

# Learning to Win

BY MARY O'BRIEN

One of the most important things I have learned about nurses since I switched careers in 1970 is that there is no such thing as an ex-nurse. Technically, of course, one quits, leaves, cases to become a practitioner, even drops one's hard-earned license. Nurses do these things in significant numbers. Yet at a deeper personal and social level, the integrity, the we-ness of nurses, the sense of community is something which never seems to fade. When I meet a woman who says "I'm a nurse," I almost always answer "So am I." So I hope the reader will forgive me if I refer to "us," even if this is technically inaccurate. We-ness is more than organization, more than sentiment, more than shared interests, more than occupational solidarity: internally we are often healthily quarrelsome! But as a professional group operating under work conditions and a work structure imposed by others, we have had to battle for status and control of our work processes, and we have not always nor perhaps even frequently been victors in these battles. We have often found ourselves in environments in which our services are seen as a bit like mothering: absolutely necessary but somehow rather trivial. Working through this contradiction of being both essential and low-status has meant that strategies for change have never been clear-cut and non-controversial. Think, for example, of bitter disagreements around the issue of unionization, of diverse views about apprenticeship training and post-secondary education, of attempts to redefine what we do in such perceptions of team nursing, nursing process, total care, whole patients and so forth. Add to these the tensions created by shift-work and the rapid development of divisions in the theory and practice of what used to be called the core task: all of these strains and others have made nursing a high-stress occupation and the phrase "burn-out" has become one to which most nurses have an instant and visceral response.

Yet despite all these and other divisive issues, nurses seem to me to have retained a sense of "we-ness" which is something deeper than the simple urge to close ranks against a hostile world; something even more profound than the shared humanitarian impulse which the ideologies of science and technique have failed to extinguish. What I think binds us, both current and ex-practitioners, is a shared but not always articulated conviction that good health is the necessary pre-condition of a good society, not only on ethical but on very practical grounds. This view,

instead of being recognized as a legitimate and thoughtful piece of social analysis, is often dismissed as mere sentiment. Yet nursing solidarity, I think, does exist precisely because nurses manage, often in the teeth of adversarial forces, to unify individual commitment with social good sense. That unity is forceful and yet problematic, because it has to be put in practice in a society where good health *is* perceived in much the same way as motherhood is perceived. It is so obviously a "good thing" that it can be taken for granted that no more needs to be said; it is so obviously "necessary" that there is no good arguing about what it actually means or how it is to be attained. Health, like motherhood, is perceived as a gift of nature rather than as historical, creations wrought by human action: society's job is simply to step in as Nature's surrogate when things don't seem to be following the old lady's prescriptions. It is profoundly significant that the *vocations* of being Nature's natural helpers in such fields as childbearing and rearing and caring for the sick are assigned to women. The *jobs* of assigning meanings to these things, of explaining how such essential services are so little rewarded and of fixing them when they go wrong: all of these are male responsibilities of high prestige and concrete rewards.

I have used this controversial word "vocation" quite deliberately, understanding it as signifying less a labour of love than working for nothing. For many years now nurses have properly distrusted the term, recognizing that to have a vocation has meant historically an exclusion from the ranks of those who work creatively and purposefully as well as for suitable economic reward. Vocational work is stuck in the realm of merely responding to necessity, and is much less prestigious than the innovative tasks of, say, making history. Yet the notion of nursing as a vocational commitment dies hard. A couple of years ago I was invited to speak to the Social Planning Council in a small Ontario town on the subject of health care. After delivering what I

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thought was a pretty good analysis of the dire results of the transformation from health care to the sickness industry, one of the women in the audience popped up as soon as questions were called for to ask if I did not *really* think that nursing was a vocation. Keeping my cool as best I could, I made one of these typically academic responses: that is to say, I moved the question into a different, in this case historical, context. I referred soberly and with much respect to the influence of Florence Nightingale on the development of professional nursing then went on to make a few critical remarks on the ideology of lamp-carrying manic-depressives. I referred to the unfortunate implications for nursing of the fact that the profession was not Miss Nightingale's major interest, and that the submerging of her concern for nursing into her wider concern for reorganizing the British army in an inflexible hierarchical structure had some unfortunate results for nurses. I went on to note that despite the problematic nature of this legacy, many nurses still wore the black bands of mourning for Miss Nightingale on their caps. I pointed out that she was really a much stronger and quite different woman than the ghostly legend suggested. I referred to her quite recently published letters, in which she boasted of having slept with women of every social class and nationality all over Europe. This rather heavy bit of debunking successfully closed off conversation on vocation, but it also confused the local press. The following week they reported the event thus: Professor O'Brien said that Florence Nightingale claimed to have slept with women all over Europe and this is why nurses wear black bands on their hats!

We cannot, of course, hold Ms. Nightingale responsible for the limiting organizational forms in which health care has developed, nor indeed for the class bias which led her to want nurses to be ladies first and professionals only in the rather limited sense of doing nasty work with grace and tough-mindedness. We must always, I think, understand the historical context of the Sickness Industry as

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something a great deal more vital than an academic structure. The bureaucratic model for getting things done is endemic in complex industrial societies, both capitalist and socialist. It is an integral part of the development of the modern state and the proliferation of state political control into all the areas of existence. The modern state is a very innovative development, for it has transformed crude authoritarian rule by the strategy of procuring the consent of the governed to its policies and practices. While this is clearly an improvement on overt violent control, it obscures the fact that armed intervention is

always available if consent is not forthcoming. We had a startling and bitter glimpse of the realities of political power here in Canada in 1972. In the October Crisis of 1972, French-Canadian nationalist groups murdered a Quebec politician and kidnapped an English diplomat. Pierre Eliot Trudeau, the Prime Minister at that time, advised Canadians to "read Sophocles" while he deployed Canada's tiny army on the streets of Montreal. The United States diplomatically moved troops to the south bank of the St. Lawrence river. We who labour in the sub-systems of the state must recognize that while we may not be subject to direct coercion, our institutions are very actively engaged in this business of the organization of consent. Thus, the proposition that what is now coming to be known as the "medical model of health care" is the only possible way—imperfect in detail though it can be acknowledged to be—is still the only rational, efficient and—blessed word—scientific method of attending to the health of the people. Old notions of shared caring and communal concern are only instances of the motherhood syndrome—charming in principle, hopeless in practice.

A letter recently appeared in the *Globe and Mail*, Canada's national print medium for the organization of the consent of the governed, from the secretary for the section on pediatrics of the Ontario Medical Association, rumbling on predictably about the dangers of home birth. This was done by very crude juxtaposition of dubious statistics, the triumph of computer symbols over language and common discourse. The good doctor refers to the practices of midwives as "primitive and bucolic," which is odd language, as much of the current home-birth movement is urban. Perhaps one should not be surprised that he doesn't know the meaning of the word bucolic: it is a long time since to be a well-educated person meant ease and precision with language, and the much vaunted statistical literacy seems to be indifferent to the death of actual literacy. The danger is that people think that they are expressing truth rather than guessing at the meaning of data. This notion of either/or, science or culture, is, in my view, both dangerous and slack minded, which is also the inadequacy of the consent model of the exercise of power—you have not only to buy the ideology but conform to the prescribed practice. Any other course is "primitive and bucolic." I suspect that by "primitive" the pediatrician meant under the control of women. What I want to suggest is that notions of caring and community control are *not* incompatible with either rationality nor scientific practice nor effective organization. They *are* incompatible with the notion that only one way of doing things controlled by one section of the community is the only way. What I think we have to do is to attempt to understand why the perceived incompatibility of organization and humanism comes to be understood as insurmountable and, more importantly, what might be done to challenge the actual power to define what knowledge and reality ought to be.

In practice, the bureaucracies which organize social life and individual choice owe their dominance to a wide

range of controlling and manipulating factors: at the same time they may have to be able to convince us that we in fact make free choices or, at the very least, concede that, though nothing is perfect, we are all doing our very best. Another way to say this is to invoke the sociological cliché that institutions may claim legitimacy by virtue of their rationality, effectiveness in goal achievement, internal efficiency and commitment to the shared values of the society in which we live. Thus, a very broad range of human needs can be met organizationally—the need for social order, of course, but also the economy, social welfare, health, art, warfare, charity, education; all of these, and you can all add to that list, are seen as creating merely logistical dilemmas which have to be managed. Human needs are not seen as posing ethical and political problems which have to be acted on. You will notice that I have not included the venerable institution of the family in my list of social structures, for the conditions of social order are perceived to include not only the separation of private from public life, itself an organized and changing division which presents particular problems for women, but also the notion of health as private and illness as public. I shall want to return to that question, but let me note here that the claim that bureaucracy is rational obscures the sheer inefficiency of most bureaucracies, while the commitment to efficient health care delivery systems permits a gloss to be spread over older-fashioned notions like justice and equality.

The claim to the scientific objectivity of organizational procedures makes it possible to shrug off—regretfully but firmly—the expression of personal or subjective criticisms by health care workers, which are redefined as the mere products of an enlightened self-interest. For example, claims that less stressful organization of working hours would benefit patient care cannot be taken seriously, for the definition of nursing care is already written in granite by some invisible force higher up the hierarchical ladder, disregarding the actual, experienced, day-to-day social relations of the agents of patients of health care systems. The passion for order, that most intransigently conservative of political and organizational principles, permits all alternative options in terms of work organization to be dismissed as disruptive of the orderly achievement of institutional goals, thus obscuring the fact that institutions don't *have* goals: people do. But the presumed consensus that order for order's sake is a high priority for every thinking person is deemed to be absolute, and blind loyalty is thus a greater virtue than imagination or creativity.

We are all familiar, both theoretically and from our work experience, with the general trends of bureaucratic organization: centralization, well-defined pecking orders, obsession with technical problem-solving, the division of labour, the tendency for what is written to be considered more real than what actually happens. The phrase "scientific management" certainly sounds more benign than the more correct description of management technique as the exercise of raw power. The effect of scientific management

on scientific health care is a very complex business. Tycoons in the business world operate above the bureaucracies which they control and which do the executive hatchet stuff and direct the people who actually produce. Similarly, the medical profession operates both inside and outside of bureaucratic structure: inside for power, outside for education, professional organization, and rewards. With this inside/outside high-wire stuff, the medical profession exercises much power in health bureaucracies in terms of being able to prescribe not only treatments but *meanings*. Doctor power, even in its most primitive magical forms, has always rested on the consent of a given society to the power of medical men to give definition to what is health and what is illness and to claim these definitions as the only legitimate, certified ones. This power to name, to prescribe meaning, is the rockbed on which all political and social power rests. It also permits a hefty claim on social goods and resources, which helps to maintain that power over the generations. Beyond doctor power, health administrators have far outstripped the social and economic gains of other health workers. Doctors control knowledge and administrators control the actual work process, and both work in close cooperation with the economic forces which have found that the sickness industry is a very lucrative market.

This control of work process is enormously important both in conserving existing power relations and in the business of organizing consent. The major strategy for this sort of control is the ever-more refined division of labour, developed originally by—and powerfully symbolized by—the assembly line, but now penetrating every kind of productive work. This is why we spend so much time revising job descriptions, which become longer and more lugubrious as the actual task shrinks—it's always possible to throw in a few principles and a bit of philosophy in a job description to achieve the goal of never giving workers credit for all that they actually do and to make sure that they understand what limited power over the work process they actually have. Each part of each task is carefully wiggled out of the whole, dusted off, analyzed, isolated, described in a document, timed, costed, specialized, and assigned to a particular worker. It is reported in the press that attempts are now being made to separate and cost the symptoms of particular diseases and the time allotments needed for attention to predictable vagaries of specific bodily functions: we are close to computerized bowel control and a scan of the proper way to throw a fit. There is, of course, a heavy strain of irony in all this for nurses. Back in the 1940s, my generation was complaining because we were supposed to do

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everything, but the remodeling of the work process and the extreme division of labour which are features of current administrative utopias tend towards the ideal situation in which one worker does one thing all the time. This was hardly the solution we sought.

The real effects of all this on the actual job are better known to you than to me: the time spent in learning the ever-changing rules and policies, in deciphering and interpreting the directives, in providing data for more of the same, learning one's place in constantly shifting work procedures, checking that others are not invading shrinking areas of responsibility, trying to win back lost prerogatives. But most important is the fact that the whole thing never really works: the tremendous gaps which the splendid, totalitarian control process has managed to leave in the lived realities of health care must all be filled in. These gaps are precisely where the destructive fires of burn-out are kindled in those who have to deal with them whether they are on the schedule or not.

The management task of organizing consent is also complex. This is what is often called ideological control: the proposition that in general we have the best possible system and that any modifications have to do with particular problems which can be worked out within defined parameters of action. This process is primitively political, and the dominant model is the State itself. I have time only to touch on a couple of features of this complex system. I have already referred to the need to conserve the capacity to legitimize what is to be known as true, good, and desirable in the hands of the controllers of the system. Consent relies on a perception by the public that, imperfect though a system may be, it is the only game in town. This does not imply that people in general are blind and stupid: it is because the medical model uses its power to create the appearance that it *is* the only game in town. Immense political energy is devoted to seeing that alternatives are nipped in the bud, rendered ridiculous, and never adequately funded. We may also note the tactic of

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option, which permits selected workers access to the lower levels of decision-making process: for example, we are not privy to a decision to cut staff, but our expertise is necessary to the working out of how staff cuts can be managed in the workplace. This is known as responsibility.

The medical profession also practices a tactic of fear: fear on the part of sick people who are convinced that health knowledge is so abstruse and inaccessible that they'll drop dead in short order if they don't get the right guy at once. Nurses assuage such fear for all of their working lives but their ability to do so effectively is con-

stantly eroded by the ideology of medical omnipotence. There is also the real fear among health workers that the failure to conform with policies which limit personal work options—shift work, specialization—may mean loss of earning power. Then there is the reward system in which the hierarchy is constantly redefined and the gradations get tinier and tinier; endless and quite often meaningless categories are added to the pecking order to give individuals a sense of promotion, perhaps a little more money, but usually a large increase in responsibility-without-power. Another important tactic in the general strategy of consensual politics is the control of education, which is given some latitude for innovation as long as it does not challenge the basic structure nor the primacy of organization, technique, scientism, certified knowledge, and hierarchical control. In my own workplace we are encouraged to study, improve, and even reform educational practice, even to criticize it. The notion that we perhaps need to break up the whole system may even be voiced, though not too often. In any case, the Ministry of Education is supremely confident that the public approves of education in general, which it properly does, and educational bureaucracies can easily scorn radical suggestions as absurd and destructive proposals to tamper with the sacred right to education, and dissident intellectuals as having a long history of ineffectualness.

The picture I have painted is a dark one, and some of you may think it exaggerated. I don't believe it is exaggerated. Far more importantly, I think that there are signs that the prevailing consensus—the view that the medical model of health care is the best and only model—is beginning to show signs of fraying at the edges. It is my considered view that progressive forces in health care are beginning to emerge. They have always been there of course, and a lot of people at this conference have worn themselves out being part of them. There are signs that these activities are consolidating, and I want to share with you my view that the nursing profession is in the vanguard of this historic process. In fact, I see nurses at this time as the only major organized group which has the courage, the coherence, the experience, the true knowledge to deny the consensus, to say this is not the only possible system and it is not anywhere near the best that we can do. My we-ness springs proudly to life when I read—in small paragraphs to be sure but no longer necessarily in the women's section—that nursing leaders are telling it like it is, most recently in a measured by clearly passionate rejection of the imposition of user fees on patients. I glow when I see nursing groups in the marches—International Women's day, peace marches, anti-nuclear marches: there we are, standing up and being counted. It is my view that increasing numbers of nurses will become involved with these movements and will bring critical intelligence and political will to the struggle for a new definition of health. I think it is nurses who will challenge the medico-bureaucratic mess in which the sickness industry currently languishes.

This is not a guess, but a reading of evidence—social, not statistical evidence. There are many reasons why this development is taking place, and many more why it is a difficult and slow and often willfully obscured process. Let me speak briefly of what I see as very significant developments of recent years.

Nurses have become increasingly politicized in a number of very concrete ways. This is something more than the single-issue politics in which all particular interest groups indulge. There are important professional interests around, for example, the Canada Health Act; but nurses are not resisting the Canada Health Act because it shafts nurses, but because it enshrines a limited and even dangerous definition of health. Particular issues are, of course, important, but politicization is also a response to the general definition which has been imposed upon nurses in the last few decades. Sustained attempts to “professionalize” nursing in terms of educational strategies, the redefinition of the “core task,” and the struggles for decent pay have all in practice had



salutary effect of forcing nurses to scrutinize the conditions of their work and their strategies for professionalization. This process has led to an increasing sense of solidarity in a political rather than sentimental or professional sense, the need to make a cold-eyed estimate not only of work process but of social standing and public reputation. To put it another way, in a search for an autonomous rather than an imposed definition of who they are, nurses have

mixed results. It would be too crude an exaggeration to say that we now have better-educated nurses doing more restricted jobs, but it is fair, I think, to argue that there has been a clear erosion of nurses' areas of responsibility, status, and control of work process. The proliferation of medical technicians has shrunk the nursing role, and I would argue that what has been added on is division: separate and higher specialties (for example, in OR and intensive care) and a greater administrative role whose real function can be understood as the persuading of nurses to accept the new definition of who they are. Further, the division of labour has been at work within nursing. The system has had only indifferent success in replacing the exploited labour of the students in the old apprenticeship system, and questions of the scope and responsibilities of the various levels of nursing auxiliaries are difficult and divisive. It is quite clear even to external observers that auxiliaries are presented as cheaper and just as effective as professional nurses. But I would argue that the systematic fracturing of the coherence of the nursing task has had the

had to confront their institutional powerlessness and are less inclined to buy myths about “informal” power and influence—that we have our own cute little ways of getting the right pill in the right mouth, that we really push patients around quite a lot.

Closely woven with these developments has been the relatively swift embracing of union activism. When I left the profession in 1971 it was still quite difficult to find nurses who did not believe that union membership represented a loss of status, and who really believed that education was the road to climbing up the class ladder while unions meant falling down it. Large sections of what is falsely called the Canadian middle class have learned lessons about this the hard way—including, I may say, academics. To be sure, post-secondary education has produced excellent research and significant development in nursing care, but it has done so, in my view, at the cost of further splitting of the profession, creating an elite corps of nurses who lurk rather uneasily between management and practitioner categories. Still, despite these tensions,

the mixed results of the educational strategy are basically positive. Education can produce new and successful recruits to bureaucratic conformity, but at the same time it provides the weapons for the critical analysis which many nurses have turned on the system. In the language of the organization of consent, education creates both consenters and dissenters, and this is a healthy trend in terms of innovative practice and leadership. The combination of increasing work dissatisfaction, the development of managerial skills, education, and union activity are all factors which tend to make people turn to political interpretations and strategies.

At the same time, the emergence of feminism as a political force has had an obvious impact on this most feminine of professions. The fact that doctor power is patriarchally structured and that the managers who have crept into the administration-by-documentation process are mostly men is now seen by many of us as both problematic and political, political in the most vulgar sense of the crude usurpation of power. It is interesting here to compare the two traditional women's professions of nursing and teaching. My colleague Dorothy Smith's work shows that there has been a quite thorough and rapid takeover of the teaching profession by men since the economic gains for which women teachers struggled for so long became available. These men have appropriated executive posts—which have proliferated—consultant status and principalships, control of mixed teacher organizations, and all



in very short order. Women teachers are losing ground. The problem in nursing looks less severe, for the increase in the numbers of male nurses, while significant, is much less than in teaching. It would be naive to take comfort from this, though; unlike

teachers, the men who manage large numbers of nurses do not bother even to acquire nursing qualifications: they are administrators, systems analysts, personnel managers, time and motion study types, and assorted esoteric manipulators. Men who practice tend also to favour technological specializations which are prestigious. They have also, with the Viet Nam war as inspiration, invented the new category of "medic," in which ten months training in a community college equips mostly male graduates for a health job which pays more than a nurse can earn after

three years or more in university.

The recognition of and resistance to this kind of masculine workplace imperialism which has been generally recognized in the women's movement is reflected in health care by an increasingly critical analysis of medical and administrative pretensions and practices and by an increasing assertion of self-worth bolstered by sisterhood among nurses, as well as women in general. The innovative political strategy known as networking, which is one of feminism's major achievements, has led to cooperation between nurses and other groups, but has also been creatively developed by nurses in terms of particular issues: the Canada Health Act struggle, the midwife struggle (although we have to be careful not to let this one divide women), affirmative action groups and many others. Networking is the organization of dissent, the process by which women begin to see common collective interests which break down institutional and occupational barriers. Most radically, the artificial barrier between public and private life, which I believe to be the social lynchpin of male supremacy, begins to crumble. The magic barrier has already been breached by the number of married women entering the work force, a process which also exposes the class myths in which many dubious professionals have been seduced into making a merely ideological distinction between middle- and working-class status. The real definition of a profession is work controlled by and in the interests of men. The notion that wives "don't have to work" has been an important element of "professional" class consciousness. Like middle management, the middle class is a powerful tool in the manufacturing of consent, in this case to the inevitability and desirability of class division and patriarchal power. Back in the sanguine 1950s, it was popular to say in North America that we are all middle class now. In fact, that myth becomes increasingly difficult to uphold in the teeth of economic ineptitude and the transformations in work process wrought by the reliance on technique and the systematic degrading of human contact as skill.

The networking process which gathers women together brings laypeople into health concerns just as it takes nurses into wider social movements. In this process, we learn the political and organizational skills which enhance those already learned in professional organizations and unions. I think that increasing numbers of nurses recognize that professional exclusiveness is in fact a divide and rule tactic which must be resisted. The profressive nature of this still early and partial but already inexorable development is reflected in the new and exciting notion that service to patients is not simply care but a political service related to the civil right of good health care. The dichotomy is not in fact between hands-on care and management skill: these are both essential and need to be unified and redefined in a non-hierarchical way. But the condition of such a unification is the radicalization of health care, the creating of alternative ways of keeping both individuals and the body politic in healthy equilibrium.

Which brings us to the third area of the radicalization of nurses: the development of the alternative health care movement. Nurses have been and are involved in many of these controversies: the movement for reproductive integrity, labelled by patriarchs and the crummier sorts of politicians as the abortion movement. Attempts to change this imposed limited image have not been too successful, and the language of "choice" is less resonant than the conservative carol about right to life. But we should at least call it the abortion plus movement, for it is of critical importance to us as women and as nurses and involves far more than abortion. There is also movement for the restoration and/or extension of midwifery, for community health care, industrial and environmental health, and nutritional and fitness movements. These are the issues which the sickness industry cannot address—and it is not merely cynical to note that there is no immediate profit in them. Alternative health movements tend to unmask the raw power which lurks behind political consensus: nothing disturbs the power brokers of the medical model so much as alternative health care proposals (except perhaps suggestions that they let more people into medical school or content themselves with more modest remuneration). It is worth remembering that the National Health Act introduced in Britain after the Second World War proposed a health structure which gave equal weight to prevention and treatment of illness. It is now popular to say that the British Health Service has failed, but of course the truth is that one-half of the act—prevention—was never implemented. It is for this reason that the notion that state intervention alone can change perceptions of health care is problematic. This has nothing to do with the propriety or politics of state intervention. Of course we must use the State where we can, but we must also name those vague "powers that be" and confront them. In other words, we must work both within and against the State.

While the issues that I raise here are common knowledge among us, the notion of overt public political solutions is newer to us, as women and as workers. Conventional, within-the-system spaces for innovation and change are inadequate for tackling the problem of the unification of individual and collective health. We cannot simply abandon older strategies any more than we can walk out of the institutional arrangements of the sickness industry. What we did first was learn that we had a lot to learn. We have expended far too much energy, personally, professionally, and politically, in winning far too little; in fact, even in losing some of the authority and public respect we once had, for as the public disillusionment with health care provisions has spread, some of it has stuck to our ancient profession. But I think it must be said that as both women and as workers we have in the past been taught to lose. What we are learning out of the stress and bitterness of this experience is how to win.

We know very well that this is a collective enterprise, not only for nurses but in fact for our species. In health

terms the human species is rapidly becoming an endangered species, and we work in a social system which attempts to cover up these real dangers. It does this by insisting that health is a matter for individuals and that curing is more useful than prevention. Think for a moment about the cancer problem. The individualistic ideology of medical-model health care says that cancer is a disease which afflicts individuals, that the cause is not yet fully known, and that only specific, medically controlled therapies are even partly effective. It follows logically that the object of cancer research is to find an individual cure. The fact is, of course, that cancer is a historically and economically specific disease induced by the environments of advanced industrialism, that individual cures are an unscientific lottery, and that prevention rather than cure is the only rational strategy. However, given the causes of cancer, the prevention of the disease can only be achieved through political strategies, the disciplining of the powerful forces which pollute the environment for profit. There are few more obvious examples of the irrationality and inhumanity of the medical model than the plight of the victims of the cancer epidemic.

What is to be done? Powerlessness tends to breed in the first instance a sense of hopelessness and inaction: we are so concerned with the immensity of the challenge that we do not even notice for a while that we are changing things. We pessimistically believe that change is usually for the worse, for we look at the bizarre and exploitative changes wrought by the powerful and find them terrifying and debilitating. Further, we have to go on in the daily struggle, often beyond the rocky edge of strength and understanding, to try to reconcile the conservation of our personal dignity with the conditions of our work, to do our best for people's health in circumstances which we do not control. We are always being exhorted to "change our attitudes." What our we-ness and our growing political awareness has taught us, I think, is that those attitudes are in fact a rational response to the lived circumstances of our lives. Change is never wrought by the changing of individual attitudes, but by collective political action to change the lived conditions which breed attitudes. It is by this solidarity, this shared activity, the analysis and transformation of institutions, of power bases, of the definition by others of what is to become acceptable knowledge and transformative practice: it is this sort of approach which can teach us to win. With our experienced sense of the inadequacy of health care, of the shallowness of the accepted definition of health, of our own enormous collective potential, of our opportunity to break the bonds of occupational isolation; with all of these, united with a historical movement of resistance to the outworn ideology of man versus nature, we are ready to win, learning to win.

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