‘Old nurses with new qualifications are best’: competing ideas about the skills that matter in nursing in Estonia, France, Germany and the United Kingdom

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1. Introduction

This chapter looks at competing ideas about the skills that matter in nursing and changing attitudes towards the formation, development and utilisation of the skills of health care professionals, especially nurses, in Estonia, France, Germany and the United Kingdom. The analysis is based upon qualitative interviews and additional contextual background material generated in the framework of the FAME research project[1] through interviews with health care professionals with varying levels of qualification, specialisation, skill profiles and functional responsibilities. Mainly nurses were interviewed, but also smaller numbers of midwives, radiographers, physiotherapists and personnel of human resources departments of health care providers. This article focuses mainly on managers' views on changing skill requirements of nurses and how radical changes in the skill formation, development and utilisation of the skills of nurses have been accompanied by continuity and change in attitudes towards the skills and attitudes nurses should (ideally) display in practice.

The main focus of the FAME project was upon changing work-related identities in Europe (with researchers from the Czech Republic, Greece and Spain also involved). Skills development and identity formation are inextricably intertwined. Any process of identity formation has to be understood in a dual way. From an external aspect it comprises 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 internalises 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 skill profiles, requirements for 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 and skill development is emphasised in a world of increasing and accelerating change.

Work-related skill development and identity formation are also political processes, and employers, employees and others may all try to 'shape' these identity formation and skill development processses. 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 and the utilisation of skills are also increasingly subject to change. 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.

Social and technological change and changing patterns of skill formation have meant that the development and formation processes of many work identities have become more unstable (Sennett, 1998; Carruthers and Uzzi, 2000). However, for employers work identities and accompanying skill sets still provide a basis for motivation, 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 radiodiagnostic technicians and English radiographers have been confronted by the same massive technological changes, but their education, training and employment practices remain in a number of significant

[1] The research project "FAME – Vocational Identity, Flexibility and Mobility in the European Labour Market" is funded under the 5th EU framework programme for the research period from 02/00 to 05/03.

aspects very different and are subject to specific regional influences, including very different labour market conditions.

Technological change, changing patterns of work organisation and changing demands for health care services have triggered significant changes in the skill needs and labour market demands for a number of health care professionals, including nurses. Many occupational roles have been transformed, along with parallel shifts in the processes of occupational socialisation. Through a variety of human resources techniques, employers and managers have become more aware that they may be able to shape not only patterns of skill utilisation, but also at least some aspects of the work identities of their employees. This chapter will highlight some of the ways managers, working mainly in hospitals, in our sample have sought to shape aspects of the processes of work-related identity formation and skill development of nurses. This chapter draws upon interviews with over forty staff in the four countries under consideration. As a backcloth to the managerial perspective the views two nurses upon their own skill, career and identity development will be presented.

In the research project the health care sector was chosen because it represents one of the traditional service sectors. The nursing profession as one of the core occupations in this sector has a long-standing occupational tradition with related identity and skill development patterns. For many centuries religious and charitable organisations have developed specific health care services, including building and running hospitals, care institutions for the elderly and other charitable and health care institutions. These historical roots have influenced work profiles and have established a more or less universal image of what qualities and skills a 'good' nurse should possess.

Since the 1980s changing work requirements, new skills profiles and a strong tendency towards professionalism in providing quality health care are questioning and opposing this traditional image. Today, the provision of health care has become a growing sector due to demographic shifts. These shifts and an ageing European society challenge nurses to become more flexible and mobile. Health care needs and provision today require a broader perspective looking at staffing and skills demands across countries, but also shifting the focus from simply providing care to prevention, counselling and the support of a patient-oriented self-help approach. All these changes mean understandings of the skills required for nursing are much more open, than in previous times, to different interpretations and there are different poles to the discourse of the skills, qualities and attitudes required of nurses. However, before looking in more detail at changing attitudes to the skills required of nurse, an important task will be to map out some of the distinctive and common features of the skills involved in nursing in the very different national contexts of Estonia, France, Germany and the United Kingdom.

2. The nursing profession in national perspective

2.1 Estonia

Being a country in transition from a former state-controlled economy during Soviet times to a democratic society with open markets, Estonia faces the challenge of redefining profiles, skills requirements and related occupational profiles of the nursing profession. The new political system and the intention to implement structural, organisational and educational reforms has also had fundamental consequences for the labour market and the health care sector. Since the former planned system no longer determines the distribution of labour and human resources, employment and deployment according to demand have become a new, up to now unknown, mechanism of human resources policy, also in public hospitals. At the same time the entire health care sector has been challenged to implement new medical technology.

For the nursing profession the driving forces for change during the 1990s were the foundation of private hospitals and the implementation of a new curriculum for the education and training of nurses. This means that nurses in Estonia not only had to deal with major changes in employment policy including employment insecurity, but they also had to adjust to new technological, organisational and educational demands. Today, nurses who trained during Soviet times have to undergo a retraining process and pass examinations according to the new curriculum to raise their status and market value as qualified staff.

The liberalisation policy allowed unions to actively shape working conditions by, for example, negotiating wages or initiating strikes. Also nurses started to become unionised and founded nurse associations in order to get their skills more widely acknowledged and to foster their status in the political dialogue. This seems to be important for the development of a new concept and profile of the nurse profession, because through associations nurses can now influence educational directions in co-operation with medical schools and government. Through this approach they can influence the establishment of new vocational standards and skills profiles for nurses that underpin their professional status. In addition, these associations also facilitate better information exchange about skills development and labour market changes within and beyond the health care sector.

The process of lobbying and the diversification of occupational paths and opportunities due to the possibility of employment in private hospitals lead to the creation of new occupational profiles of nurses at work and new training programmes. However, these developments do not automatically imply a general upgrading of the work-related and social status of nurses. Wages are still uneven depending on the employment contract and the employing institution. For example, larger hospitals offer more complex and expensive services and they often turn out to be a more popular employer than small hospitals since they can offer higher wages. Private hospitals can offer a more modern and flexible work environment. Since most of them were founded in the early 1990s they had the opportunity to create and implement an organisational culture which fosters new work concepts, occupational profiles and identities of nurses. These also go along with the emergence of a new set of values influenced by the demand for commercialisation of the health care sector. New organisational and work-related features of private hospitals include greater responsibility and independence of nurses, a stronger emphasis on the quality of care and working in small teams. But even in private hospitals a new partnership model regarding the communication and co-operation between doctors, nurses and patients still has a long way to go before becoming a daily work reality.

Public hospitals are still to a certain extent characterised by structural, organisational and habitual features of communist times. However, it is only state and communal hospitals that are authorised to accredit and award certificates for the nursing profession. This seems paradoxical because it is the private hospitals that could much more effectively implement a nursing profile that fulfils the requirements of the new curriculum. These are excluded from the accreditation process although they are only allowed to employ certified nurses.

With regards to continuous professional development nursing in Estonia has established itself as an independent discipline with the possibility of following an academic career in nursing. But the dominant opinion in society, and of employers, about what qualities and skills a ‘good’ nurse should possess, still comes close to the rather traditional image. That is, nurses should in the first place be devoted to their profession as a vocation, harking back to the original charitable mission, under the supervision of doctors. In addition, safety and stability in respect to work and the workplace seem to be values of growing importance in an unstable economic environment. There is perhaps a general feeling that, in a changing world, at least we have a clear image of nurses, the skills they have and the work they (should) do.

2.2 Germany

The German health care system also underwent important structural reforms in the 1990s that affected the nursing profession by setting new standards for the financing and organisation of health care provisions. After a period of expansion, specialisation and implementation of the latest technology during the 1980s the German health care system had to face a significant cost explosion that forced politicians to take action pushing the German government to restrict and control expenditures for health care services. As a result a major legislative reform was put in place in the mid-1990s that substantially changed the organisation of hospitals and other health care institutions. It implied that subsidies for public hospitals would now be determined by medical case and outcome, unlike before when hospitals were given lump sum allowances per patient and hospital day. The former procedure allowed for more flexibility in the number of days patients could stay in hospitals.

Today, the number of days patients stay in hospital and the number of treatments that require a hospital stay are reduced to a minimum and all hospital processes and structures are subject to quality assessments and evaluation. Service providers are required to document every single intervention and prescription of treatment and have to justify why no cheaper treatment could be chosen. To reduce the costs for in-patient treatment a concept is favoured that supports out-patient pre and post treatment instead. The length of stay per patient in hospitals is reduced to an average of 6.3 days, a duration that in most cases does not allow for the completion of a successful healing process. Hospital wards organised as profit centres and the flattening of hospital hierarchies also are seen as solutions to achieve cost reductions. While each physical service and medical treatment has to be documented and justified in order to get reimbursed through the health insurance system, social interaction and communication with patients suffer. Hospital staff often find themselves exposed to conflicting demands, the restrictions by health insurance on the one hand and patients' expectations on the other hand. With increasing competition between health care providers hospitals are forced to provide patient-friendly services to become more attractive to their customers. Customer orientation, high quality of care and economic efficiency are new criteria not only hospitals have to meet but also other health care institutions like residential care institutions for the elderly and domiciliary health care providers.

In the case of care institutions for elderly people and home visiting health care services an additional statutory insurance was implemented in the mid 1990s. The objective of this specific care insurance (compulsory for every German employee) was to support financially elderly and people with special needs in a way that they could continue living as long as possible in their private homes with the support of domiciliary health care providers. As a new institutional structure the statutory medical service defines the level of care old people are entitled to receive by assessing the level of caring needs combined with the patient's ability to care for him- or herself. Based on this assessment the statutory medical service gives or refuses allowances for health care services and medical treatment. The statutory medical service also monitors the quality and performance of institutions and health care services, the infrastructure of institutions, the training of personnel, the organisation of work schedules, etc. For nurses working in care institutions for elderly people or domiciliary health care providers this means that they are requested to document every single activity while often working under severe time constraints and very tight financial resources. Still, these kinds of service ensure growing employment possibilities for nurses, because the additional insurance made new financial resources available thus encouraging the development of a new market for private and charitable domiciliary health care providers. The result was the creation of a large number of jobs in this area. This market is still growing while the need for jobs in hospitals slightly decreases. Although the stressful physical, psychological and interpersonal demands lead to a high turnover of staff, domiciliary health care services are expected to flourish in the future.

With the cutback of in-patient treatment and care more responsibility is transferred to the individual patient and principles of modern health care are designed to encourage the patient's capacity for self-care. This approach also requires a new attitude and knowledge of nurses on how to best support patients in activating their self-healing potential.[2] On the patient's side, their demands also have changed. Patients today are much better informed about health issues and health care procedures. They show a more proactive attitude and have higher demands on the quality of care and treatment. For example, patients have become much more involved in making decisions regarding their medical treatment. This attitude of patients also demands better and more detailed information exchange bringing a new focus on consultation, giving guidance and counselling into the health care process. As a consequence nurses and other medical staff are increasingly challenged to meet these expectations and counselling methods have become an important aspect of the training of nurses. As a general trend, the professional profile has shifted form a hierarchical oriented structure towards a model that emphasises self-organisation and independent action by patients and nurses.

The legislative reform as the driving force for change forced all kinds of health care institutions to develop new work concepts and patterns of work organisation to meet the new reality of extremely limited financial resources. Personnel being the major cost factor the reform also influenced the deployment of a large number of nurses in hospitals and other health care institutions. Quality control has become a major focus and in order to ease nurses from the burden of an increasing amount of administrative work, a new professional profile, the ward secretary, has been introduced. Most hospitals today operate with a pool of highly mobile and flexible staff to meet peak work loads in different wards or to compensate for staff shortages. Working in health care more and more requires a high degree of flexibility.

The job profiles, and associated skill demands, of staff are changing insofar as institutions and management increasingly put emphasis on efficiency, quality control and documentation. Market economy standards and financial constraints in hospitals and other health care institutions put pressure on staff. Work intensification, time constraints and, in particular, not having enough time to care for the individual patient are major issues. Human resources management of hospitals see nurses facing an increasing complexity at work. Information and communication technologies, co-ordination and the management of complex data processing combined with a new approach towards customer orientation redefine the traditional profile of health care services. On the other hand, skill requirements and patient-related core activities in nursing change slowly as many work processes are highly ritualised. Thus, innovation and the introduction of new approaches in health care are difficult to put into every day practice. In summary, the following general trends in health care can be observed in Germany:

Increase of administrative tasks
The amount of administrative work is increasing and can reach up to two thirds of the total working time of nurses in hospitals. This results in nurses having less and often not enough time for providing direct patient care. Most nurses feel that they are overqualified for performing administrative tasks and would rather prefer to concentrate on working directly with the patient.

Striving for efficiency and a new division of labour
There was, in some respects, a mismatch between a modern approach of performing integrated, high quality health care (supported by theory and science) on the one hand, and severe time constraints and very demanding efficiency criteria on the other hand. In a way these two extremes illustrate the 'management perspective' in contrast to the 'employee perspective' of nurses. Budgetary restrictions recommend that in the future work processes

[2] In the UK there was a simlar shift from a directive 'control' approach towards an 'empowering' approach to care that relies upon the establishment of trust, with a focus on support and development.

will be dichotomised between simple tasks to be carried out by lower qualified assistants and coordinating/supervisory tasks carried out by higher qualified nurses. However, the increasing coordinating role of nurses would leave the direct interaction with the patient to the lower qualified nurse assistants. This type of division of labour contradicts the aim for providing integrated health care services of high quality.

Professionalism

Nurses increasingly show a more 'professional' work attitude that would overcome an idealised model of nurses, which had been dominating the image of the profession until maybe a decade ago[3]. The tendency towards professionalism goes in line with a rather recent attempt in Germany to establish nursing as an independent profession in a way that nurses are not just subordinated to medical doctors, but are seen as experts in their own field. In this regard opportunities for continuous professional development play a key role and an academic path to step up the career ladder has been introduced recently. Health care strives for equal partnership with medicine, especially now that nurses increasingly also take over responsibilities for the economic aspects of hospital organisation. Through nurse associations this approach could be strengthened, but due to the diversified German health care system, which is split into a variety of different institutions and bodies of responsibility, it is difficult for nurses to form unified political bodies to negotiate with policy makers and the legislature. In contrast, the medical profession represented by doctors relies upon a strong political voice of their associations. Other factors contributing towards professionalism and changing role models in nursing in Germany are the increasing proportion of male nurses (currently approximately 15-20 per cent) and a more professional work attitude of recently trained nurses.

Vocational education and training

Initial education and training in the German health care system is designed like other VET programmes of the German dual system, but vocational schools for health care are not under the governance of the state like most other vocational programmes. General guidelines exist regarding education and training for certified nurses, but each responsible body insists upon introducing a specific approach and ethos to the apprentices regarding the way of how to provide health care services. In contrast to other European health care systems nurses in Germany specialise in three different educational paths: general nurse, nurse for the elderly and child nurse – a concept which is increasingly questioned. Today various discussions on VET policies in health care favour a more unified educational path to increase flexibility and international competitiveness of German nurses.

2.3 France

According to the 2002 World Health Organisation (WHO) assessment the French health care system is rated as one of the best in the world in terms of four basic criteria: the overall level of health attainment of the population; the (limited) extent of health inequalities between individuals; the health system's responsiveness towards change and patient satisfaction; and the distribution of the financial burden. The system is well equipped to satisfy these criteria. Within this system, nurses form a well-established occupational group, although like in most other countries they are lacking social recognition compared to the medical profession represented by doctors. This is noticeable, for example, in terms of the comparatively poor salaries for the increasing work-load and responsibilities nurses have. With regards to the division of tasks, doctors primarily have functional (medical) responsibilities whereas health care services and the daily work in hospital wards are mainly organised by senior nurses.

[3] This idealised model emphasis society's and patient's ideal of a nurse as the always friendly and smiling woman who is devoted and willing to perform a large variety of services on demand.

Nurses in France show a strong professional identity closely linked to the attachment to the ethics of the nurse profession.[4] This attitude fosters a high work morale combined with organisational structures of hospitals and job profiles that provide a rich learning environment and support learning processes. These seem to be important preconditions for the continuous integration of innovations in health care and the use of modern medical technology. Although the organisational and hierarchical structure of large institutions of the French health care system are characterised as heavy and complex, human resources management acknowledges a general acceptance and commitment of employees regarding innovation and continuous learning. Of course, the complexity of hospitals in France is linked to their respective size. Usually small clinics are private and more flexible in their organisation and structure.

Nurses working in the public sector (mostly in hospitals) are employed as civil servants with a high level of job security. Unionisation is relatively high for this category of employees. By contrast, there are no employment guarantees within the private sector. Although nurses are generally highly attached to their profession and the French health care system, an increasing inner-European and border mobility can be observed. Nurses' desire for higher salaries and better working conditions has created an interest in job opportunities outside of France. This is particularly the case for nurses working for the private sector. For example, some nurses in the Alsace region prefer to work in Switzerland where salaries are relatively higher than in France.

In summary, nursing in France is regarded as a profession of high status protected by unions and integrated into a strictly regulated system. Nurses generally are well qualified and flexibly respond to the necessities for continuous learning. In both segments of the sector, public and private, nurses show a strong identification with the quality of services provided to patients. However, like in most countries the professional identities of nurses and other medical staff are undergoing important structural changes. This is basically due to the following recent reforms and developments:

- Health care related technological innovations are encouraging the home-use of disposable medical equipment by patients. The emergence of out-patient medical treatment, auto-diagnostics and home care services has effectively decreased patient's short-term stays in hospitals. Concurrently, the need for long-term hospitalisation has increased due to partially or fully dependent patients. Reforms in hospitals take these structural changes into consideration by effectively combining increased efficiency (through quality control) with reduced costs for universal health care coverage.
- Within the new structure of health care management, 24 regional hospital authorities have been established for planning health care needs and allocating hospital's annual budgets. These authorities form contractual agreements with individual hospitals to define objectives and requirements. The aim is to create pools of excellence by merging hospitals and closing down, if necessary, hospitals with occupancy rates of less than 60 per cent. Nursing and other staff are then transferred between hospitals. The budgeted funding is allocated according to a system of accreditation for the identified efficient hospitals.
- In order to track down health care spending and improve the functioning of the sector through computer-based technologies, each social security affiliate is given a 'VITALE' smart card. This card links the person through a secured computer network with all kinds of health care providers: public hospitals, private clinics, general practitioners, specialised doctors, nurses, etc. As this card enables a direct electronic transfer of the patient's medical records and prescriptions to health care reimbursing funds, it is also used as an

[4] Nurses in France are strongly attached to the ethics of their profession in two ways. First, through the 'acte propre' that relates to a nurse's caring mission with autonomy, responsibility and a high level of psychological and relational interaction with the patients. Second, through the 'acte prescript' that relates to the medical mission characterising a nurse's daily work-related relational interactions with doctors within hospitals or clinics.

instrument for controlling health care spending. Through controlling expenditures it is ultimately also a tool to implement sanctions against hospitals and doctors if necessary.

- The introduction and implementation of the 35-hour maximum weekly working time regime has significantly affected the work organisation in hospitals. This regime, although welcomed elsewhere, has increased the work burden and involuntary time allocation for hospital staff, especially for nurses. This is primarily due to the need for 24 hour shift working, and in the absence of the use of staff on overtime for replacement 'cover' when short-staffed. As a consequence work-loads are sometimes significantly increased and the implementation of the whole system in this context is under review and the scheme is likely to be adapted.
- The 'supplementary pool', or adopting a more literal translation the 'pool for compensation and replacement' (*Service de Compensation et de Suppléance*), facilitates flexibility in the use of health care professionals. It is used to compensate for temporary staff shortages in hospitals. Although staff are drawn from the pool as required, the use of the 'list' is pre-planned from the individual's perspective and staff have permanent work contracts. Being a voluntary system, the pool recruits nurses in a similar way to other departments. Mostly basic grade nurses are then functionally and horizontally mobile on demand between different departments of public hospitals. In the light of different departmental needs (within the hospital) of temporary work or replacement, the pool distributes them between its members according to their profile and their pre-planned time for shift work (proposed two months in advance). It might be thought that individuals just move from the list to work on permanent attachment to particular departments. In fact, there are some advantages to being in the pool, most notably that you are much more in control of your own working time, whereas those working in departments will have to agree rotas.
- An initiative for facilitating and increasing the internal mobility of nurses between different departments of hospitals is currently under discussion with the social partners (with the intent that this would not be subject to the usual formal constraint upon job-transfer). At present, outside the 'supplementary pool' the internal mobility of nurses is still limited to the units of the same department.

Although the above mentioned developments do considerably affect work structures and organisation, they do not seem to induce major dynamics or shifts within the French health care system. There is no sense that the nursing profession is undergoing a redefinition process. The health care system, including the nursing profession as currently established, is held in high regard by the public, is financially well equipped, and does appear to be evoking a high level of satisfaction for both medical staff and patients. The French health care system delivers generally high quality service provision for all affiliates of the social system without any kind of discrimination and regardless of whether they are use public or private provision. This structure of equality evokes a high level of satisfaction and attachment of nearly all providers and users of the French social security system.

2.4 The UK

In the UK, flexibility in work organisation had been a major goal of employers in pursuing the NHS modernisation agenda from the mid-1990s (Department of Health, 1997). However, since the 2001 general election the emphasis is upon recruiting and retaining more staff making the approach to flexibility more employee-focused 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 all night for the full range of possible duties across a hospital. This practice proved problematic 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.

In the UK nurses and professions allied to medicine 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. Nurses are increasingly willing to move to other hospitals, particularly on completion of initial or further training or for promotion. In addition, 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 many professional groups and hospitals have used access to further training as a means to encourage applicants. The possibility for promotion as extended scope practitioners (promotion that involves continuing in practice rather than moving into management) is also seen as an aid to retention of staff.

All the health care professionals interviewed in the UK were working in National Health Service (NHS) hospitals. NHS hospitals are very clear examples of organisations where the commitments to flexibility and transferability have been given particular emphasis within the broader political aim of modernising the NHS (DoH, 1997). The organisational changes in hospitals and the NHS, changes to professional training and development, changing ideas about the nature of practice and philosophies of care, changing patterns of work and demand for services, the adoption of new technologies and new techniques have created a turbulent environment for practice for health care professionals working in hospitals.

These changes mean the skills to be used by nurses in practice following initial qualification need to be refined. The newly qualified still have much to learn before others and they themselves regard them as experienced practitioners with acknowledged expertise in an environment characterised by flexibility, transferability and work intensification. Newly qualified health care professionals still have much to learn. In order to make a successful transition in becoming an experienced practitioner the ‘novice’ will need to negotiate six major learning challenges involving:

- Successful engagement with major work activities
- Successful interaction with others
- Successful learning from experience
- Alignment of professional and personal values
- Commitment to continuing professional development
- Coping with the demands for flexibility, transferability and work intensification in the workplace.

The context in which the work takes place, a hospital department with demanding performance targets, itself acts to reinforce some tensions between working and learning. For example, decisions about balancing the competing requirements for service delivery and how to support skill development most effectively have a number of dimensions. These influences upon service delivery include professional judgement about the most appropriate approach to care and practice; organisational issues around how to cope with the particular context in which health care is provided; caseload management; and departmental management. This means that in any particular setting there is not a single model of best practice as to how health care professionals should act. Rather hospital departments have to make contextualised decisions about how best to optimise service delivery and skill development in the settings in which their practice is grounded (Brown et al, 2000).

What the managers' interviews in health care in the UK show is that the occupational identity of nurses is 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. However, alongside these pressures for change upon occupational identities, at the same time there are very strong continuities with the past and images of the skills and qualities nurses should ideally possess. One major problem concerned work intensification, but even this is starting to be acknowledged as an issue that needs to be addressed.

It is important too to make the point that, even though there are pressures for the radical reconstruction of skills profiles and work identities, for many staff working in health care occupational identities are rooted in 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.

3. Managers' views of the work identities of nurses in Estonia, France, Germany and the UK

The above national contexts have clearly illustrated that the social construction of the skills of nursing is a complex process with explicit social, economic, political, psychological and organisational dimensions. A simple technical process it clearly is not. Looking at commonalities in developments in Estonia, Germany and the UK it might appear plausible to construct a model with 'imperatives' leading to the 'modernisation' of nursing according to the demands of marketisation, economic efficiency and effective organisation. The problem with this model is that it clearly does not apply to France. Rather the French experience shows that these factors are not 'imperatives' rather they are grounded in 'choices', values and a willingness of staff to act collectively in support of their goals.

Indeed one of the most interesting aspects of the discussions with French managers was not that they did not wish to shape patterns of skill utilisation of nurses in a more radical way. They did. Rather trying to bring about changes to the work identities of nurses in public hospitals in France was effectively a non-issue precisely because of public support and 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 largely because of traditional hierarchical patterns of work organisation, the presence of very strong trade unions, and long-standing bureaucratic recruitment procedures based on the 'replacement lists'.

Managers complained that aspects of the French system are bureaucratic and rather inflexible. Even for nurses there are some disadvantages in that transfer between departments is difficult and some nurses might wish for less routine and greater variety in their work. For most nurses, however, these disadvantages are outweighed by the social stability and stability in outlook the system generates. (Also a nurse wanting more variety could join the 'replacement pool'). This is all the more striking if a comparative perspective is adopted. In the other three countries there is a sense of a 'profession under pressure' and many nurses as individuals facing much greater uncertainty and stress than their French colleagues.

This is not, however, an argument for the transfer of the French model pre se to other countries. Indeed some English health care professionals liked the greater degree of individual control over their work that they had and felt there was more opportunity to exercise a fuller range of skills in their work than their French counterparts had (certainly in taking over more clinical responsibilities from doctors). However, there is the rub - it is an individual form of coping and control. In France, nurses exercise a stronger degree of collective control and processes of skill utilisation and identity formation are being changed in a more controlled (and slower). In the other three countries occupational identities in health care are under much more pressure and there are explicit discourses about what skills nurses require and managers actively contribute to that discourse.

However, for the French managers voicing such complaints as they had in the interviews appeared cathartic rather than a prelude to action. There was a weary acceptance that effective direct recruitment was not possible (the replacement pool had to be used) and that employees' interactions with management were, in most cases, mediated by a representative of the trade union. Thus, managers considered that 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 and skill utilisation, because of the existence of highly regulated and 'introverted' occupational identities, supported by the involvement of strong trade unions. Overall then, managers felt constrained, and nurses felt secure, in how the skills of nurses would be utilised in public hospitals in France.

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 (in relationships with patients, colleagues, physicians), new developments in medicine and health care, organisational restructuring and changing patterns of work organisation. The nursing profession, along with the rest of the health care system, in Germany was expected to adapt to the modernisation (and audit-driven) culture.

However, in comparative perspective, there was one other interesting challenge to the 'traditional' image of nursing and 'traditional' skills profile of nurses, occurring in Germany: that was the relatively high number of young men going into nursing (up to one in five entrants to nursing). This was partly attributable to the large number of young men opting for 'community service' rather than 'military service' after being 'called up.' A significant number of these young men find out from experience that they do have the skills, qualities, attitudes and values necessary for 'caring' work and subsequently enrol for nurse training.

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, was 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, being tainted by the past 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 approbation 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 their behaviour 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.

Many hospitals in the UK are facing staff shortages and face challenges to retain the staff they have. This is true for medical staff, nurses and other professional staff. Staff shortages have resulted in recruiting nurses from other countries and introducing greater flexibility in work organisation. However, there are, of course, limits to the scope for flexibility in the health professions, because the employment of staff is subject to national regulatory frameworks. Human resources policies react to the problems of recruitment and retention of professional staff by, for example, changing the skill mix between doctors and nurses 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 involving doctors, nurses and other support staff.

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).

4. Nurses' perceptions of how their skills developed and of their own work identities

The main focus of this article is upon the views of managers on the changes in attitudes towards the formation, development and utilisation of the skills of nurses. However, it is perhaps also useful to present some context of what 'working as a nurse' involves (for example, while working as a member of a 'replacement pool' in a French hospital) and give some sense of the pressure and stress some nurses feel in doing their job. So rather than summarising the reactions of all the nurses interviewed in the four countries, it might be easier to get a richer flavour of the work-related skill development and identity formation processes they experience through the use of a couple of extended illustrative cases drawn from Germany and France. Members in a number of settings in the four countries pointed out that from their perspective for optimal skill formation, development and utilisation the 'ideal'

was to have a mix of 'anchors' and 'new blood', representing continuity and change in attitudes towards working, skills utilisation and identity formation. Hence the two cases have been chosen to represent those two types - their names have of course been changed.

4.1 CASE I

Marianne is 48 years old, married with a step-son and works in a German hospital. Since her childhood she always wanted to become a nurse, as she grew up with a positive attitude towards the value of caring, as she had a bedridden mother who had had a heart attack at the time of Marianne's birth. After three years of vocational training as an ordinary nurse in a church-run hospital she decided to join a public hospital, as she found that the church hospital was "too small". Marianne began working in the same unit where she is still working today, the urology ward, in 1974. At that time she was immediately offered a good post and this strengthened her view that "it was good to have changed the hospital".

Today, Marianne has been working in the same hospital and also in the same ward for 28 years, which she herself regards as being "very rare in these changing times". She is still satisfied with her area of work as she finds urology extremely interesting in its connection to various other areas of medicine. Therefore she still feels that this ward is "her place". Marianne helped establish the urology ward and has been its director since 1979 supervising around 15 nurses.

When Marianne was around 40 years old, she experienced a personal crisis and considered considerably reducing her working hours. At that time she began to feel burnt-out and tired of the routine – she felt that she had been 'caring too much' putting a lot of her personality and energy into her professional life. As Marianne reflected upon her personality, she realised that already in the beginning of her career as a nurse she was too close to the patients, which was "good for them, but not for myself." She identified with the sufferings of the patients to the extent that she often felt exhausted and fell sick herself. As a consequence she even considered leaving the profession and the health care sector. It was through her own initiative and with the help of a series of seminars that she learnt how to maintain an emotional distance from the patients and to cope with psychological stress caused, for example, by deaths of patients. With the help of these seminars she learnt to redefine her own function as a rather supportive nurse. Today Marianne has learnt to apply a more professional approach and is very happy with her work situation and the responsibilities she assumes.

Marianne is still highly motivated to widen her knowledge and regularly attends different training courses the hospital offers. She also considers it necessary to be up to date with the most modern technologies and medical treatments. Often such learning takes place informally through colleagues and representatives of pharmaceutical and medical-technical companies, with whom she co-operates. Broadening her knowledge brings a lot of movement into her field of work and motivates her to continue learning, even after 28 years of working in this area.

When asked about her career development, Marianne stated that she never really chose to become the director, it "just happened." As director of the ward she is predominantly responsible for administrative and organisational tasks and is hardly involved anymore in direct caring and nursing. That is something she is regretting as she would prefer to work more closely with the patients. Nevertheless, Marianne feels strongly attached to her job and place of work. She sees herself destined to work where she is at present and accepts the negative aspects which she experiences at work, for example stress, as part of her job. In her current position Marianne sees herself as "an all-rounder", who carries out a whole range of different tasks, some of which are not necessarily her responsibilities. This has led to an increase in the workload and Marianne regards this to be part of a "fundamental change within the whole health care sector", which not only affects the work of nurses, but also that of doctors and other medical staff.

Cost-reduction has played a dominant role in the discussions about reforms in the German health care sector for the last five years. As the ward director Marianne wasn't given any formal training in accounting or financing, which is usually necessary for the implementation of cost-reduction schemes. Instead, she had to learn this for herself on the job. Today, she also trains her colleagues on this informally.

Marianne lays emphasis upon her counselling role and encouraging the patients to do as much as they can by themselves. Today, she sees her role much more as an advisor or a supporter than as a helper. The nurses do the complete nursing job only when the patients totally depend on external help. But the 'empowering' approach takes a lot of time, which is more and more scarce, thus creating a strong time and work pressure, in other words, stress. Furthermore, the reduction in the number of beds from 36 to 20 has further contributed to work intensification, because the number of patient admissions is increasing. The result is to improvise with provisional solutions by, for example, organising temporary beds.

Despite these organisational problems staff fluctuation in the urology ward remains low. Marianne accredits this to the interesting field of work, a good work environment and her supportive attitude as ward director by which she is always encouraging her staff. She regrets, however, that she cannot give financial rewards to those who work very well, because she considers financial incentives would be a very effective encouragement for the staff.

Marianne cannot imagine herself working until she reaches retirement age, because she does not think that she could continue to cope with the workload with increasing age. She thought of changing her field of work but at the same time was doubtful whether this would be possible at her age. Indirectly, Marianne also expresses her disappointment about the fact that she is not sufficiently remunerated for her performance at work. However, Marianne's job satisfaction is still very high and she does not wish to work in any other area or field.

Conflicts:
On the one hand, as a nurse Marianne is dissatisfied with the reduction in the number of beds, since this means more work for her and her colleagues. But on the other hand, as the ward director she tries to understand the concerns of the management about cost reduction, although she is rather dissatisfied with the present situation. Marianne sees herself (and basically all of the hospital staff) in a conflict between the pressure for cost reduction and the demands of providing high quality care.

Marianne likes to carry out organisational tasks, but experiences an inner conflict since she does not have enough time for direct patient care. She wished she had additional staff, for example a secretary, who could take over some organisational tasks so that she would have more time for the patients.

In relation to job demands Marianne stated that the expectations of the nursing directorate are difficult to put into practice. She also feels that the nursing directorate should work as a lobby for the needs of the nursing staff, which is not the case. In relation to structural changes, Marianne considers that certain consequences of structural changes, such as unsatisfactory care conditions of patients, are not taken seriously. According to her the health care sector does not have a lobby. She envisions that it probably requires a breakdown of the system for society to realise that more money and personnel is required to improve the situation.

4.2 CASE II

Yvonne illustrates the case of an ordinary nurse[5] who is a member of the 'Compensation and Replacement Pool' in a French public hospital. This pool is considered as an effective intermediary promoter of fluidity in an otherwise stable staffing context by allowing nurses' voluntary transversal flexibility and mobility between different health care departments within public hospitals belonging to the same group of corporation. She represents a nurse with a strong professional identity who has effectively the capacity and the will to combine her strong attachment to her work and its changing requirements (in terms of flexibility and mobility) with a strong involvement (also in her function as a nurse) in other socio-cultural and humanitarian activities outside their usual occupation.

Yvonne is an ordinary nurse in her late thirties. She joined the 'Pool for Compensation and Replacement' in June 1995 through a voluntary internal transfer on a permanent work basis (as an assimilated civil servant). Her tasks and missions are basically the same as those exercised by a non-member of the "pool". The only difference lies in the fact that she is more flexible and mobile transversally through different health care departments for short-term replacements (of less than two months).

On the basis of a Scientific Baccalaureate (obtained in 1980) and after 33 months of nursing studies at Nursing School she obtained the French State Nurse Diploma in 1983. It is this national nursing diploma which gave her direct access to her first job as an ordinary nurse in the "medical reanimation (resuscitation) department" within one of the public hospitals in the same town where she studied in September 1983. Since then, she has not benefited from any further formal certification-based education and training, which automatically would allow for climbing up the hierarchy in the nursing profession (to become, for instance, an executive or a specialised nurse). However, since her first job in nursing she has been benefiting from a variety of short CVT, for example Cancer treatment (1984); Health care courses of action and medical filing (1986); Reanimation (1986); English language (1986/87); Feeding (1987); Non-verbal communicability with patients (1989); Physical and human challenges to surgical reanimation (1990); Sense of touch (1990); and the Introduction to communication, computing and the management of emergency (1995).

For her, all these forms of work-related learning and training were undertaken mainly within employer-directed CVT schemes (but taken following her own initiative) to update and enrich her competencies in accordance with the requirement to keep up with technological and professional change. These courses also helped her to develop her professional polyvalence and transversality, in the light of the required flexibility and mobility within and between different departments of the hospital(s). In addition, they enhanced her capacity for self-reflection as a nurse and relational interactions with others within and outside the workplace.

Like any ordinary nurse, Yvonne's work is organised on a moving-shift basis (3 x 8). But being a member of the "pool", she usually only works on the two first moving shifts: the morning and the afternoon shift. In either shift, she works in a team (usually composed of an assistant nurse and a doctor) in charge of about a dozen of patients. As is the case with all other nurses, she benefits from certain autonomy in her basic mission ("acte propre"), but she is relatively dependent on the doctor for any medically prescribed act ("acte prescrit"). However, her professional responsibility is normally engaged for both acts, especially towards the patient. For her, the level of work-related interactions with colleagues and patients is dependent on the nature of the respective department she is temporarily assigned to. But on the whole, the duration of two months maximum for each assignment does not allow her to develop a high level of personal and professional relational interactions within the working teams.

[5] 'ordinary' is used in the sense of having no special or additional qulaifications

As a member of the "pool" she has been experiencing a high level of work-related functional mobility within and between different departments. This lateral mobility is for short-term replacement of two-month period maximum for each assignment. It also is voluntary (concerning the choice of shift-working time), but planned two months ahead and confirmed just 15 days before the effective implementation of the assignment. Accordingly, this mobility requires a high level of functional flexibility and polyvalence, i.e. the capacity to be constantly prepared to cope with different work situations. Her working time flexibility is voluntarily pre-planned within each work assignment by the pool. For her, this mobility and related flexibility have some advantageous and disadvantageous effects. The advantages are three-fold: the development of spontaneity, transversality and openness to change; less problems of conflict, tensions and hence less stress linked to being attached to regular (long-term) working teams; and more independence and freedom of choice at work. However, in her view, the temporary replacement does not give priority to professional development and knowledge in one particular domain. Also, the lack of real and lasting work-related related interactions within working teams is regarded in a negative light (i.e. lack of integration within a working team may lead to the development of "individualism" or even introversion).

Initially, Yvonne stayed for two years in her first job in the department of "medical reanimation". After a personal unpaid leave of two months in South America (Bolivia) she asked for a transfer to the department of "surgical reanimation" within the same hospital where she stayed for over 6 years (between 1985 to 1991). Her reasons for change were basically two-fold: the heaviness of work assignments combined with lack of fluidity in work-related interactions with the hierarchy within the department of "medical reanimation"; and the work and work-related interactions within the department of "surgical reanimation" was professionally more interesting.

Halfway during her working period within the department of "surgical reanimation", she took another period of personal unpaid leave for six months for undertaking certification-based training in tropical medicine in Belgium. Then before her move into the intensive care unit of the cardiology department within the same hospital in June 1992, she took an-eight-month period of unpaid leave for a humanitarian mission for refugees in Afghanistan.

After about three years of work within the intensive care unit of the cardiology department she joined voluntarily her present job within the "pool". Her choice was motivated by at least two basic considerations. First, it gave her an attachment to the nursing profession that was more open to change, new challenges, polyvalence and the development of a wider range of work-related interactions. Second it accorded with her preference for pre-planned working time and greater stability in her pattern of working hours.

Yvonne is highly committed to her profession as a nurse with openness towards change and the challenges of undertaking a wide range of actions and work-related interactions based on human solidarity and values. She is professionally satisfied with her work as a member of the "pool", because it allows her to be more mobile and continuously experiencing new kinds of work-related interactions. It also helps her to develop a personal human capital of know-how. It gives her the liberty of choice and action and to choose and pre-plan the time of her work in shifts.

Her commitment to nursing as an occupation did not prevent her from having a passion for other activities such as her involvement in supporting Afghan refugees since 1991 and the association "médecins sans frontières" since 2001. Her personal evaluation of the current situation of the nursing profession confirms the reflections made by other interviewed nurses. That is, in spite of the progress made so far within the overall health care sector, the nursing profession still has not gained enough social recognition, especially in terms of incentives and support for a sustainable career development. Also the wages are still not at a level which

compensates for the increasing responsibility and burden of work (amplified by some rigidities in the implementation of the regime of 35 hour working week).

5. Reflections on the changing patterns of skill development and utilisation and identity formation in health care

5.1 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 stability 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, health care professionals 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 for 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 perceived distance, 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. 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 exploring this tension, 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 attention though needs to be given 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 need 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. This was vividly illustrated by the case of Marianne described earlier. In any case 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 practice 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.

5.2 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. A trainer or manager may be able to draw up profiles of the skills, knowledge and understanding, and even the appropriate values and attitudes, required. However, it remains particularly difficult to map these against 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 problem was acknowledged by managers of 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.

The interviews in all countries 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 tension 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. These pressures reinforce the importance in such circumstances of having mechanisms where individuals can talk these issues through with colleagues. Some 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 skills, qualities, attitudes and values.

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 the promotion of expressive caring remains a goal, 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 balancing the development of technical skills and caring abilities is a considerable challenge in training and development. However, even if it is successful, 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 and variations in this within and between the four countries studied emphasises this point. 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.

An example of the competing pressures for demonstrating care and increasing patient throughput can be taken from radiography. Recent changes in work routines in the UK are giving radiographers more responsibility but they are often allied to other changes that are increasing the pressure on staff. Radiographers are expected to do more for each patient (checking allergies, giving injections, scanning), but they are still expected to see the same number of patients as previously. Patient throughput must be maintained. Another example of

work intensification is where previously 6 minutes were allocated per patient for a chest X ray plus 4 minutes in more severe cases (as when someone was physically incapacitated and so on), now there are only 3.5 minutes, without other requirements having changed. To compensate for this reduction, radiographers have to talk faster, with the patient possibly losing out on receiving information, and act faster (for example, when patients have to lie down staff are told to 'tell patients there is no need to take their shoes off ').

6. Conclusions

Our review of managers' attitudes towards deployment of health care professionals in four 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 difficulty exists 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. What is also clear from this review of managers' attitudes towards nursing is that current changes in the skill formation, development and utilisation of the skills of nurses are promoting a much wider discourse about the skills that really matter in nursing and the delivery of health care more generally.

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