NMC. During the 1990s post-registration training programmes and courses proliferated both within and outside the Health Service. The ENB Education Institutions and Programmes code book lists several hundred codes for such courses and programmes (ENB, 2002).

Current practice may not relate to the first qualification undertaken. Registrants with dual qualifications might pursue careers within the field of practice permitted by post-registration training. For example, adult nurses might take up psychiatric work after RGN training, whilst a mental nurse might move to a health visiting career after post-registration training as a general nurse. Employer type data provide an alternative perspective of the nature of current employment, though with its own inherent limitations. These issues will be discussed later concerning UKCC Irish nurses.

It is feasible that some nurses did undertake training for more than three parts of the Register. This would be highly unusual in face of the costs to service organisations, and it appears that these potential data were not being sought from registrants. There was some qualitative evidence from interviewees indicating hostility from clinical colleagues and managers towards those staff pursuing further training; one interviewee recalled being labelled a 'perpetual student' for undertaking more than one post-registration course, in addition to other educational opportunities.

Frequency counting for all lapsed first registration cases shows 0.7 *per cent* of entries to be unspecified. The same procedure for active cases elicits no unspecified cases. Policy demands in relation to maintaining a live Register might suggest perhaps a greater willingness to 'polish out' dirty data. It seems more feasible that greater rigour with regard to data collection and entry was being exercised by UKCC data managers (Norman, 2002).

Analysis of second qualifications for all lapsed registrants show only 25.7 *per cent* held a second registered qualification. For active cases this proportion rises to 33.2 *per cent*. This might indicate greater enthusiasm for further training by later candidates, though this assumption is undermined by the possibility that lapsed records are incomplete. However, recoding and filtering of active or live cases by registration date permitted some comparison.

Fever nurses show fewest entries - 639 active cases for either first, second or third registrations. Unlike other parts of the Register the lapsed cases here, totalling 2,079, outnumber active registrants. This can be explained by discontinuation of training for this speciality within the United Kingdom, and the subsequent closure of this part of the Register to new registrants. This reflects a professional training response to the decline of infectious disease as a public health issue and the post-war run down of the sanatoriums and fever hospitals. Cross-tabulation and filtering for this sub-group show 341 first registrations to be recorded, dates ranging between 1958 and 1975. Most first registrations, 186 valid cases, (54 *per cent* of valid cases), took place from 1961 to 1970. Only 30 valid cases were registered from 1971 to 1975.

More recent closure of parts of the Register relates to the discontinuation of training for 'second level' qualifications, otherwise known as enrolled nursing (This issue is explored in more detail within the literature review regarding the excessive number of minority ethnic nurses recruited into this second level entry gate, particularly the findings by Akinsanya (1988)). Alongside the establishment of a single level of entry, the UKCC Register also created four additional Parts - 12, 13, 14 and15 - when first level training for Parts 1, 3, 5 and 8 moved from certificate to diploma level.

Part 12, adult nursing, and its certificate predecessor, Part 1, general nursing, constitute the largest sub-category. Of Part 12 active cases, 69,720 are listed as a first qualification, Part 1 contains active 32, 9488 cases. The number of adult, or general qualifications, falls substantially, when acquired as a second, or third qualification. For second registered qualifications in adult nursing, there are 8,148 live cases and 16,366 lapsed cases. This shows evidence for the historical popularity of 'double training', a favoured route to further promotion or transfer to another field of practice. This would entail undertaking a shortened, post-registration course after initial registration, and perhaps a period of practice within that part of the Register. Typically, general nurses undertook midwifery or mental nursing as a second, post-registration training, whilst psychiatric nurses sought a general qualification. Mental handicap nurses favoured mental nursing as a secondary training option.

Far fewer nurses possess a third registered qualification. Many of the active and lapsed cases so qualified are likely to be employed within midwifery and health visiting. Historically, health visitors were required to undertake a registered training prior to commencing health visiting practice. This usually meant general

nursing, followed by midwifery. Entrance to midwifery training itself usually required previous registered general training. Direct entry courses for midwifery remain limited. Data for district nursing and occupational health nursing were not made available within the data file supplied by UKCC Information Services.

UKCC Irish Nurses

A similar pattern of returns persists compared to all UKCC cases above, when all active and lapsed Irish cases for the birth country and home country categories are counted (See Table 6.7). When comparing valid entries, by 'Irish' registrants for ethnic origin against home country, there were 53.4 per cent more responses.

Table 6.7: *A*ll active and lapsed Irish cases for the Birth country and home country

UKCC categories containing all 'Irish' cases	Frequency	Per cent	Valid per cent
Ethnic Origin (White Irish)	11,055	1.2	4.8
Nationality	15,235	1.6	5.6
Birth Country	16,778	1.8	4.0
Home Country	20,705	2.2	4.4

Though ethnic origin does not include a sub-category for 'Northern Irish', it is possible to contrast all active and lapsed valid data entries for nationality, birth country and home country.

Table 6.8: **UKCC categories containing all 'Northern Irish' cases.**

	Frequency	Per cent	Valid per cent
Nationality	1,703	0.2	0.6
Birth Country	13,923	1.5	3.3
Home Country	14,292	1.5	3.0

To assist analysis, a further Eire or non-Eire categorical variable was created from those cases coding Ireland as their country of birth. It is worth noting here that analysis of the Beishon data has already demonstrated that nurses born in Ireland and working the United Kingdom had entered mainland Britain as young adults. Previous analysis has shown that more than four in five of all Irish Beishon nurses declared their first employment to be nurse training in Britain (See Chapter Five). The remainder of the Beishon Irish nurses had obtained posts in the National Health Service, after qualification to practice in Ireland. The Beishon survey did not include nurses working outside of the British NHS.

Cross-tabulation of **active and lapsed cases** with the above 'born in Eire' variable revealed active cases to total 6,840 (1.1 *per cent*) of 627,602 live registered practitioners. Alternatively, lapsed Eire cases total 9,938 cases, or 3.5 *per cent* of all lapsed registrants, totalling 296,836 cases.

All active and lapsed cases, cross-tabulated with sex, show Non-Irish female and male cases to respectively total 826,197 (90.3 *per cent*) and 88,301 (9.7 *per cent*). For all cases, Irish women constitute 1.9 *per cent* of all female cases, a slightly higher percentage compared to Irish men, who represent 1.4 *per cent* of all men registered with the UKCC. For all Eire cases, females total 15,532 (92.6 *per cent*), against 1,246 male Eire cases (7.4 *per cent*). When filtered for active cases only, Irish men appear overall to be under-represented compared to their non-Irish, male counterparts.

Table 6.9: **Age range for UKCC active Irish nurses.**

Age range	Beishon Irish Nurses per cent	UKCC active Irish Nurses per cent	Beishon all Nurses per cent	UKCC all active cases per cent
21 - 30	22.3	21.0	17.6	21.2
31 - 40	48.9	52.2	36.5	35.1
41 - 50	19.8	21.4	27.2	25.1
51 - 60	7.0	4.6	18.2	17.7
61 - 70	2.0	0.8	0.5	0.9

The largest subgroup amongst UKCC Irish active nurses falls within the 31 to 40-years age band (See Table 5.9). At 52.2 per cent of all Irish cases, this suggests an ageing workforce. For non-Irish UKCC nurses, the largest sub-group falls within the same band. When this band is combined with that of the 41 to 50 years age band it is possible to see that Irish nurses, on average, are relatively younger than all other active cases. Beishon observed that Asian and black nurses are relatively ageing in contrast to all white nurses sampled by the PSI study (Beishon, 1995, p.149).

Nevertheless, proportionally far fewer Irish nurses were coming in to register to practice. Far fewer older, Irish nurses appear to remain on the Register towards retirement, in contrast to non-Irish colleagues. Only 5.5 per cent of UKCC, Irish nurses are registered to work beyond 51 years of age, unlike their non-Irish counterparts.

Table 6.10: **Active Irish registrants cross-tabulated by sex.**

Age range	UKCC active male Irish Nurses per cent	UKCC active female Irish Nurses per cent
21 - 30	22.0	13.0
31 - 40	52.4	50.1

Age range	UKCC active male Irish Nurses per cent	UKCC active female Irish Nurses per cent
41 - 50	20.4	29.3
51 - 60	4.4	6.4
61 - 70	0.8	1.3
71 - 80	0.1	0

Nursing as demonstrated by the data from the Irish active cases here remains a predominantly female occupation (See table 6.10 above), though the sex ratio of 89.5 *per cent* for women to 10.5 *per cent* for men, is closer to Black than White ratios as reported by Beishon (Beishon, 1995, p.147).

Date of birth

Date of birth for all cases was recoded to 'number of years old' at April 2002. This was recoded again to sub-categories by decennial groups. Further recoding allows statistical comparison with broad, ethnic groups, with Irish cases filtered from the White sub-category. Unlike Beishon (p.142), access to the original UKCC data allows descriptive analysis to establish average age for active UKCC nurses in 2002 (statistical mean=42.6 years, SD=10.3). Descriptive statistics for active, Irish nurses shows a younger average age, mean=36.84 years, SD =7.8. However the standard deviations show a wider spread of cases for all UKCC nurses. Average age rises slightly when mean is calculated for all UKCC non-Irish active cases (42.6, SD=10.3).

The largest sub-group amongst UKCC, Irish nurses falls within the 41 to 50-years age band. At 62 *per cent* of all Irish cases, this suggests an ageing workforce. For non-Irish, UKCC nurses, the largest sub-group falls within the same band. However, younger colleagues, between 41 and 50, follow closely as the next largest sub-group. Proportionally far fewer Irish nurses are coming in to register to practice. Also, far fewer numbers of older, Irish nurses appear to remain on the Register.

Irish sex, cross-tabulated against banded age distributions suggests fewer Irish men are entering nursing (13 *per cent*), when compared to Irish women for the same entry age group (22.0 *per cent*). Closer examination of the data in relation to age on entry is required to see if this is compensated by an older age group of men (29.3 *per cent*), who appear to be making a second employment career change, compared with female registrants within their age group (20.4 *per cent*). A great fall-off in registration begins after 40 years of age for both male and female registrants. The proportion of Irish men aged below 41 years is 64.1 *per cent*, whilst even more Irish women are aged below 41 years (74.4 *per cent*). At 51 years and beyond, there are far fewer active registrants, though a slightly higher proportion of Irish men - 7.7*per cent* continue to register in contrast to Irish women, at 5.2 *per cent*.

First registered training

As indicated by active Irish registrants, first registered training shows general and adult nursing to be the most common entry point, with over 70 *per cent* of all cases registering at first level (Table 6.11). Second level, or general enrolled, nursing falls behind at 7.4 *per cent* of all cases. First level mental nursing is slightly over at 13.1 *per cent*.

Table 6.11: Active Irish registrants first registered training.

First registered training	Number	Per cent
Health Visitor	6	<1.0
Midwife	126	1.9
RN Adult	614	9.0
RN General	4193	61.3
RN Mental Health	72	1.1
RN Mental Illness	820	12.0
RN Learning Disabilities	37	<1.0

First registered training	Number	Per cent
RN Mental Handicap	225	3.3
RN Children	24	<1.0
RN Sick Children	71	1.0
EN General (Eng & Wales)	503	7.4
EN Mental Illness (Eng & Wales)	73	1.1
EN Mental Handicap (Eng & Wales)	22	<1.0
EN (Scotland & Northern Ireland)	54	<1.0
Fever Nurse	0	0
Total	6,840	100

Cross-tabulation of Irish, active cases with *first registration training* and sex (Table 6.12) shows general and adult nursing to have a higher proportion of Irish female nurses - nearly 75 *per cent* of all female Irish cases, compared to 65 *per cent* for their non-Irish counterparts. Conversely, those women first registered for second level general nursing in England and Wales totalled 7.1 *per cent* for Irish cases, and 15.2 *per cent* for all non-Irish cases.

Table 6.12: **Cross-tabulation of Irish and non-Irish active cases by sex and first registered training.**

First registered training	Active non-Irish nurses				Active Irish nurses			
	Female		Male		Female		Male	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent
Health Visitor	1,484	<1.0	45	<1.0	6	<1.0	0	0
Midwife	14,966	2.7	19	<1.0	126	1.8	0	0
RN Adult	62,373	9.9	6733	1.2	573	8.4	41	<1.0
RN General	30,385	48.4	2,141	<1.0	3,985	58.3	208	3.0
RN Mental Health	10,634	1.7	5,158	<1.0	56	<1.0	16	5.1
RN Mental Illness	22,020	3.5	15,597	2.5	471	6.9	349	<1.0
RN Learning Disabilities	2,864	<1.0	834	<1.0	33	<1.0	4	<1.0
RN Mental Handicap	75,79	1.2	3,799	<1.0	185	2.7	40	<1.0

First registered training	Active non-Irish nurses				Active Irish nurses			
	Female		Male		Female		Male	
	N	Per cent	N	Per cent	N	Per cent	N	Per cent
RN Children	8,478	1.4	454	<1.0	23	<1.0	1	<1.0
RN Sick Children	3,998	<1.0	75	<1.0	70	<1.0	1	<1.0
EN General (Eng & Wales)	95,632	15.2	3,731	<1.0	484	7.1	19	<1.0
EN Mental Illness (Eng & Wales)	8,622	1.4	3,453	<1.0	42	<1.0	31	<1.0
EN Mental Handicap (Eng & Wales)	3,256	<1.0	1,265	<1.0	19	<1.0	3	<1.0
EN (Scotland & NI)	17,442	2.8	1,454	<1.0	49	<1.0	5	<1.0
Fever Nurse	341	<1.0	1	<1.0	0	0	0	0
Total	56,353	100	64,028	100	6,122	100	718	100

Employment

Frequency counting shows Irish nurses to be listed within every employer type coded by the UKCC; 5,583 active valid cases are recorded (See Table 6.13). Furthermore, only 1,257 cases have missing data on employment (18.4 *per cent*).

Most Irish nurses are employed within the public sector, though mainly within National Health Service organisations. There are five, identifiable private sector employers (PSE) listed. For purposes of analysis, it is not possible to include sub-categories for 'practising outside UK' or 'occupational health'. These are likely to include private sector employers, for example the oil industry. However, it is also possible that nurses are working for charitable agencies, or public sector occupational health services. Though Irish nurses here are small in number, there were a significantly greater proportion of men employed within all of these aforementioned non-NHS employer types. Within PSE types, of 877 cases, 11.7 *per cent* are male. The ratio within nursing agencies rises to 13.9 *per cent* males for 330 cases. It should be noted that 'independent practice' probably includes a large percentage of midwives, thus the relatively low number of men identifiable.

A similar case can be made for NHS primary care, which includes a large number of community midwives, district nurses and health visitors. Of 234 cases here, only 5.4 *per cent* of the registrants are male. In contrast, of 311 NHS Trust mental health cases, 56.3 *per cent* are male registrants. Primary care is a desirable career route for many registrants (Beishon 1995). The data for educational institutions also indicate excess male representation amongst academic staff. Of 89 cases, 20.2 *per cent* are male. This provides an interesting hint regarding career development. The NHS Nurse Regrading Exercise in 1988 saw a common, clinical spine established for UK nurses (Disney and Gosling, 1998), this ranking exercise also drew in nurse tutors employed within the NHS. They had been previously linked to nurse managers with regard to remuneration arrangements, their pay exceeding that of ward sisters and their male charge nurse equivalents. Beishon, rather oddly, does not refer to this significant career route for nursing and midwifery staff, and the sample frame fails to include such non-clinical staff.

There is then a considerably more uneven sex distribution across different NHS employer types, with certain agencies differing widely from the overall average. Unfortunately, with the exception of educational institutions and primary care data, the UKCC employment dataset does not provide much comparable detail regarding career attainment. Nevertheless, qualities for career success can be inferred from some of these data and other information regarding level of registration and speciality.

Table 6.13: **Employer type for active, Irish nurses by sex.**

Employer type code	Irish female	Irish male	All Irish
500 NHS Hospital, NHS Trust or DMU	1,261	135	1,396
505 Private hospital	259	22	281
510	26	5	31
515 General practitioner	135	3	138
520 Educational institution	71	18	89
525	13	4	17
530 Nursing agency	284	46	330
535 Nursing home	84	14	98
540 Independent practice	540	4	34
545 FHSA	355	37	39
550 Industry	36	6	42
555	5	2	7
560	35	7	42
565 Other	246	15	261
570 NHS Trust acute	964	81	1,045
571 NHS Trust mental health	199	112	311

Employer type code	Irish female	Irish male	All Irish
572 NHS primary care	572	12	234
573 NHS other	120	7	127
574	169	22	191
575	8	7	15
576 Occupational Health	39	3	42
577 Local Authority	12	3	15
578 Practising outside UK	361	50	411
599 Not currently practising	33	1	34
Total	4967	616	5583

Creation of a *Northern Irish* category from the country of birth data shows 13,923 valid cases, or 1.5 *per cent* of all registrants. Filtering for active cases only reveals a slightly higher proportion of Northern Irish nurses currently registered to practice. This contrasts with the findings for Irish nurses above.

National Training Boards

First National Board training shows 9,279 registrants, 55.3 *per cent* of all Irish cases, did not list any of the four UK National Boards as the first point of registration (See table 777). This suggests either failure to record this entry, by either registrants, or data entrants at the UKCC. Alternatively, these registrants might have undertaken their first registered training elsewhere, rather than through British nursing schools, nursing colleges or higher educational institutions, or pre-registered training was undertaken prior to the establishment of the UKCC boards.

When Irish cases cross-tabulated for first Board training were filtered for active entries only, the proportion of all National Board, Irish cases rises to 59.6 *per cent* of all cases for Irish born entrants (Table 6.14). Therefore, amongst active Irish registrants there are 40.4 *per cent*, or 2,763 cases which have not been identified to a UKCC Board. This may include those Irish nurses who trained in Ireland, or elsewhere overseas. It may also include older registrants qualified before the establishment of the UKCC Boards.

Table 6.14: Irish active cases and Board training.

UKCC First National Board Training containing active 'Irish' cases	Frequency
No Board, other UK, or overseas pre-reg training identified	2,763
English National Board	3,068
Northern Irish National Board	604
Scottish National Board	332
Welsh National Board	73

The English National Board (ENB) appears to have easily recruited the largest number of all active and lapsed pre-registration student nurses from Ireland at 5,993 registrants, or 35.7 *per cent* of all active and lapsed Irish registrants. As a proportion of all National Board Irish recruits cross-tabulated, but excluding those not listing a UK Board, this rises to 80.5 *per cent*, from a total of 7,499 active and lapsed cases.

Filtering for ENB active cases totals 3,068, or 44.9 *per cent* of all Irish active cases. As a proportion, of all active National Board, Irish recruits, the proportion of Irish ENB cases increases to a total of 75.3 *per cent* (totalling 4,077 cases).

Irish ENB cases make up 34.4 *per cent* of all lapsed Irish cases, including non-Board entries. Table 6.15 below shows proportions of Irish cases between UKCC Boards. This shows the largest sub-group, 2,925 Irish ENB cases, easily outnumbering 299

Irish Northern Irish Board (NIB) cases. The proportion of lapsed Irish ENB cases, 85.5 *per cent*, for all Irish Board cases, compared to the same calculation for active Irish ENB cases, 75.3 *per cent*, suggests a decline in Irish recruits to English, nurse-training schools.

Irish all Board lapsed cases, at 34.4 *per cent* as a proportion of all Irish lapsed cases, can be compared against the same calculation for Irish active cases, at 59.6 *per cent*. This might suggest a significant overall decrease in the number of Irish-born nurses seeking registration to practice with the UK and Northern Ireland Boards. However, the larger proportion of non-Board, Irish registrants is likely, at least in part, to be a historical effect as discussed above. It seems more reasonable to consider calculations conducted on Board subjects only to possess greater validity, as for example with the apparent decline in Irish ENB registrants.

Table 6.15: Percentage of Irish cases between National Boards.

UKCC First National Board Training containing lapsed 'Irish' cases	Frequency	Per cent of all Board Irish cases
No Board identified, or other UK or overseas pre-registration training	6,516	N/A
English National Board	2,925	85.5
Northern Irish National Board	299	8.7
Scottish National Board	172	5.0
Welsh National Board	26	0.8

The next largest active, Irish sub-group gave the Northern Irish National Board as their first training destination - 903 registrants (5.4 % *per cent* of all cases, or 12.0 *per cent* of UK Boards). This raises a question as to whether these are Eire- born students entering Northern Ireland, or whether Northern Irish-born student nurses have expressed a political identity affiliation not catered for by the Register data returns design.

Nevertheless, NINB active 'Irish-born' cases remain the second largest UK Board sub-group, with 604 cases, or 14.8 *per cent* of all Board cases. Historically, this is consistent with the lapsed, NINB Irish cases, they also formed the next largest sub-group, of 299 cases.

Scotland, rather than Northern Ireland, offers potentially more training places, but falls some way behind Northern Ireland in taking only 504 Irish student nurses to registration (3.0 *per cent* of all cross-tabulated cases, or 6.7 *per cent* of all UK Board cases). This is remarkable when Non-Irish registrants from the Scottish National Board (SNB) and The Northern Irish Board (NIB) total 99,639 and 28,544 cases respectively. Active filtering for Irish SNB cases reveals 332 cases, or 8.1 *per cent* of all Board cases. Wales, with rather more training places to fill than Northern Ireland, only produced 73 Irish-born active cases (1.8 *per cent* of all Board cases), from cross-tabulation of Welsh Nursing Board (WNB) entries.

Cross-tabulation of the 'born in Eire' category with the first registered qualification shows RGN and adult P2000 training to be the most common options. Unlike their non-Eire colleagues, a substantial proportion of Irish nurses took up mental health nursing as the second most common training option for Irish nurses. There were also a substantial number of enrolled nurses. Note the ratio of speciality nurses against each other within and across first and second level training.

Health visiting and midwifery are the most common second or third training for all cases. It is intriguing to see that fever nursing does not possess any Irish born registrants.

Data regarding Second and Third Board training provide worthwhile data on career progression and potential information on equal opportunities. Before the development of higher educational programmes targeting health care professionals, training and other educational development was substantially within the gift of health employers. As stated above, 'double training', or the acquirement of a more than one first level registration was a recognised pre-requisite for promotion within the same speciality. Hospital-based nurses seeking a move into community or midwifery work would also need to undertake further training within that field of practice.

Northern Irish nurses

Northern Irish nurses, or rather those declaring themselves born in Northern Ireland within the birth country category, total 13,923, of whom 2,354 cases are active registrants. Cross-tabulation, with first Board training shows members of this sub-category for all active and lapsed cases to have undertaken their initial pre-registered training within Northern Ireland (82.5 *per cent*). ENB registrants formed the second largest sub-group, with 1,410 cases, or 10.1 *per cent*. A total of 483 registrants (3.5 *per cent*) had entered Scottish schools. Few pursued a Welsh Board training (0.4 *per cent*). It is worth noting that only 502 cases did not specify UKCC Board training. It is possible that some of the registrants opted to train in Eire, aside from other options referred to regarding Irish cases previously considered above. However, of all valid cases for active and lapsed, Northern Irish registrants, only 3.6 *per cent* did not identify a UKCC Board for first training.

Postcode as an indicator of settlement

This section considers analysis of findings from the UKCC dataset concerning postcodes given by 'live' registrants residing and working within Britain. These data potentially allow some understanding of settlement and assimilation regularities for different, minority ethnic groups working in British nursing.[5] These data are of particular interest when considering historical settlement against contemporary patterns of migration, not least the claim that Irish settlement more broadly follows the African Caribbean example (Walter, 1989).

Some caution should be exercised as to what might constitute permanent residence for a professional occupation characterised by relative youth and single status, as is

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[5] Postcode data concerning nurses resident in Northern Ireland show that Belfast codes totalled 7,161 cases, of which 4,786 designated themselves British White, 2306 Irish White and 49 chose Other White. All other ethnic groups in Belfast total less than 20 cases. (3.3 per cent of all Table 6.16 cases). This data closely correlated with broader patterns of settlement according to religious affiliation of employees within the private sector in Northern Ireland (Shirlow, 2004).

particularly the case for Irish nurses compared to other minority ethnic groups. The reported higher occupational mobility of minority ethnic nurses should also be noted (Beishon, 1995).

Neither can the findings reveal longitudinal patterns, since the dataset only contains postcode data for current addresses given at the time of either initial registration or renewal. However, the effective enforcement of registration by employers gives some weight to the claim of the Register to be representative of nurses working in the UK. The latter legal and professional requirement is enforced every three years to maintain a live Register of nurse practitioners.

Further limitations should be recognised with regard to incomplete records for individual cases. This is especially true of data on ethnic identity (see Table 6.16). Of 634,442 active total cases, 216,456 (34.1 *per cent*) gave both ethnic identity and postcode responses.

Table 6.16: **Active cases giving ethnicity and postcode**

Self identified ethnic category	Number of active cases
British White	177,455
Irish White	10,057
Other White	6,072
White Black Caribbean	408
White Black African	202
White Asian	361
Any other mixed	646
Indian	1,883
Pakistani	246

Self identified ethnic category	Number of active cases
Bangladeshi	330
11	3,530
Black Caribbean	5,087
Black African	5,411
Any other Black	412
Chinese 15	2,947
Any other ethnic group	924
99	485
Total	216,456

Ethnic origin (2001 Census categories) and post codes

The total number of active Irish cases here equals 11,055, or 4.8 *per cent* of all respondents who gave both ethnic origin and postcode details. They represent the second largest group after 'White British' respondents, who total 188,780 cases, or 81.8 *per cent* of respondents giving ethnic origin and postcode details (See Table 5.17 below).

Table 6.17: Respondents giving ethnic category and postcode

Ethnic Origin (2001 Census categories)	Frequency	Percent
White British	188,780	20.3
White Irish	11,055	1.2

Ethnic Origin (2001 Census categories)	Frequency	Percent
Any other White Background	6,950	0.7
White & Black Caribbean	422	0.0
White & Black African	216	0.0
White and Asian	384	0.0
Any other Asian Background	680	0.1
Indian	1,971	0.2
Pakistani	262	0.0
Bangladeshi	333	0.0
Any other Black Background	3,671	0.4
Black Caribbean	5,422	0.6
Black African	5,611	0.6
Any other Black Background	437	0.0
Chinese	3,187	0.3
Any other Ethnic Group	957	0.1
Declined to Notify	542	0.1
Total postcode entries	230,880	24.8
Missing postcode entries	700,398	75.2

Ethnic Origin (2001 Census categories)	Frequency	Percent
Total	931,278	100.0

Not surprisingly perhaps, the largest number of minority ethnic nurses whose postcode data are summarised here (See Table 6.17 above) gave London postal addresses. It is worth noting that the postcode data for black Caribbean and black African categories are particularly concentrated in greater London, with a very heavy concentration of African, black postcodes in South London. In comparison, Irish nurses are far more widely dispersed across the South East of England, with far fewer cases appearing in those pre-war areas historically associated with Irish migration, notably Glasgow, Birmingham and Liverpool. Unlike their Asian and Black colleagues, Irish nurses have settled substantially beyond the major urban conurbations.

London postcodes

The UKCC dataset contains reliable postcode data for 'active' cases. The information supplied identifies the post town or district. London postal districts largely cover a radius of five miles from the centre of the city.

In comparison, frequency counts show most black African registrants citing residence within Eastern districts of Greater London. The highest concentration of black African postcode cases occurs in South East London, with 794 cases. The postal district of Peckham, SE15, towards central London, showed a frequency count of 93 cases; this district contained the highest number of any minority ethnic nurse category within all postal districts of Greater London (Table 6.18).

Table 6.18: **Number of Black African nurses per London postcode area.**

London post code areas	Black African nurses by area
NW London	208
N London	378
East London	564
City of London	19
W London	794
SW London	282
Total	2,245

Adjoining districts to Peckham also contain above average numbers of black African registrants: SE1, 61 cases; SE17, 61 cases; SE5, 50 cases; SE8, 42 cases. A further concentration of cases lies within two postal districts further eastwards towards Essex: SE18 with 66 cases and SE28 containing 50 cases. Neighbouring districts within East London, also bordering Essex, contain above average numbers of African cases - see details below for East London findings. Overall, there is a considerably uneven distribution of cases across all South East London districts, from two cases in SE24 to 93 cases in SE15.

The postcode area of West London, after the City of London, contains the least number of identified black African postal codes, with a total of 72 cases. Four postcode districts here contain no black African cases. Slightly higher numbers of cases were counted for the adjacent areas of North West London and South West London - 208 and 282 cases respectively.

A frequency count of active Irish nurses shows Irish nurses to be resident within every postal district of Greater London, with two exceptions, NW8 and St. John's Wood, in North West London. A fairly even distribution across London postal

areas, with the exception of the City of London (See Table 6.19), masks a more uneven distribution within postal districts.

Table 6.19: **Postcode area totals for Irish nurses**

London postal Areas	No. of Irish nurses by area
NW London	116
North London	174
East London	178
City of London	25
SE London	169
West London	132
SW London	125

Irish nurses living north of the river total 493, compared to 426 nurses living southwards. On the Northern outskirts of East London E17 contains 41 cases, with two adjoining districts; E4 and E18 respectively show 16 and 33 cases each. District E17 and its neighbour, E11, hold the highest number of Irish cases within London. The greatest concentration of postcodes in South East London falls in SE15 (11 cases), SE22 (20 cases) and SE23 (14 cases). Another concentration of addresses runs out of South East London covering the adjoining districts SE11, SE22, SE123, SE26, and SE612.

In South West London, codes are particularly concentrated towards outer postal districts; SW17 (20 cases), SW14 (14 cases). The next three highest districts in SW London, SW16, SW18, and SW15 adjoin them and form the outer boundary of SW London (See discussion below regarding outer postal districts).

A more disparate picture is evident in West London. Two concentrations exist, one towards the City of London (W9,10 cases; W11,18 cases; W1, 9 cases) and a belt of districts across the outskirts of W London, W7, 25 cases; W13, 9 cases and W4,11

cases. In North West London, three adjoining districts, which largely form its western outer boundary, show a cluster of codes: NW10, 26 cases; NW2, 25 cases, NW15, 15 cases; NW7, 9 cases. No cases were identified for NW8.

A string of post districts runs from N1 flanking the City towards the outer boundary of N14, with 10 or more cases per district. N1,12 cases; N7,10 cases; N19, 11 cases; N8,12 cases; N10,15 cases; N13,13 cases; N14, 11 cases.

There are 35 postal districts in total in the Greater London ring. Of these, 19 contain nine or more Irish cases each, including the four most densely occupied postal districts within London: E17, 41 cases; E11, 33 cases; W7, 25 cases; NW10, 26 cases.

The overall range of Irish cases for the North London postal districts is more limited (3 to 15 cases), in contrast to other London postal areas (see table 6.20).

Table 6.20: **Range of cases and mean average Irish cases for each London postal area.**

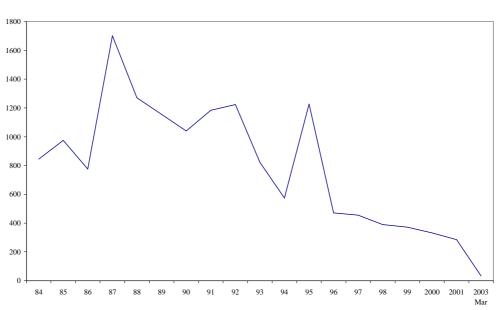| London Postal Areas	Range of Irish cases within each district of postcode area	Mean average mean Irish cases for each postal area
NW London	0 - 26	(9.5)
North London	3 - 15	(7.9)
East London	2 - 41	(9.9)
City of London	0 - 12	(5.0)
SE London	1 - 20	(5.8)
West London	2 - 25	(9.4)
SW London	0 - 20	(6.6)

A substantial majority of Irish nurses registered to practice live in outer London. Of 919 Irish nurses giving London post addresses, only 2.7 *per cent* identify City of

London post codes. When adjacent codes are included this percentage only rises to 80 cases (8.7 *per cent*): N1, E2, E1, SE1, W1, NW1.

Even when including districts that fall adjacent to the above districts: N7, N5, N16, E8, E9, E3, E14, SE16, SE15, SE5, SE17, SE11, SW8, SW3, SW7, W2, W9, NW8, NW3, NW5, this only rises to 196 cases, or 21.3 *per cent* All of these inner London postcodes approximately fall within a two mile limit of the centre of London.

The UKCC and National Board statistics revealed here show a pattern emerging in relation to regional staffing needs. Wales, Northern Ireland and Scotland are able to recruit locally whilst exporting surplus labour to England. English registrations further reflect labour demands within the South East of England, including London, so Irish nurses can be seen to be following contemporary labour market patterns.

A longitudinal viewpoint can be extracted from these cross-sectional data, by recoding date of first recorded qualification and annual frequency counts of Irish, active and non active cases. The latter have been included here to build up a longer-term perspective. UKCC data cleaning policy formally retained lapsed records for ten years after payment of fees discontinued.

Figure 6.1: **Annual number of UKCC Irish registrants 1984-2003**

Figure 6.1 above shows the number of Irish nurses annually registering their first recorded qualification with the UKCC. There are clear falls and rises, from a highpoint of 1,702 nurses obtaining their first recorded registration, to a low of only 285 Irish nurses obtaining registration in 2001. It should be borne in mind that registration would take place after three years of training. In relation to employment opportunities in Ireland, official unemployment figures for those registered available to work had fallen from 126,400 in 1998 to 65,000 in 2001 (CSO, 2006). Analysis of annual UK registration data for the Beishon dataset also shows a sharp rise in registrations from 1987 onwards for Irish-born nurses, reaching a peak in 1992.

CONCLUSION

The data are limited in terms of the overall number of variables in comparison to the Beishon study, but this analysis confirms that the sheer size of the dataset does offer substantive descriptive findings. There are also additional findings not previously revealed by Beishon. With regard to the Beishon analysis it not only confirms the continuing presence of large numbers of Irish men and women working as nurses in the UK, particularly within the NHS, it also demonstrates that they remain the leading ethnic minority group. However, examination of annual registration data show fewer Irish cases are appearing on the register. Nevertheless, significant numbers of Irish nurses continue to register to practice in the UK, this appears partly to be a continuing effect of economic core periphery relations.

Analysis of employer data show that Black and Asian nurses, unlike their Irish counterparts, are excessively represented within the nursing home and agency sector, this is also a gendered issue. This sector has been characterised as an employer of low paid, largely female and frequently part time staff (Laing & Buisson, 2004, p.53). Conversely, Irish nurses are over represented within the primary market of the NHS, which potentially offers nurses, as Beishon recognised, internal career structures, unionisation and opportunities for better working conditions and training. Again, analysis of speciality and employer data show that Irish nurses within this market are over represented in general acute care, children's' nursing, midwifery and community posts.

They also have an especially strong presence within education. This is a particularly prized segment of the nursing labour market, with significant improvements in conditions of work and promotional opportunities in comparison to clinical labour, within either the NHS, or peripheral areas like the nursing home and agency sector. Though employment within the university sector seems somewhat removed from the NHS, it is intimately bound to the latter through its historical presence within the health service and extensive contracting for nursing education and research activity.

Particular findings of note here include the statistical over representation of men in higher education, this is especially with important with regard to status and financial remuneration discussed above. Comparatively large numbers of Irish men also figure within the mental health sector, both within the data for employers and first registrations. Adult nursing and learning disabilities appear to be less popular choices, the statistics show significantly fewer Irish men either qualified or working within these fields of practice. The data also show that qualifying to work in learning disabilities is also a less attractive option to Irish women.

Fever nursing attracts no Irish, either historically, or amongst the handful of the remaining active cases. More importantly, the data also show that fewer numbers of Irish women and men figure on the register in enrolled nursing in comparison to other non-white minority ethnic groups. Both of these registrations are now obsolete as training options. However, far larger numbers of enrolled nurses remain actively on the Register, and according to these data they can be found working in significant numbers in the NHS and other sectors of employment. According to Seccombe *et al.* (1997) enrolled nurses faced considerable difficulties in attempting to retrain as first level registered nurses, despite UKCC policy supporting this option.

In conclusion, this chapter builds on the empirical analysis and policy critique within Chapter Five. It also provides further empirical evidence of career progression for Irish nurses, especially in comparison to potential competition from other minority ethnic groups. The theoretical and policy implications of this analysis, already signalled within the literature review and problematic chapters, will be further addressed in the concluding chapter of the thesis.

CHAPTER SEVEN

CONCLUSION: IRISH NURSING CAREERS IN THE NATIONAL HEALTH SERVICE

INTRODUCTION

This thesis uncovers an important part of the hidden lives of Irish nurses working in the NHS. Historical and contemporary sociological accounts have tended to emphasize the experience of an out-group, whether in historical terms of refugees fleeing the great famine, or in distinctly gendered post war analyses of Irish migrants literally reconstructing a new Britain. In terms of gender and class, the exploration here of the career experiences of Irish nurses challenges and enriches our assumptions and understanding of the working lives of Irish people in Britain.

This chapter will finally summarise the key points from these novel findings and consider their contribution to theory and policy on ethnicity and nursing in the UK, in particular, how this work informs the very limited existing literature on the presence of Irish nurses as a social category in the British NHS.

The historical background of Irish emigration to Britain was previously established within Chapter Two, this also considered the core periphery conditions that shaped the particular economic and social experiences of Irish women taking up nursing in the UK. Race relations were also explored in the context of the exploitation and discrimination encountered by black and Asian people entering the British post war labour market, specifically those recruited to work in the National Health Service.

The problematic of identity was critically addressed in Chapter Three. This established the validity of ethnic categorisation and examined the theoretical implications of reinstating Gramsci's original conception of subaltern status, against the celebratory perspective of the Indian Subaltern studies movement. The analysis then moved on to considering the habitus surrounding nursing supervision at the everyday level, and critiqued the particular practices which could potentially exclude, or marginalise those held to be unsuitable. The following chapter on methodology and methods presented the justifications for the dominant less

dominant empirical design that shaped the subsequent data analysis. The procedures for the mixed methods deployed were also described and defended in detail.

The resulting analytic chapters moved on to map out and then triangulate findings from the two primary data sets with regard to the particular features of career pathways and the relative success enjoyed by Irish nurses. Further, the analysis has discovered through exploring unpublished data how this ethnic group has compared to other Subaltern groups working in the National Health Service. The analytic chapters also reported on where qualitative data confirmed these data, and provided contradictory cases.

Qualifying success for Irish nurses

I want to revisit at this point some epistemological implications of the empirical inquiry conducted by Beishon. The implicit conceptualisation of race within the Beishon report reflects a broader focus within race relations theory and policy. Yet this key study had effectively blocked interpretation of any data gathered on the career experiences of Irish nurses. Hickman and Walter have more broadly argued for the necessity of recovering the lost narratives of an Irish diaspora abroad (Hickman & Walter, 1997). Their own critique has suggested that the Irish in the UK continue to suffer discrimination and marginalisation. Understanding the experiences of Irish nurses training and working in the UK would make an important contribution to that debate. Nursing was, and remains, an important occupational choice for that migrant group.

A problematic here lies in the challenge of understanding Irish identity in terms of race and ethnicity, thus enabling an empirical exploration of its extant and hidden features for the actors concerned. This has been a reoccurring theme throughout the thesis with regard to the theorization of Irish identity. Carter offers a theoretical and methodological passage for sociological research (Carter, 2000). First, by deploying analytical dualism, it becomes necessary to distinguish between systemic integration and social integration for this group, and other potentially competing groups of actors (Carter, 2000, p68). So British post war polices may have generally encouraged systemic integration of Irish workers, albeit in a laissez faire fashion, to meet pressing labour shortages, notably within the expanding NHS. On the other

hand, the literature offers extensive evidence of discrimination against emigrants from the so-called New Commonwealth alongside residual hostility to the Irish (Ryan, 2004). So this potentially differing experience for these groups of actors can be explained, in terms of analytical dualism, by their possession of distinct properties and temporalities. The varying peripheral relationships of Ireland, post colonial attitudes towards whiteness, citizenship and wartime restructuring have respectively benefited Irish women against later black African incomers concerning system and social integration (Castles & Miller, 2003, p.73). These cultural advantages would be particularly important in making sense of relational habituses, and negotiating power relations under the gaze of nursing experts.

Second, it is necessary to distinguish how Irish nurses have been distinguished as collective actors and agents in two forms of social context, which condition their social activities, situational and structural, which posses differing capacities and emergent properties. At the micro level situational interactions can be influenced by what is determined by the actor, for example, the whether to pursue further training opportunities as a midwife or health visitor, or to ascribe themselves as Irish or British in Northern Ireland. But in pursuit of these goals subaltern groups must successfully align themselves with the dominant discourse. To achieve successful affiliation, through for example competent role performances as a 'reflective practitioner', demand access to certain knowledges and skills in social interaction. This also means managing to rise above potentially ascribed negative stereotypes associated with ethnicity and gender.

A gendered division of labour operates for Irish men, who appear to continue to construct themselves as suitable candidates for work in mental health, though interestingly not learning disabilities. They have also successfully pursued promotional opportunities within education and clinical management, and so conforming to the role patterns of their British and Asian male counterparts (Dingwall, 1972; Porter, 1992). The potential for patriarchal relations to work towards the material benefit of men in a feminised profession, as signalled in Chapter Three appears justified by examination of the Beishon and UKCC data.

The statistical over representation of men in these areas of employment, again evidenced from analysis of the Beishon and UKCC data, shows here that such self representations have a higher degree of influence over such emergent definitions of

reality and self identity. The data shows this not only through their statistical over representation within these occupational roles, but, also as a key independent variable within the log linear regression model of clinical career success.

The methodology employed within the thesis has depended heavily on substantial amounts of data extracted from existing quantitative datasets. The process of evaluation here has engaged in exhaustive detailed description. I have sought to avoid a view of linear causality, not least in testing hypotheses that cannot unpack the complexities of open systems. I accept the contention of Pawson and Tilley that "experimental evaluation either ignores these underlying processes, or treats them incorrectly as inputs, outputs or confounding variables, or deals with them in a *post hoc* and thus arbitrary fashion" (Pawson & Tilley, 2006, p.54). Aside from causal modelling within the Beishon chapter, I have also largely tried to resist what Bryman (1998) has termed the management metaphor in exploring this data. My intention has been to allow where possible the statistics to speak for themselves, even at some length, in developing a more naturalistic account. Interviews have additionally unveiled a richer and more in depth perspective on the meaning of categorization at the personal level.

However, such self-definition in specific episodes of situated activity does not drive a broader stratified reality (Layder, 1990, p.132). This is evident in the history of the nurse trade described in the literature review, which clearly emerges from the post colonial and imperial political and economic relations between two capitalist societies whose social mechanisms drive their reproduction. Particular contingent events, such as the collapse of family farming in Pre-war Ireland, and the consequent economic and social exclusion of Irish women create a ready labour supply. This reserve army of labour is continually drawn into the post war British welfare state, which is easily able to exploit core peripheral relations with Ireland to its own benefit. Such particular contingent events then shaped the otherwise irreducible embeddness of mechanisms in a historically sedimented social reality, which has not lost its historicity or particularity (Manicus, 1998, p.324-325). So there are possibilities for exploitation by contemporary social actors and agents, some of whom may have resources structurally unavailable to others, not least in climbing the potential career ladder of nursing within the British National Health Service. So a subaltern identity status for Irish nurses carries different consequences for

allocation of resources in comparison to other competing subaltern groups entering into British nursing.

A more complex account of discrimination and opportunity for varying groups of social actors has therefore been distinguished in the findings, the cost of success appears to be at the expense of black and Asian colleagues through job queuing, that is employers giving preference to white Irish applicants over other non-white minority ethnic groups. Moreover, Irish men are at the front of the queue, notably in academic posts and mental health, as previously argued above and clearly evidenced in the preceding analytic chapters. Irish women do not pursue careers in mental health in similar proportions; this may be a product of gendered assumptions about mental health work and its lower comparative occupational status in Ireland. Nonetheless, they appear to succeed in their choices elsewhere. Irish women are particularly successful in entering midwifery, health visiting and higher status specialities of medicine and surgery within general nursing. It is worth noting direct entry is not the usual portal of entry to midwifery and health visiting, successful applicants have usually undertaken general or adult nurse training as a necessary prerequisite. Irish women have an exceptionally high profile within midwifery as illustrated by the descriptive data, and again midwifery has been a key secondary qualification to professional advancement in general nursing. They are also less well represented within enrolled nursing, unlike their black and Asian counterparts.

Gramsci did not wish to celebrate subaltern groups, his analysis recognised their diversity, but he was well aware of their attempts to replace the dominant class formation with their own hegemonic prescriptions, he also foresaw relative success in affiliating themselves to dominant groups. The structural context here exerts a much more refractory process on black and Asian nurses seeking as collective actors to improve their occupational status through specialization and promotion. There is no evidence of solidarity here across subaltern groups, though it is intriguing to see that the quantitative and qualitative data indicates they are more likely, than their English white colleagues, to admit that racial discrimination occurs against non-white colleagues. The analysis of supervision shows the potential for discrimination, as Jenkins (1996, p.142) suggests, sharing occupational identity still leaves room for discrimination against those who are individually suitable in terms of achieved

competence, but not acceptable because they are an ascribed category, black, or women.

There is little evidence of direct discrimination within the Health Service against Irish nurses, either within the literature reviewed above, or through the empirical data gathered for the thesis. The latter qualitative data again suggests some individual actors were able to exploit situational contexts as suggested by Jenkins with regard to negotiation at the organisational boundary (Jenkins, 1996, p.141). The interviews indicate wider opportunities with regard to social and occupational mobility for Irish nurses moving to Britain, particularly those moving up the managerial career ladder. This greater mobility was demonstrated in the Beishon data and interviews. These people might therefore be considered primary agents, in that settlement choices for them are constrained by a range of historical and contemporary exclusionary measures. Cross sectional analysis of the UKCC postcode data also begs further questions on external and internal migration. Not least, the extraordinary ratio of Irish nurses to British White nurses working outside of the United Kingdom; this might be partially explained by people returning to work and live in Ireland, which is lent some weight by analysis of Irish registration data by Yeates (2004). Further longitudinal analyses and cases studies would help establish if regularities are emerging here.[6]

The study does not therefore unpack the experiences of nurses returning to Ireland, this would warrant a further thesis in its own right, a feasible project given that the Irish Registration Authority, An Bord Altranais (ANA), maintains a database of with many similar features to that of the British Nursing and Midwifery Council (NMC). The author has been granted permission to access a randomized sample from the ANA register with the intention to pursue further study of this phenomenon.

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[6] Future studies would possibly benefit from adopting a case analysis methodology. Other longitudinal perspectives, such as event history modelling, as advocated by Pawson and Lilley on ad hoc studies would also be advantageous in understanding career progress and exclusion.

Structural conditions within Ireland have had an enormous impact on broader employment issues. The overall decline in unemployment within the last decade coupled with increased alternative opportunities for women is closely correlated with the overall decline in registrations from the UKCC data up to the early years of the twenty first century. However, Ireland remains a peripheral economy especially vulnerable to downturns in the global economy and shifts in international financial markets.[7] This study has also not addressed particular and complex issues of discrimination within Northern Ireland and the consequent impact on its human geography, this topic would also merit a thesis in its own right.[8]

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[7] The Irish Government Central Statistics Office released data showing that Irish unemployment was at its highest for thirteen years, taking the unemployment rate up to 11.8 *per cent.* Ireland was the first euro zone country to enter recession and has the second-worst jobless rate within the European Union, second only to Spain. Meanwhile, the number of people claiming jobless benefits in Ireland has nearly doubled over the last 12 months to 418,592. In June, 2009, 21,721 more people were claiming unemployment benefits than had been in the previous month.

Ireland experienced a property boom since the late 1990s, with multinationals arriving to take advantage of one of the lowest corporate tax rates in the euro zone. However, the ailing housing market has had a major impact on the economy and property prices have plunged by more than 40 *per cent* since their highest point in 2006. In April, the country's Government unveiled an emergency budget after admitting that the country's budget deficit was spiralling out of control.

[8] Shirlow (2006) has specifically drawn attention to the effects of occupational and residential segregation now existing in Northern Ireland. Catholic disadvantage in labour market experiences within Northern Ireland during the 1990s was well documented, though the causal factors remain contentious. A study by Gudgin and Breen (1996) emphasises religion-based 'behavioural' differences, which affect fertility, migration and 'job-quitting'. This 'cultural' account, though recognising higher levels of Catholic migration, does not acknowledge unemployment as a function of labour market position and socio-economic position. Moreover, the writers attempt to refute 'systematic discrimination'. Sheehan and Tomlinson (1998, p.451) identify a number of sociological and policy processes which influence this labour market. These include complex social and economic processes which produce occupational crowding and segmentation, and polarisation of work and unemployment at the household level, and specifically those factors which influence Catholic/Protestant differences in short term and long term unemployment. Despite a reputation as a lame duck region in economic terms Northern Ireland had 38 *per cent* of its workforce in employed in the public sector (McGarry and O'Leary, 1995). Much of this employment has been characterised as being 'chiefly engaged in servicing or controlling each other - through the provision of health education, retail distribution, construction, security and local services' (Rowthorn and Wayne, 1983, p.83).

It is also clear that the Beishon data is now somewhat dated. It would be timely for the Department of Health to fund further research work on the impact of its equal opportunities policies within NHS nursing. It is also a major concern that the successor body to the UKCC and the national boards, the Nursing and Midwifery Council, until fairly recently seemed to have abandoned any serious attempt to understand the ethnic composition of nurses working in the United Kingdom. This included no longer requesting ethnicity data from applicants to the Register, reversing a key UKCC policy position on this issue. This seems to run against the spirit of the Stephen Lawrence enquiry and the subsequent legislative requirement to monitor for equality in public sector bodies (Audit Commission, 2002). It is possible that this policy may be reversed in light of the likely potential reform of an organization recently criticized for alleged institutional bullying and racism (Carvel, 2008, p.5).[9]

In conclusion, I want to revisit Pawson and Tilley on the complexity of an Irish dimension in understanding their career histories in British nursing. Pawson and Tilley (2006, p.71) have argued that the logic of realistic explanation necessarily requires:

> [t]hat the basic task of social enquiry … explain interesting, puzzling, social significant regularities (R). Explanation takes the form of positing some underlying mechanism (M) which generates those regularities, and thus consists of propositions about how the interplay between structure and agency has constituted the regularity. Within realist investigation there is also investigation of how the workings of such mechanisms are contingent and conditional, and thus only fixed in particular local, historical or institutional contexts (C).

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[9] On 18th February 2008, Jim Devine, Member of Parliament for Livingston, during a House of Commons debate on the Health and Social Care Bill, alleged racism and bullying within the NMC and called for action. Ben Bradshaw, Minister of State for Health Services, responded by requesting that the Charity Commission and the Council for Healthcare Regulatory Excellence undertake an independent investigation of the governance and operating processes of the NMC, which led to the resignations of the Chief Executive and Chair. Under new leadership the NMC has since announced a policy stance taken a broader and pro active position on equality and diversity issues. This includes recollecting data from registrants on ethnicity, disability, sexual orientation and religion or belief.

The Irish case for me has offered several such examples of these conditional and contingent 'workings' that can be understood within a morphogenetic account, and as my historical critique makes clear they are fixed within the particular historical and institutional contexts of the emerging post war British welfare state and Ireland's export of its surplus labour. This is well illustrated by comparing Irish unemployment statistics for Ireland show a correlation with Irish nurses registering their first recorded qualification with the UKCC. A highpoint in Irish unemployment in the mid 1980s is matched by a corresponding increase in Irish nurses either training and qualifying in Britain, or subsequently registering there after qualification in Ireland. Conversely, as unemployment in Ireland begins a sharp decline in from the mid 1990s more Irish registrants appear on the UKCC register with a first recorded qualification. What is also intriguing here is the subsequent decline in Irish registrants from 2000 onwards, despite unemployment in Ireland beginning to rise in the same period. This seems to suggest a decoupling effect in the traditional nurse trade.

My thesis has not been simply concerned to replicate Beishon and her simple dichotomy of white and non white race relations and the possibilities for discrimination. I hope this exploration adds to a recently growing literature on Irish women in Britain, whose migration histories have been neglected (Samuel, 1998, p.36; Ryan, 2004).

I conclude by arguing, based on the historical and contemporary data explored here, that Irish women and men have entered the nursing market in Britain as a group of social actors comparatively privileged by shared language and cultural assumptions, sharing particular relational habituses, including perceptions of race. This study has not sought to provide a predictive formula for Irish nurses working in the British NHS, the thesis rather offers contribution to an analytical history of emergence. The regularities of career success shown here are traceable consequences from their gendered subaltern status in a post-colonial society that was able to structurally exploit the contingent possibilities arising from core periphery relationships between Britain and her former colonies.

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