Changing Vocational Identities in Europe: how vocational identities are decomposed and reconstructed in the Czech Republic, Estonia, France, Germany, Greece, Spain and the United Kingdom

'Old nurses with new qualifications are best': managers' attitudes towards recruitment for occupations in health care in Estonia, France, Germany, Spain and the United Kingdom

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1. Background

Identity gives a sense of stability during the multiple changes in life. Professions and occupations have been classical media for young people in Europe that have helped them to develop a sense of self, an identity. However, rapid social changes make it difficult to develop a stable identity, and many vocational identities have been through processes of decomposition and reconstruction. In many European countries, vocational and occupational identity used to provide the basis for motivation and good work performance, commitment and quality. Vocational identities have though developed in different ways in particular historical, cultural and social contexts.

From a social cultural perspective one needs to address the development of collective social identities, organised around professions and occupations. Is the phenomenon of vocational/occupational identities as a constituting element for collective social identities about to disperse due to multiple social and technical changes? How does a future European approach to vocational education and training need to consider and govern this process? On the other hand, an individual perspective raises the question about the biographic quality associated with the stability professions and occupations can provide which a mere job concept cannot. Is the identity formation process in relation to occupations a stabilising factor in individuals' lives and is it about to lose some of its potency? What will be the effect on work performance of changing attachments to work and occupations?

Occupational identity has traditionally represented a highly significant basis of the social identity of many people. Work was sometimes regarded as a medium for personal realisation of meaning and interpretation of existence and implementation of biographic intentions and interests. For some people their occupation proved to be a normative horizon for their entire life. Even work attachment is not that strong work can still represent one of the key sites for meaningful social relations. Goffman (1959) saw occupation or profession as a primary or at least a major source of the feeling of one's own value or one's view of oneself, with which someone presents herself or himself to the outside world.

The FAME project is a European Fifth Framework project investigating changing occupational identities in Europe. There are seven partners drawn from the Czech Republic, England, Estonia, France, Germany, Greece and Spain. We have been seeking to get some shared conceptual understandings and we are investigating whether the idea of decomposing and reconstructing vocational identities could act as a unifying theme for our endeavour. We have separately outlined (FAME project team, 2001) a number of theoretical approaches that touch upon the issue of

(vocational) identity.[1] The common element of the surveyed approaches is that, explicitly or explicitly, directly or in a more implicit or mediated way, they adopt what has been termed an 'identity bricolage' perspective,[2] or provide frameworks that are compatible with such a perspective.

In the project as a whole we consider the twin aspects of the development of work identities. Any process of identity formation has to be understood in a dual way. Form an external aspect it shows society's offer of social roles (family, gender, social status, work etc.) to the individual while in an internal process the individual accepts, chooses or rejects and internalise certain roles. Identity formation is, par excellence, a process dependent upon the dynamic interaction and interdependence of structure and agency. Already existent structures like occupations with work profiles, requirements of certain educational backgrounds and certifications, social acknowledgement and traditions are set up independently of the individual. However, those structures, which of course change over time, do not necessarily fix the individual into a given structural path. He or she always has the opportunity to leave, reject or act to change aspects of an occupational identity, as socialisation is never complete and individuals interpret and remake occupational identities as part of a dynamic process (Brown, 1997). The dynamic nature of identity formation is emphasised in a world of increasing and accelerating change.

The empirical work of the project is divided into two phases. In the first we sought to elicit managers' perspectives on changing work identities and in the second, starting in earnest this autumn, we will seek the views of employees. We carried out contextual interviews with managers and others with significant national or local perspectives about structural characteristics and processes associated with a number of chosen occupations in the metal working industry; health care; tourism and telecommunications. In this paper though we intend to focus upon one element of identity formation and that is upon managers' attempts to shape certain aspects of work identities. We will in this paper, for reasons of space and time, also restrict our discussions to a single sector: health care. It is also noteworthy that only five of the seven countries involved in the research did empirical work in this sector.

2. Context

Work identities are influenced by broader societal shifts and it may be a useful starting point just to map briefly some of these broader trends that provide a backcloth against which to consider how vocational identities are changing. First, the development of what Field (2000), drawing on the influences of Giddens (1991) and Beck (1992), calls a culture of reflexive individualisation means that workers as individual agents may play a more active part in their own identity formation, with

[1] 'Identity' refers here to a connection between the 'social' and the 'personal' and to sense of sameness with some and difference with others, a feeling of 'us' and 'them'. It implies an element of active engagement on the part of those that adopt a particular identity, an element of self-definition, while at the same time identity is circumscribed and even shaped by existing social structures and processes (see Jenkins 1996; Sarup 1996).

[2] According to Carruthers & Uzzi (2000) identity bricolage, which as an idea originally stems from Levi-Strauss, 'involves the decomposition of existing identities into their constituent components and their recombination into a new identity' (p. 486). Habermas (1976) too saw as a key characteristic of an adult the ability to build up new identities and integrate them with those overcome.

fewer aspects of identity assumed to be given. In this sense we are all supposed to have greater choice in who we are and who we can become. This lifestyle shift has taken place at the same time as the ascendancy of the liberal democratic market paradigm in much of Europe has narrowed political choice in a traditional sense. The closure of some conventional political avenues (and sources of identity) has been accompanied by the opening up of various aspects of social life that used to be more circumscribed and even closed off to the common people or 'protected' by an ethical 'social closure' mechanism (Parkin, 1971). This means that the element of choice has been upgraded in everyday life. Increasingly actors, individually or collectively, find themselves in a better position than in the not so distant past, to actively shape their own profiles and identities, including work-related identities.

At the same time many of the structural aspects of work are also increasingly subject to change. The more open social environments of work may be affected by economic crises, the renewed intensification of competition, the spread of informatics, flexible specialisation, the pursuit of greater flexibility in working methods and by the acceleration of globalising tendencies. Taken together this means that many aspects of work identities are changing, through processes of decomposition and reconstruction. Workers can select various social features and characteristics from different models of conduct and practices that have multiplied and are currently available and accessible. Managers too, however, may wish to shape both some of the models available and aspects of work identities, either directly or indirectly. Induction into particular work roles though is a complex socialisation process in which external selection is supplemented by a degree of self-selection: a meshing of choice and constraint.

Technological change, the incorporation of informatics in industrial labour processes and the tertiarisation of economic activities all trigger general changes in skill needs and labour market demands. Such general factors then provide a backdrop for changing patterns of work organisation in particular organisations. Many occupational roles have been transformed, along with parallel shifts in the processes of occupational socialisation. Therefore, it would appear that processes just delineated inexorably lead to a loosening of existing work ethics and the occupational ethos. The consequences of these changes may be represented in different ways. Sennett (1998) argues that overall they lead to the 'corrosion of character', while Flecker and Hofbauer (1998, pp120-1) consider they lead to a 'fragmentation of identity' and/or the emergence of 'partial identities'. However, what is not in dispute is that there has been decomposition of many aspects of occupational and professional identities as we have come to know them. On the other hand, while some individuals have their work identities and attachments shattered, work identities in particular organisations and occupations are reconstructed and made anew. Indeed, through a variety of human resources techniques, employers and managers have become more aware that they may be able to shape at least some aspects of the work identities of their employees. This paper will highlight some of the ways that organisations in our sample sought to shape aspects of the work identities of their employees.

Social and technological change has meant that the development and formation processes of work identities have become more unstable. However, for employers work identities still provide a basis for motivation and good work performance, commitment and quality. Also different national or regional traditions and structures of labour markets mean that employers and employees face some similar and some

different challenges in the formation and negotiation of particular work identities. Spanish and English radiographers have been confronted by the same massive technological workplaces, but their education, training and employment practices remain in a number of significant aspects very different and are subject to specific regional influences, including very different labour market conditions. Managers in Estonian and German healthcare workplaces are both trying to modernise and become more patient-focused, but current and previous work identities of their employees mean these efforts have very different meanings to those affected by proposed changes in their work. Because of this abundance of diversity in structure and traditions the needs, challenges, and manifestations of identity formation processes concerning working lives in Europe appear as a colourful bouquet of models and expressions. Evidently a single European homogenous trend does not exist. The question on value and future of work related identity formation in the European labour market rather has to address ways how work identities decompose and are reconstructed and if links and general trends of such processes can be observed.

3. Managers views of work identities of radiographers and physiotherapists in the UK

In the UK hospital radiographers and physiotherapists tend to have strong occupational identities, and managers are well aware that in many hospitals recruitment and retention of these groups of staff are major concerns. Managers are aware that professionals in both groups can and do move to other hospitals, particularly on completion of initial or further training or for promotion. On the other hand, personal circumstances and locational factors (high cost of housing; less attractive working and/or living environments) can combine such that for some posts hospitals receive very few applicants. Managers have had to come to terms with the possibilities of increased mobility for these professional groups. This means that hospitals have used access to further training as a means to encourage applicants, and the possibilities of promotion as extended scope practitioners (promotion that involves continuing in practice rather than moving into management) as an aid to retention of staff. Many hospitals have had to come to terms with staff shortages in these areas and to face challenges to retain the staff they have. Such realities on the ground have had profound implications for attempts to introduce greater flexibility in work organisation.

Flexibility in work organisation had been a major goal employers in pursuing the NHS modernisation agenda from the mid-1990s (Department of Health, 1997), but since the 2001 general election the emphasis is upon recruiting and retaining more staff. This has meant that the approach to flexibility has becomes more employee rather than employer centred. Significantly, there is less talk of driving through change and more attention given to staff as if they are part of the solution rather than being the problem. One example of the previous approach, occurred at the height of attempts to impose greater flexibility in work and expect staff to accept resulting changes in patterns of work organisation, and involved a single radiographer being on-call for the full range of possible duties. This proved problematic in practice as many of the radiographers did not feel confident to undertake the full range of duties that may be required of them when they were on-call alone and had no one with whom they could consult over possible problems.

There are, of course, strict limits to the scope for flexibility in the medical profession and professions allied to medicine (such as radiography and physiotherapy) because they are subject to national regulatory frameworks. However, some changes to human resources policies and patterns of work organisation are being influenced by problems of recruitment and retention of professional staff. For example, one attempt to lessen the effects of staff shortages has involved changing the skill mix between consultants and radiographers and making greater use of assistants. This was occurring within a context where there was an explicit attempt to put greater emphasis upon team working, although this represents a much greater challenge for many doctors than it does for either physiotherapists or radiographers.

Managers' perspective on individual scope is that individuals are being given more autonomy and responsibility, in a context of increasing demand for services. Individual commitment has always been strongly identified with the occupation and the department or service. Some human resources staff are consciously trying to reshape the focus of commitment more towards the inter-departmental team so as to improve overall quality of service to the patient. However, there is also recognition that individuals and departments are under increasing pressure because of increasing demand for services (and in many places staff shortages).

What the managers interviews in health care in the UK show is that occupational identities in hospital physiotherapy and radiography are undergoing significant change, partly in response to 'modernisation', changing patterns of work organisation and education and training, technological change and increasing demand for their services. This creates a clear context of pressures for change upon occupational identities in this area, but at the same time there are very strong continuities with the past and nearly all the changes are operating to make the role of hospital physiotherapists and radiographers more significant. One major problem concerned work intensification, but even this is starting to be acknowledged as an issue that needs to be addressed.

One reason we have started with this case is that it makes the point that although we are interested in the decomposition and reconstruction of work identities there are many occupational identities where there is a strong sense of continuity between past, present and future. Members of these occupational communities in general feel these continuities much more strongly than the discontinuities. Perhaps, however, there is one area where individual choice is influential upon systemic role performance and that is in the very few physiotherapy students that opt to specialise in working with the elderly.

4. Managers' views of work identities of radiographers in Spain

If working as a radiographer in the UK symbolises working in an established occupation growing in status and influence, then the contrast with technicians performing the role in Spain could hardly be sharper. In radiology departments in both countries there are three groups of staff involved in service delivery: doctors, nurses and technicians. However, whereas in the UK the technician role is long-established, considered as a profession allied to medicine and now involves undergraduate training, in Spain technicians have only recently had a role in the health care system. Traditionally in Spain doctors and nurses were responsible for all aspects of service

delivery in this area. So in Spanish hospitals the role of radiography technician is still evolving, but at the moment it is rather on the periphery of a health care system in which the organisational model is of a specialised medical service as the core around which all activity is organised. Medical specialisation has grown alongside the introduction of new technologies and the generation of new knowledge, but expertise is both concentrated (in doctors) and fragmented due to the existence of different specialised services.

One striking aspect of the interviews with managers is how they highlight the importance of a rigid recruitment system, both complex and centralised, that gives no structure to the careers of staff such as radiographers and the lack of any appropriate development or support policies for such staff. Within radiology services, the introduction of new technologies in the past decade have made obsolescent traditional approaches to radiography. The role has changed significantly, but staff recruitment and development procedures have remained essentially unchanged. Existing permanent staff were civil servants, whose positions had been gained by passing the appropriate civil service exams, and reconversion and retraining were offered within the service. Staff unable to adapt to the new demands were moved to another section and, if necessary new staff were recruited on temporary contracts and without being civil servants (who could only be recruited from the official list of applicants: *bolsa de trabajo*). Competence and expertise are therefore completely independent of employment status.

Medical professionals are trying to keep their traditional high-status in the face of reforms. It should also be remembered that the interviews were performed in the public sector and that recruitment practices are very different in the private sector. There is also a dualised labour market within the public service, as the mechanisms for role allocation are very different depending upon whether you are operating within the internal labour market (after having secured civil servant status) or are trying to gain access to a permanent position from the external labour market.

The hierarchical levels within the service are very clearly differentiated: doctors, nursers and technical staff. However, expertise does not follow the same pattern. For example, because of the lack of specialisation in the education of nurses there is little scope to pass much of the technical work from doctors. Nor are doctors likely to be able to rely upon technicians, because there short contracts (typically less than six months) give little opportunity to build up a relationship allowing for the transfer of responsibility for certain activities.

Recruitment of technicians is wholly based upon the lists of applicants (*bolsa de trabajo*). It is therefore useless for a hospital to ask for a specialist in radiology, because it is seniority in the list that gives priority in appointment. Technicians are staff with the least general qualifications and that is what ensures they are pushed to the periphery. Their specialist expertise in, for example, radiography therefore carries no weight in the formal recruitment process as civil servants. While waiting to get sufficiently high on the list to get a permanent position, technicians work in hospitals on temporary contracts for periods of 3 to 6 months. Upon completion of that contract they will move to another hospital. They cannot stay and build up experience in a single role in one hospital. From the hospital's perspective too once they have learned the job they must leave it because of circulation within the list, thus leaving the hospital to train the next technician. Experience shown on your CV does not count

within the list either, thus personal merit (from for example having done a good job while on a temporary contract) plays no role in the recruitment policies, except insofar as this may influence your performance in the examination. Although as this is a relatively new job profile there is little history or tradition upon which staff could rely in relation to recruitment decisions.

There are many courses, conferences and seminars on radiology because it has been a fast growing area of medicine in recent years. However, all the heads of service interviewed complained about the same issue: training is a problem largely affecting nurses and technicians. Yet training in the main is not addressed to either of these groups and in any case members of both groups are often reluctant to attend training. The interviewees said this was an 'intrinsic feature' of these workers, who are not motivated either by their profession or by their particular job or workplace. For nurses this is attributed as partly due to the lifelong feature of their work as civil servants, while it is attributed as partly due to the insecurity of the lists for technicians. The staff, however, have a different viewpoint on this. Both nurses and technicians point out that doctors are paid registration fees, daily allowances and so on by the hospital directorate, while nurses and technicians must pay all of these from their own personal budgets.

Regarding vocational education, there was overall agreement among the interviewees that the theoretical background of technicians is not strong enough for contemporary practice. Some initiatives had been taken by some hospitals on this issue, like offering a course by radiologists to teachers in vocational schools. The course was planned for 100 hours, but because of lack of agreement between the educational administration and the health administration it had to be stopped.

Problems with vocational education not being sufficiently up to date, work experience placements where students are given insufficient support, lack of access to continuing training, and short-term work contracts all combine to ensure much of the technical work continues to be carried out by doctors rather than by technicians. The excess of responsibility on the side of doctors and the lack of responsibility on the side of technicians reflects more generally the strong hierarchical system of work in the health system.

Most of the above represent structural constraints that militate against the development of a cardre of hospital radiographers with technical expertise and a strong sense of occupational identity. For the moment neither employee agency nor employer action can make much headway against such constraints. However, another set of relationships may develop. The high cost of the technology currently used in radiology means not all hospitals provide these services. This is partly due to the externalisation of some services and the subcontracting of some of them to private clinics or specialist organisations. In the latter case a technology provider may offer scanning services to a number of hospitals without such specialised equipment. Technicians 'on the list' may be working operating this equipment, while waiting and hoping for a permanent hospital appointment.

Overall then, managers have clear views about the competencies they would like their employees to develop, as well as upon the definition of the tasks to be performed by experienced skilled raiographers and, to a certain extent, upon redefining the relations among different job positions within departments. They would also like their

employees to demonstrate a willingness and commitment towards work that should be the core axis upon which experience and qualifications of workers are built. However, in the radiodiagnostic departments, as in all other departments in public hospitals, it is the entry procedures set by the public administration for any area which runs recruitment, retention and promotion practices. Given the nature of the civil service in Spain, these are highly regulated and, therefore, they constitute one of the most important sources of problems for the development of the sector. Structure rules.

5. Managers' views of work identities of nurses in France, Germany and Estonia

One of the most interesting aspects of any discussion of the work identities of nurses in public hospitals in France is how this was effectively a non-issue for managers precisely because of the existence of such strong and highly regulated patterns of work-related identities. Such issues had not entered any arena of public discussion or negotiation. This was largely because of traditional hierarchical patterns of work organisation, the presence of very strong trade unions, long-standing bureaucratic recruitment procedures based on 'replacement lists'. Managers complained to the researcher of:

- the heavy and complex organisational structures, where the dominant mode of work organisation is a combination of hierarchy and team-working groups. Competency-based nursing teams are working within well established hierarchies, with units and departments usually run (around doctors) by executives from the nursing staff. At the top of the hierarchy, all nursing activities are run by one of a group of senior executive nurses. Team-work on a project-basis is limited to important research and development projects. There are some staff shortages but these are filled from 'the list';

- how the introduction and implementation of the regime of the accreditation of work-related learning is underway, but it will not include doctors and nurses;

- the highly institutionalised and regulated professional identities, whereby the basic medical professions are only slowly opening up to doctors and nurses with foreign qualifications and there is no accreditation of any type of work-related learning within the core professions;

- how the existence of these highly institutionalised introverted occupational identities supported by the involvement of a variety of strong trade unions, constituted a major source of tension and resistance to change.

These complaints, however, appeared cathartic rather than a prelude to action. There was a weary acceptance that effective direct recruitment is not possible due to length and weight of formal procedures to be respected in any kind of recruitment. In addition, employees' interactions with management are, in most cases, mediated by a representative of the trade union. Thus, formally established rules and regulations specific to the particular professions are viewed as a refuge and means of protection against change. By contrast, envious comparisons were made with the activities of the growing private sector that is on the whole characterised by simple organisational structures with more flexible and open modes of human resource management and

work organisation. The managers though did acknowledge that staff were open to innovation and the use of modern technology in health care activities. It was just that managers were frustrated by their failure to be able to exercise control over significant aspects of work organisation, because of the existence of highly regulated and 'introverted' occupational identities, supported by the involvement of strong trade unions.

In Germany work identities in nursing are influenced by formal regulations, particularly insofar as the formal occupational profiles that govern nurse training have been updated. Changes are also being seen in ideas about the organisation of work in hospitals and other health care settings. Most of the managers in the German case studies believed strongly in the importance of nursing as a vocation: 'one should not enter the profession unless you really want to work as a nurse.' However, there was a recognition too that nursing was changing, and when recruiting personnel managers were looking for different personality profiles from say seven years ago. Individual characteristics required included:

- Communication skills in order to meet expectations of patients and their relatives
- Ability to learn, demonstrated through attendance at continuing education activities and a willingness to keep up with knowledge requirements associated with developments in medicine and health care
- Need to manage their work and work environment efficiently
- Commitment and motivation
- Being able to cope with a profession that is very interesting and challenging but also has a high potential for pressure and strain.

Nurses were also expected to exhibit a high degree of flexibility in response to the social environment (patients, colleagues, physicians), new developments in medicine and health care, organisational restructuring and changing patterns of work organisation.

In Estonia, managers had similar views about how the modern skills profiles for nurses still include a sense of vocation. One of the interviewees, a head nurse, is of the opinion that nurses in smaller town hospitals may be just as good or even better at nursing as their colleagues at technically more developed Tallinn hospitals: 'this is because tools are nothing but tools, and without empathy, intuition and a good hand, there can be no nursing'. This mixing of role and personality informed the analysis of other respondents too. Where managers identified skill gaps these were attributed to having employees with the 'wrong personality' or because staff failed to realise that 'nursing is a mission. It is hard for people to work as nurses because of the low wages if they don't understand the work as a mission'.

All work identities in Estonia have been changing in the context of a post-Soviet transition (Loogma and Vilu, 2001), as part of the 'civilisation shift' (Lauristin, 1997) involved in Estonia's 'Return to the Western World' (Lauristin and Vihalemm, 1997). In sectors such as timber and furniture workers who have been unable to adapt to marketisation and the promotion of an entreprenneurial culture have lost their jobs to such an extent that there is actually now a shortage of skilled workers with what

employers believe are the right attitudes. In the marketised sectors any continuity of attitudes from Soviet times can be fatal for your employment prospects.

However, this is not the case with nurses who trained in Soviet times. They have had to be retrained, and take further examinations, because of the need to meet new standards, but those that have been successful, while retaining their 'old' attitudes, are regarded particularly favourably by managers. This is because only those with a really strong nursing-centred identity will invest their time and money in such a poorly paid vocation, with the result that the managers believe that 'the old nurses with new papers are the really good ones'. Interestingly, younger nurses with Western values still train, but this is attributed to the fact that their qualifications are accepted elsewhere in Europe, and there are, for example, formal arrangements where nurses train in Estonia for employment in Norway.

6. Reflections on changing work identities in health care

6.1 Expressive caring as an ideal

The above commentary indicates that health care managers have a variety of views about what they see as most appropriate staff attitudes and qualities for working in caring professions. Interestingly, in many cases (including in very different settings) they look **both** backwards and forwards in time when considering the qualities they would ideally like their staff to have, and reflect upon the importance of **really caring**. Our respondents also seem to be aware of the danger expressed by Benner (1992) that lists of required skills or behaviours related to the tasks to be performed in nursing can be apparently never ending, but still not get to the heart of professional practice. These views can also be seen as part of a much broader debate that addresses fundamental issues about the shape and direction of health care. Many of those engaged in health care philosophy, policy and practice are trying to come to terms with changing ideas about relational and caring constructs, and there is a recognition that there are major social, economic and political dimensions to attempts to pay greater attention to therapeutic caring relationships.

Ethics and values are therefore necessarily involved in judgements about service delivery and skill utilisation and development in health care. That is ideas about the skills and attitudes of staff required for effective and caring service delivery are inevitably connected to views about how the service should be delivered, and patients, professionals, managers and the general public all have views on that. Amidst this debate about effective delivery of health care, the newly qualified practitioner seeks to develop a stable work identity. In order to accomplish this an individual has to move towards a position where he or she is happy that his or her personal values align sufficiently with the professional values broadly espoused by the community of practice to which he or she belongs. For example, physiotherapists doing community work need to believe in the value of patient advocacy as an important component of their work: a stable work identity being associated with role congruence rather than role conflict.

For professionals working in health care there is broad agreement that, ideally at least, the job should be about more than just technical competence. A distinction can be made between the technical skills required and the need 'to develop and sustain therapeutic caring relationships with patients and clients which are conceptualised and

practised in an integrated and holistic fashion' (McAleer and Hamill, 1997, p.99). Playle (1995) identifies the shift in the caring professions away from illness-cure models and the objectification of patients towards a more holistic, person-centred approach that 'promotes mutual respect, genuineness and joint partnership in the achievement of patient centred goals' (McAleer and Hamill, 1997, p.5). Wright (1994) highlights the value of expressive rather than instrumental care: caring about the patient not just caring for the patient. Expressive caring means professional activities should reflect the value of each individual person, and be imbued with the values of respect, dignity and individuality. Expressive caring contains a more explicit affective dimension compared to instrumental caring in which actions are predetermined in the form of a technique or strategy.

Expressive care for all patients then represents an ideal, but any shifts in practice towards more expressive caring are at least partly dependent upon the personal meanings and the degree of commitment of staff, perhaps particularly those newly recruited to the profession. However, Oakley (1993) draws attention to the paradox that the increasing technical competence associated with greater professionalisation may serve to distance practitioners from those for whom they care. Managers in several countries were explicitly concerned about this, and in Estonia particularly there was the almost plaintive cry that younger nurses do not **really** care like some of the older nurses. In any case the policy response of emphasising more person-centred models of care has not always been in step with how to facilitate this in training and implement it in practice.

At the professional level therefore, decisions to opt for particular models of care to underpin practice could affect skill utilisation and development profoundly. These decisions could be taken in one respect at an individual level, whereby an individual opts to approach her or his practice in a particular way; their professional identity being bound up with being a particular type of practitioner. On the other hand, departments or hospitals too may favour particular models of care, although there may be disjunctions between the policy as espoused and how it is represented in practice.

Practitioners and managers in some settings were acutely aware of these tensions. For example, several respondents in UK hospitals point to the consequences that follow if a physiotherapy department encourages an 'empowering' approach to care. Such an approach requires the individual patient to take increasing responsibility for her or his own care, and this can be very time intensive in the early stages, even if it eventually requires fewer interventions. This is because the 'empowering' approach relies upon the establishment of trust, with a focus on support and development; taking time; listening to and dealing with problems, as the individual takes on greater responsibility. The 'control' approach, where the practitioner is much more directive, focuses upon what the client has to do, but with 'ownership' of the process resting with the practitioner, may be used as a means to cope with large numbers of patients. Tensions may arise between these two approaches, and the newly qualified practitioner may require support in this respect, as the controlling approach may initially be easier to accomplish.

One important question though is, even if everybody agrees on the need for more expressive caring, how will practitioners learn to exemplify expressive values? Dench et al (1998) report that trainers working with carers found difficulties working with

values, and Bradshaw (1994) points out that it can be quite difficult to confront the tension between personal values and meanings and caring for others. Furthermore, McAleer and Hamill (1997) found that nurse tutors themselves often lacked confidence in doing this, partly because they had difficulty articulating the concepts of caring and its attributes. Values and meanings need to de discussed, and perhaps their application should be modelled in practice. Individuals too should receive support within educational and organisational structures to think about the value frameworks of themselves and others. Some engagement with these issues could take place through discussions associated with reflective practice.

Some care though needs to be taken to ensure that there are explicit discussions about caring and values, not least for the newly qualified practitioner because it could lead staff to arrive at a richer understanding of expressive knowledge, practice and their own self-understanding. By that means it should be possible to facilitate the development of a richer discourse about feelings, emotions and care, rather than just positing an ideal model. McAleer and Hamill (1997) argued that tutors in supporting the learning of health care professionals needed to engage with a much wider variety of discourses about caring in order to help practitioners discuss their experience of care.

Newly qualified staff also have to come to terms with the personal costs of caring for them as individuals. For example, one unintended consequence of the emphasis upon authenticity of feelings, and that health practitioners should always really care (and give of themselves) is that this could result in many otherwise capable practitioners feeling that they do not live up to the model. For this reason Taylor (1992) argues that due account needs to be taken that nurses are perceived as people with everyday common human qualities not just in terms of their professional role. This is perhaps most evident in the balance required of staff for their own psychological well-being of caring about their patients but, at the same time, not caring too much. It is also by no means clear that unconditional service to others is always the most desirable course of action. The context is important in this respect. Empathy and support may be inhibiting in some circumstances, as they could be disempowering in the sense of restricting patient autonomy and cutting down on opportunities for recovery to be more self-directed.

Expressive care for all patients may represent an ideal, but it is important that any attempt to implement this is informed by what happens in practice. For example, Stockwell (1972) pointed out that, in practice, some patients are more popular with staff than others and that practitioners use their power in a discriminatory fashion. This would suggest that the values underpinning expressive care need to be developed during initial training or, as some of the interviewed managers argued, that those recruited to the profession should already have developed these values. However, some nurse tutors, interviewed by McAleer and Hamill (1997), believe that the increasing cognitive demands made in nurse training mean that such development may be squeezed out of the curriculum. As a consequence any shifts in practice towards more expressive caring would therefore be largely dependent upon the personal meanings and the degree of commitment of newly qualified staff.

Overall then, those working in health care need to display ‘caring’ qualities, as well as being technically proficient and being aware that ideas about professional competence

and caring are constantly evolving. Ideas of care therefore need to be framed in a particular context and at a given time, but it nevertheless remains important that personal and professional values are in broad alignment. Some of the managers interviewed were perhaps somewhat unrealistic in this respect arguing (or just wishing?) for staff with attitudes from one era coupled with skills from another. It is interesting, however, that understandably technical proficiency is often taken as a given, and little attempt is made to examine the interplay of trying to develop both caring and technical competence at the same time. Yet there are clearly tensions here too.

6.2 Tensions in the interplay of the development and utilisation of technical skills and caring abilities in work

One problem for those with responsibility for training and development of health care professionals is that it can be very difficult to be very explicit about what you are trying to achieve. This is because it is particularly difficult to map the full complexities of performance in practice (McAleer and Hamill, 1997). For example, most managers are aware that newly qualified staff may be less proficient in certain respects when they start practice. Some of our respondents pointed out that particularly in complex non-routine situations the newly qualified were 'less expert' in some of their judgements than more experienced staff. Some commentators believe the key differences are in the speed with which individuals build up their expertise relate to 'generic' competences based upon personal attributes such as critical thinking, problem-solving and analysis (McAleer and Hamill, 1997).

This was acknowledged by managers in departments in UK hospitals that regularly recruit newly qualified staff (because they do not get experienced applicants) who emphasised how they liked to recruit staff who would be effective learners. One pressure was to appoint staff who would rapidly be able to contribute fully to achieving performance targets: here there was an in-built bias towards technical proficiency rather than the encouragement of the development of more rounded (and caring?) performance. In these settings the quality of mentoring, supervision or other support is critical, as the less experienced should have opportunities to discuss and practise thinking about complex cases handled by their more experienced colleagues.

Our interviews in each country support the observation by Webb (1996) that current discussions about health and social care are intimately bound up with ideas about practice as it is, how it might or should be, and relations between occupational groups. The latter point was clear in that most respondents in all countries discussed aspects of relations with medical staff as having a significant impact upon the performance of nurses and of the professions allied to medicine. This was most evident in attempts to offer a more holistic approach to health care, as this had implications for intra-team training, if the goal of multi-disciplinary working was to be achieved.

Demonstrating commitment through caring as well as exercising technical skills adds complexity to the performance of a role, but in addition it can make the role much more demanding. Morrison (1992) points out that those working in the caring professions have to deal with issues of emotional involvement, stress, work constraints, and role uncertainty. This reinforces the importance in such circumstances of having mechanisms where individuals can talk these issues through with colleagues. Some of the UK managers emphasised that their departments had such

mechanisms in place, although they varied in the extent to which they made use of formal or informal methods. Taylor (1992) argues that such an approach is vital as those working in the caring professions needed to relate to each other as people, not just in terms of their professional roles. McAleer and Hamill (1997) emphasise that professionals need to be regarded ‘as people who share the everyday common human qualities of their patients’ (p7) and not be regarded as carriers of a range of super-human qualities.

For the foreseeable future the supply of ‘natural carers’, with highly developed cognitive and technical skills, wishing to work in nursing or the professions allied to medicine, is likely to be less than the demand. If so, and we still wish to promote expressive caring, an interesting question arises. Can certain affective responses themselves be incorporated into patterns of behaviour, whereby individuals give the appearance of caring: can someone learn to give the impression of being genuinely interested in you?

So the balancing the development of technical skills and caring abilities is a considerable challenge in training and development. However, even if it is successful there, a further considerable challenge remains – that of coming to terms with the social organisation of work. One point emphasised in the preceding arguments was how health care professionals may come to a richer understanding of expressive knowledge, practice and their own self-understanding. This recognition of the value for staff of organised reflection upon their own role, however, has to be complemented by a recognition that their individual practice takes place within particular social contexts. Perhaps the most obvious influence upon how nurses operate in practice is the social organisation of work. May (1990) points out that focusing upon the dynamics of nurse-patient relationships takes little account of how the social organisation of care influences care-giving, not least by assuming that nurses have a relatively high degree of autonomy in how they carry out their work. The increasing drive for efficiency and performance within health care systems may also limit the time nurses have for activities that convey caring.

7. Conclusions

Our review of the managers’ attitudes towards recruitment for health care occupations in five countries shows that one recurring theme is the challenge of finding enough people with the full range of skills and qualities managers believe to be desirable. In particular, there is thought to be a tension between technical and cognitive skills development and the inculcation of the values associated with expressive caring. Managers and trainers are engaged in attempts to shape aspects of their employees’ work identities, although the consequences of these attempts are seldom fully thought through. It remains easier to erect an ideal than to effect change in practice. This is perhaps partly because, particularly for nursing, some of these tensions appear to be affecting beliefs as to what should constitute the bedrock of nurses’ changing occupational identities.

Should nursing identities be primarily based upon mastery of a distinctive body of (scientific and clinical) knowledge similar to doctors and other professions allied to medicine? Or does their identity principally derive from their role as expressive specialists, with particular skills, knowledge and understanding of therapeutic

relationships? If it is to be the latter then it is important that the curriculum for nurse training should be opened up in ways that would facilitate the development of a richer discourse about feelings, emotions and care. McAleer and Hamill (1997) remind us that tutors as well as students can struggle in this respect. They argue that ‘there is a danger that, in the absence of a fully developed and respected body of language to enable nurses to discuss nursing experience of care, they will be forced to accept accounts of nursing which are restricted to the technical and instrumental aspects of care and are unable to fully deal with alternative forms of human experience expressed in moral, political and cultural dimensions’ (p. 100). Their remedy includes a new approach to curriculum construction and assessment that acknowledges ways of knowing which embrace interpretivist, constructivist and feminist research, critical theory and could draw upon the humanities and philosophy in trying to develop the reflective capacity of both tutors and students (McAleer and Hamill, 1997).

Given the radical nature of such suggestions and length of time it might take to train nurses in such an approach it might allow for a completely different interpretation to the view that ‘old nurses with new qualifications are best’. On a more serious note, the extent of engagement of managers with issues around changing work identities in health care is symptomatic of some fundamental challenges facing all with an interest in health care policy and practice. The next stage for us is to find out from employees themselves how they are negotiating these challenges and what type of work identities they are developing.

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