

Why Nurses Should Be Marxists

Abstract

The argument that nurses should be Marxists is made by looking at the primary areas of nursing activity in turn, giving an example of how capitalist economic relations negatively impact upon that activity, and providing a Marxist explanation of the reasons why it has that impact. In relation to the nursing activity of health promotion, it is argued that capitalism's generation of social inequality undermines the health of the population. In relation to curative activities, the focus is on how capitalism's reckless pursuit of profit has subverted the sustainability of bactericidal interventions. The argument in relation to comforting and assistive care is that the ownership and control of health services by capitalist corporations undermines therapeutic relationships. Finally, in relation to supportive care, it is contended that capitalism's requirement for a disciplined workforce can compromise healthcare professionals' support of employees. It is concluded that if nurses aspire to have some control over their activities, then it is a good idea for them to avail of Marxism's capacity to identify the socio-economic mechanisms by which capitalism affects nursing care.

Keywords

Capitalism, inequality, surplus value, nursing care, health services, privatisation

Introduction: Setting the Parameters

Before arguing why nurses should be Marxists, it would be helpful to lay out the parameters of the discussion. By making such an argument, I am not claiming that Marxism is capable of providing a metanarrative of sufficient capacity to guide nurses through all the health-related challenges they may face. The most obvious limitation of its remit is that within the biopsychosocial trinity, it can only claim clear pertinence to the social (although I will argue that it has explanatory power in relation to how other areas of care are operationalized). Even within the social domain, it cannot aspire to an explanatory monopoly. Given the crosssectionality of influences upon contemporary human health and experience, a lot more analytical 'isms' are required to provide a comprehensive foundation for care – feminism and anti-racism come immediately to mind. Underlying all three is the fundamental notion of humanism, by which I mean the intentional stance to other human beings that accords them a humanity as full as that which we accord ourselves.

However, if the last decades have taught us anything, it is that humanism is not enough. It has become painfully obvious that, as arrogant little animals who have taken the prehensibility of our thumbs and the reflexivity of our minds to mark us out as independent from the rest of life on the planet, we are well on the way to engineering the destruction of the health and well-being of vast swathes of animated existence, including ourselves. We have entered the era of post-humanist concern in which actions predicated upon environmentalism become ever more crucial to survival.

My claim is not that Marxism provides a sufficient guide for all our responses to the challenges to health we face, but that, by illuminating the socio-economic determinants of health and illness, it provides a necessary component to our understanding. Not only does it highlight the crucial influence of economic, social and cultural relations pertaining in contemporary society, but it provides an explanatory framework that exposes how unequal and exploitative relations impinge upon our health and wellbeing.

To start to put some meat on the bones of this very generalised claim, we need to be clear about the activities that nurses engage in that might be affected by the social forces and relations that Marxism claims to be able to explain. There are at least five types of activity that fall within the rubric of nursing care. The first type entails health-promoting activities, which consist of those actions designed to ensure that people's resources, environment and behaviour are as conducive to their good health as possible. The target of these activities may be extremely broad, encompassing whole populations. The second type relates only to those who are ill. Curative activities are those designed to restore the sick to health. Whether illness is acute or long-lasting, it frequently involves both physical discomfort and / or emotional upset. Comforting activities strive to eliminate or minimize the physical pain and psychological distress of those who are sick, while assistive activities consist of helping people to do the things that they would do for themselves if they were healthy. Not all those who fall ill will recover quickly or at all. Supportive activities have the aim of optimizing the health, wellbeing, comfort and independence of those with a disability, long-term condition or terminal illness.

Using examples from the UK and the USA, I contend that every one of these activities of care is deeply affected by the forces and relations of production that pertain in the society within which they take place. To support my contention that Marxist analysis is both pertinent and useful to nursing, for each activity I provide an

example of how capitalist relations of production impinge upon it. Before each example, I lay out briefly the aspect of Marxist theory that can best explain the processes involved, and after the example, I set out my argument about Marxism's pertinence in more formal terms.

Health Promotion

Marxism

Marx characterised capitalism as a social and economic system riven between two groups – the bourgeoisie (or capitalists), who owned and controlled the means of production, and the proletariat (or workers), who did not, but who sold their labour to the bourgeoisie. Proletarians earned wages for their part in the production process, while the bourgeoisie accrued profits by selling products and services at a price greater than they cost to produce or provide. For Marx, increasing economic inequality between the bourgeoisie and the proletariat was built into the system because of the impetus for capitalists to squeeze out a higher rate of profit by increasing wages at a slower rate than the increases in workers' productivity: 'Hand-in-hand with the increasing productivity of labour goes, as we have seen, the cheapening of the labourer, therefore a higher rate of surplus value even when the real wages are rising. The latter never rise proportionally to the productive power of labour' (Marx, 1990, p.101).

Capitalism and Nursing

If it is part of the nursing role to promote good health, the corollary is that nurses have an obligation to act in ways that negate or mitigate factors that engender poor health. As Richard Wilkinson and Kate Pickett (2009) have demonstrated, one of the most significant drivers of poorer health is inequality of income. While the citizens of very poor nations will tend to have poorer health and lower life expectancy than those of richer nations, at a certain tipping point, the relationship between the wealth of a nation and average life expectancy of its citizens weakens dramatically. From that point on, the crucial factor becomes the level of income inequality, with higher rates of infant mortality, obesity and teenage pregnancy, and lower life expectancy all being positively correlated with income inequality in richer countries.

A popular conception of wealth distribution is that the Marxist prediction that the gap between rich and poor would continue to widen got it wrong, in that the issue was largely resolved by reforms initiated by Roosevelt's 1930's New Deal in the USA and by the post-WWII welfare reforms in the UK and elsewhere in Europe. It was indeed

the case that during this era income inequality lessened considerably, largely due to state intervention to enforce redistribution. However, the historical context of these developments needs to be taken into consideration. Following the failure of the Western powers to crush the Bolshevik revolution, by the 1930's the Soviet Union posed a powerful counterbalance to a capitalist system that had come to the brink of collapse in the Great Depression, and had only managed to regenerate through the huge Keynesian project that was the Second World War. The threat to capitalism was three-fold: the existence of viable alternative in the USSR and, later, the People's Republic of China; a politically aware and militant domestic working class; and falling rates of profit that required to be boosted by an increase in people's consumption, which in turn required them to have a sufficient income to buy a wider range of goods and services. Capitalism had to compromise to survive.

But this was only a temporary setback for capitalism. Simultaneously with the crumbling and eventual collapse of the USSR, Ronald Regan in the USA and Margaret Thatcher in the UK began to loosen the controls on capitalism that had obliged it to redistribute a proportion of its wealth (Porter, 2013). Income inequalities rapidly began to rise again. At the same time, these new right governments began a sustained assault on their industrial bases. The decimation of mining and heavy industries in the UK was matched by the creation of the rust belt in America, and with these losses went much of the power of the industrial working class. Finally, a new 'solution' was found to the problem of falling rates of profit. Instead of ensuring sufficient income equality to enable people to earn enough money to buy the things that capitalism made its profits from, they were enabled and encouraged to go into debt to fund their consumption. This of course had the added advantage to capitalism of enabling it to make even greater profits from selling money (which is what giving credit with interest involves).

In the USA in the quarter century after 1979, the share of income going to the top 1% of earners doubled from 10% to 20% of total income. This huge rise was exacerbated by a reduction in state transfers and taxes (Congressional Budget Office, 2011). These developments more than wiped out the gains in income equality that had been made since the New Deal. Thus, in 1927, the top 0.01% of US families had an average income of 892 times the average income of the bottom 90%. By the early 1940s, this had dropped to less than 200 times, a multiple that was maintained until the early 1980s, since when it has been climbing rapidly, so that by 2006 the multiple had overtaken the 1927 figure, standing at 976 times the average earnings

of nine tenths of the population (The Nation, 2008). Rather than letting up after attaining such obscene levels of income inequality, the momentum towards the concentration of wealth has been given a powerful fillip by the change in taxation initiated by Donald Trump.

A very similar trajectory can be mapped out for income and wealth inequality in Britain (Wilkinson & Pickett, 2009), with the very rich getting ever richer. Thus, having risen from £450 billion in 2013 to £724 billion in 2018, the combined wealth of the richest 1,000 people in the UK was 128% of the combined wealth of the poorest 40% of the population (The Equality Trust, 2018).

Marxist Nursing

From all this I wish to distil four premises on which to base a Marxist nursing approach to health promotion. First, it is part of the nursing role to promote good health. Second, income inequality leads to poorer health. Third, increasing income inequality is an inherent dynamic of capitalism. Fourth, this dynamic has only ever been successfully reversed by political praxis that has challenged the dominance of the capitalist class. We can therefore conclude that if nurses are serious about improving the health of populations, then they have an obligation to engage in such praxis.

Curative Care

Marxism

My implication in the introduction that Marxism has not addressed the issue of the environmental consequences of capitalism was unfair to Marxism. Marx's close collaborator, Friedrich Engels, was acutely aware of the destructive consequences of the capitalist obsession with the accumulation of profit at all costs:

As individual capitalists are engaged in production and exchange for the sake of the immediate profit, only the nearest, most immediate results must first be taken into account. As long as the individual manufacturer or merchant sells a manufactured or purchased commodity with the usual coveted profit, he [sic] is satisfied and does not concern himself with what afterwards becomes of the commodity and its purchasers. The same thing applies to the natural effects of the same actions. What cared the Spanish planters in Cuba, who burned down forests on the slopes of the mountains and obtained from the ashes sufficient fertilizer for one generation of very highly profitable coffee

trees - what cared they that the heavy tropical rainfall afterwards washed away the unprotected upper stratum of the soil, leaving behind only bare rock! In relation to nature, as to society, the present mode of production is predominantly concerned only about the immediate, the most tangible result (Engels, 2007, pp. 260-61).

Capitalism and Nursing

As part of inter-professional teams, nurses have an important role in activities that are designed to restore the sick to health. In recent years, with the expanded role of the nurse, this activity has taken on even greater significance. A hugely effective curative intervention over the last century has been the use of antibiotic drugs. Responsible for a dramatic reduction in morbidity and mortality caused by infectious diseases, the efficacy of this class of drugs has meant that those in the West at least have lived their lives largely protected from the scourge of pathogenic bacteria. But no longer - we are facing into an era where bacterial infection will kill ever-increasing numbers of people. What I wish to argue here is that the end of the age of antibiotics is in large part a consequence of capitalism's insatiable and blinkered pursuit of profit.

The development of penicillin is the stuff of medical heroics. From Alexander Fleming's discovery of the antibacterial effect of penicillium mould to the development of a technique to extract penicillin from the mould by Howard Florey's team, and Mary Hunt's discovery of a mould with sufficient concentration of penicillin to be used for mass production, it is a textbook example of human ingenuity in pursuit of the good. All the more so because there was no profit motive involved in this quest to combat infection – penicillin was not patented (Sidebottom, 2012).

Looking on at the phenomenal success of penicillin, pharmaceutical companies saw the potential for huge profits if they could develop, patent and produce alternative antibiotic agents. Their search was successful and in the period between 1948-1950 major antibiotics of commercial value, such as oxytetracycline and chloramphenicol, came on to the market.

Meanwhile, as early as the 1950s, the outbreak of antibiotic resistant infections provided evidence that the relationship between bacteria and antibiotics was a one of a Darwinian race between genetic mutation and novel drug development. The continued efficacy of antibiotics depended upon the rate of innovation remaining

ahead of the rate of mutation. Capitalism, with its slavish obsession with the accrual of profit, ensured that precisely the opposite occurred.

Slowing the spread of resistant strains depended on the parsimonious application of antibiotics, confining it to instances where it was required. The logic was that the fewer bacteria that were exposed to antibiotics, the lower the number of resistant survivors there would be to spawn future generations possessing their attributes. Unfortunately, parsimony does not make for profitability, which depends on maximising unit sales. The pharmaceutical companies invested heavily in strenuous marketing, including the encouragement of speculative prescription of antibiotics, which was so successful that by the late 1960s most antibiotic prescriptions were inappropriate (Podolsky, 2015).

Such profligate abuse of this precious resource yielded huge profits, but not enough to satisfy capitalism's greed. There was a whole new market to be exploited consisting of the animals that we eat. The discovery that the addition to animal feed of small amounts of antibiotic agents promoted dramatic increases in animal growth rates led to an enormous expansion of antibiotic sales. This market was even more lucrative because the supplements to animal feed consisted of the waste products of human-targeted antibiotics, and therefore did not require additional production. Simultaneously, corporate capitalism was encroaching into farming and bringing with it intensive farming techniques to maximise its profitability. A side effect of this intensity was the strengthening of disease vectors by overcrowding. The profitable solution to this problem was of course the general application to animals of even larger doses of antibiotics. These developments in agriculture further accelerated the spread of resistant strains that had no respect for species differentiation and were quite capable of colonising human organisms (McKenna, 2017).

On the other side of the race, after initial investment in the discovery of alternatives to penicillin, the pharmaceutical companies were content to rest on their laurels and let the profits roll in while they focused their attention on other areas of drug development, most notably those that were designed to mitigate the effects of long-term conditions (and were therefore prescribed over long periods). Thus, for example, the most recent antibiotic designed to combat gram-negative bacteria was developed half a century ago in the 1960s (Spellberg, 2010).

Following this period of profitable complacency, the response of capitalism to the current challenge of rising rates of bacterially caused morbidity and mortality has been one of market failure. On one side of the equation, the costs of developing new antibiotics are high – having already identified the easy pickings, the discovery and development of novel agents is complex and time consuming, while the cost of evaluating their effectiveness through clinical trials has increased considerably. On the other hand, income generated by drugs that are frequently administered for less than a week is paltry compared to those that are required to be taken in perpetuity. As a result, all but a handful of pharmaceutical companies have moved out of the antibiotic market (Spellberg, 2010).

Marxist Nursing

My argument in relation to nurses' curative responsibilities is based on the following premises. First, that within the bounds of finite resources, the prime consideration in the application of curative interventions should be their effectiveness; second, that they should only be applied in situations where there is evidence that it is probable (or *in extremis*, possible) that they will be effective; third, that scientific evidence concerning how to maintain that effectiveness should be heeded and acted upon; and fourth, that the obsession of capitalism with the pursuit of profit means that it will inevitably valorise this pursuit in favour of any of the above criteria. The conclusion that arises from these premises is that the capitalist obsession with profit maximisation is anathema to the nursing emphasis on sustainable human health.

Comforting and Assistive Care

Marxism

This section will be based on two areas of Marx's thought – his conception of the relationship between capitalism and the state and his theory of alienation. Marx's writings on capitalists' relationship with the state were fragmentary and ambiguous. On the one hand, he announced with Friedrich Engels that 'the executive of the modern state is but a committee for managing the common affairs of the whole bourgeoisie' (Marx & Engels, 1967, p. 82). On the other hand, he recognized that in modern representative democracies, 'there has no longer been any doubt as to the meaning of universal suffrage ... It is the 'Charter' of the classes of the people and implies the assumption of political power as a means of meeting their social requirements' (Marx, 1980, p. 244).

A modern Marxist interpretation of this ambiguity is that capitalist democracies are

founded on conflicting principles, one emphasising 'the merit of free market forces'; the other 'based on social need or entitlement' (Streek, 2011, p. 7). Within this conflict, capitalists, who promote the former principle, 'are in an exceptionally strong position as compared with other economic groups' (Miliband, 1969, p. 54). However, they do not necessarily have a monopoly of influence. As we have already seen, in eras when the working class is strong, it is capable of influencing the state in the direction of general social need (Porter, 2013).

Marx developed his theory of alienation early in his career. Like so much of his thought at the time, it emerged from his engagement with the German idealist philosopher, G.W.F. Hegel. Hegel (1977) had observed that anyone who produces something is actually reproducing something that was initially in her or his head. Hegel regarded this 'externalisation' of human thought into the products of labour as intrinsically alienating because the product is separate from (or alien to) its producer. Marx disputed the trans-historical claims of Hegel's notion of alienation, and argued that it only occurs in specific circumstances in which the things that people produce are not the result of their own ideas but those of others to whom they have sold their labour. In other words, it is the capitalist system that generates alienated labour because what the worker produces is of no intrinsic value to them; it is merely what they have to do to earn a wage (Mandel, 1970). But the problem as Marx saw it was much more profound than the workers' alienation from the product of their work; it also alienated them from their own humanity. He argued that alienated labour:

alienates man [sic] from himself, from his own active function, his life activity; so it alienates him from the species ... For labour, *life activity, productive life*, now appear to man only as *means* for the satisfaction of a need, the need to maintain physical existence ... In the type of life activity resides the whole character of a species, its species-character; and free, conscious activity is the species character of human beings ... Conscious life activity distinguishes man from the life activity of animals (Marx, 1964, p. 16).

Indeed, the problem is even greater than that. Not only does labour in capitalism deny to us a fundamental aspect of what makes us human, it also alienates us from each other: 'A direct consequence of the alienation of man from the product of his labour, from his life activity and from his species-life, is that man is alienated from other men' (Marx, 1964, p. 17).

Capitalism and Nursing

Ensuring that the sick are comfortable (Nightingale, 2000) and assisting them in doing the things that they would do for themselves if they were well enough (Henderson, 1966) are core nursing activities. Moreover, it is a fundamental tenet that these activities should be carried out in collaboration with patients (Cahill, 2008). This means that the quality of care depends upon the authenticity of the relationship. Using the example of recent developments in the English NHS, I wish to consider whether current trajectories in the organisation and control of health service institutions are facilitative of this egalitarian, humanist requirement for the quality of nurse/patient relationships.

Since the 1990s, a persistent state policy has been to introduce corporate capitalism into the running of the NHS (Pollock, 2005). It began with a concordat between the Labour Government and the Independent Healthcare Association, which the latter saw as heralding 'a time when the NHS would simply be a kitemark attached to the institutions and activities of a system of purely private providers' (cited by Leys & Player, 2011, p. 1). To operationalise this aspiration, two strategies were adopted. First, private commercial activity within the NHS was facilitated through initiatives such as the Independent Sector Treatment Programme and the Extended Choice Network. Second, NHS providers were restructured into business-style organisations by the inauguration of foundation trusts with managerial independence (Leys & Player, 2011). Meanwhile, the Private Finance Initiative meant that an increasing proportion of the NHS's capital spend was on leasing privately provided resources (Pollock, 2005).

The Conservative/Liberal Democrat coalition government took this process a stage further through the Health and Social Care Act 2012, which widened private access to NHS markets by decreeing that 'any willing provider' should be able to bid for healthcare provision contracts. Moreover, this government also abolished limits on the ability of foundation trusts to earn private patient income, and permitted them to borrow on the private markets, thus moving them even further towards becoming commercial entities (Peedell, 2011).

There are a lot of reasons why we should be alarmed by these developments. Not least is the fact that, if the paragon of free enterprise healthcare is anything to go by, the effectiveness of healthcare systems controlled by corporate capital is woeful. Papanicolas et al.'s (2018) comparison of the USA and 10 other high income

countries shows that, despite spending by far the largest proportion of its GDP on healthcare (17.8% compared to a mean for all 11 countries of 11.5%), it has the lowest life expectancy and highest infant mortality rate of all those countries.

For a cautionary example related specifically to nursing, we might look at the debate around safe staffing levels. The entrenched opposition of the American Organization of Nursing Executives to minimum mandatory ratios of nurses to patients and its insistence that decisions about ratios should be the exclusive remit of corporate managers is another indication that capitalist control over health is not the way to go (Munier and Porter, 2014).

However, the specific issue being addressed here is the effect that new forms of corporate control has upon the relationship of care. It is my contention that the now well-embedded business ethos of NHS management, with its emphasis on productivity rather than health gain, and its adoption of financial criteria to measure success, is losing sight of broader concerns relating to balanced health outcomes. The designation of health professionals to the role of corporate employees and of patients to commercial consumers has had a disempowering effect on both sides of the clinician/patient dyad. For professionals, the loss of control entailed has meant that the satisfactions involved in working together with their patients to fulfil important human needs are in danger of becoming by-products of accountancy criteria. In other words, they are becoming alienated from their labour. The tragedy of all this is that, outside the corporate elites, there is little support for this process of disempowerment:

The plain fact ... is that all health care professionals ... want ownership of their own field of action, the public wants some form of collective ownership of the NHS as a public service, and patients want joint ownership of decisions about their own diagnoses and plans for their own care not as consumers but as participants (Hart, 2010, p. 145).

When Hart talks of ownership, he is making an argument very close to that of Marx. He uses the word ownership in the sense that healthcare interactions are owned and negotiated by the clinicians and patients involved rather than being dictated by corporate demands; that optimal care requires non-alienated interaction between the persons involved. This mutual sense of humanity and personal responsibility cannot flourish in an industrialised model where control has been vested in the managerial

elite. His solution is 'to re-establish the NHS as a gift economy for all of the people, outside and beyond the world of business' (Hart, 2010, p. 147).

Marxist Nursing

The premises for a Marxist approach to nursing in this instance are as follows. First, the NHS was the product of an era when state actions were powerfully influenced by 'the classes of the people ... as a means of meeting their social requirements' (Marx, 1980, p. 244); second, over the last two decades, the state has been acting in the interests of capital by facilitating its infiltration into the NHS; third, a consequence of that infiltration has been the increasing alienation of healthcare professionals from their work; fourth, their alienation militates towards alienation between them and their patients; and fifth, mutual respect and authenticity of interaction are essential components of the caring relationship. The conclusion to be drawn is there is a need for UK nurses to defend and improve their public service, and for those nurses in countries whose health systems are characterised by corporate control to demand an end to profit-based healthcare.

Supportive Care

Marxism

For Marx, the generation of profit in terms of the price attained for a good minus the costs of production, including raw materials, production plant and labour, was the core pursuit of capitalism. Thus, the role of workers in the capitalist system is to generate value that is in surplus to that which they are paid, thereby generating profits for the bourgeoisie through their labour:

Capitalist production is not merely the production of commodities; it is, by its very essence, the production of surplus-value. The worker produces not for himself, but for capital. It is no longer sufficient, therefore, for him simply to produce. He must produce surplus-value. The only worker who is productive is one who produces surplus-value for the capitalist (Marx, 1990, p. 644).

Anything that reduces workers' capacity to produce surplus value is therefore a challenge to the accumulation of profit.

Capitalism and Nursing

Supporting those with long-term health problems is not just a key nursing activity; it is also central to the work of other healthcare professionals. The particular issue that I

wish to address here is a healthcare activity that, in the UK at least, has been seen as part of the general medical practitioner (GP) role, but which may increasingly become the remit of nurses and allied health professionals – long-term sickness certification.

A major review commissioned by the British government (Black and Frost, 2011) found that sickness absence rates involved a loss of 2.2% of all working time (Black and Frost 2011). In financial terms, direct costs to employers in 2010 were estimated at £16.8 billion, and indirect costs at £13.2 billion (Confederation of British Industry, 2010). Of this, 22% took the form of long-term sickness absence (LTSA), usually defined as absence for more than four weeks.

One of the characteristics of LTSA is that it has to be validated by a GP. Since Talcott Parson's seminal analysis of the sick role, it has been recognized that the physician's role in negotiating sickness absence operates on two levels. At an individual level, 'the role of the physician centers on his [sic] responsibility for the welfare of the patient in the sense of facilitating his recovery from illness to the best of the physician's ability' (1951a, p. 447). At a social level, in their efforts to minimize the incidence of illness-related absence from work, physicians perform 'functions of social control' (1975, p. 268). Thus, the physician 'stands at a strategic point in the general balance of forces in the society of which he is part' (1951b, p. 460).

Marxist commentators have been more specific in attributing this function of social control as being directly in the interests of the bourgeoisie (Wilding, 1982). From this perspective, members of the medical profession act as agents of capital by helping maintain a disciplined workforce in order to ensure that it continues to produce sufficient levels of surplus value (Navarro, 1978). However, while this may be the plan, the assumption that the interests of capitalism will be paramount in the doctor-patient encounter may not always be justified. There is evidence that, when considering certification of LTSA, GPs put more weight on the preferences and needs of their patients than they do on the requirements of the organisations that employ them (Higgins et al., 2014). This is partially related to GPs' belief that encouraging a return to work is only one component of the package of holistic care they offer their patients. This leaves GPs as unreliable enforcers of the discipline required to ensure optimal labour productivity.

The role and position of healthcare professionals is not determined solely by the interests of capital, but is contingent upon the interaction of countervailing powers (Light, 2000) emanating primarily from the state, capitalism and the professions (Krause, 1996). In this particular struggle, the British state, while promoting the interests of capital, has done so hesitantly, and not entirely successfully.

In their review of sickness absence for the Department of Work and Pensions, Black and Frost observed that, rather than relying on GP's, employers 'would value access to independent expert advice on the functional capabilities of sick employees, especially in longer-term and more difficult instances of sickness absence' (2011: p. 5). As a result, they recommended the introduction of an independent assessment service directly accessible by employers with the power 'to validate or refute a claim to sick pay' (Black and Frost, 2011: p. 28). They also proposed that the assessment service should be made up of multi-disciplinary teams including nurses and allied health professionals.

However, the resultant 'Fit for Work' service that the government commissioned the American outsourcing corporation, Maximus Inc. to operate, failed to gain traction, largely due to the fact that it was ignored by GPs, 65% of whom did not refer a single patient to the service (Bower and Kirton, 2017). As a result, it was wound up in 2018 after only three years. However, the government has not given up on its aspirations to break GPs' virtual monopoly over sickness certification. Part of its response to winding up the service was a commitment to look at legislation to extend fit note certification powers to other healthcare professionals including nurses (Paton, 2018).

Marxist Nursing

The premises founding my arguments concerning long term sickness certification are as follows: First, that an integral part of supportive care is to ensure that patients are not obliged to engage in activities that are inimical to their health requirements; second, that this includes their right not to engage in work when they are not sufficiently well to do so; third, that assessment of whether or not this is the case should be part of a holistic approach to their care; and fourth that it is in the interest of capitalism's pursuit of profit that workers' right to withdraw from work due to sickness should be strictly circumscribed. The conclusion that can be based on these premises is that the involvement of nurses in a role that is exclusively concerned with certification, rather than the holistic care of patients, does not represent a positive development in supportive care, in that it could be construed as entailing an

abrogation of responsibility for individual wellbeing in order to support the requirements of capital to ensure that workers are disciplined to ensure that they maximise surplus value for capitalism.

Conclusion

On the basis of my discussions with colleagues while writing this paper, I suspect that the response of many readers to its proposition that nurses should be Marxists will have been a degree of bemusement, if not amusement, at the combined archaism and chutzpah of such a claim. I can only hope that those that have got to this point, even if they do not agree with the arguments that I have posited, appreciate more clearly the crucial role that economic relations play in shaping the parameters within which nursing care operates.

Such an appreciation is hugely important. Because so much of nursing takes place on a one-to-one basis, there is an inevitable tendency for nurses to conceptualise what they do at an individualised level. But if that means that account is not taken of the socio-economic context in which care takes place, then the potential for nurses to influence that context will not be realised. As a result, nurses will have little influence over the forces that determine what they should do and with whom. In short, lack of political engagement equals disempowerment.

Far from being a bogeyman dreamed up by Marxists, capitalism is a brute fact. The internal logic of the dominant mode of economic organisation in the West involves the accumulation of capital through the production of profit, which is at least partially generated by the surplus value produced by those who sell their labour to capitalist enterprises. Where debate comes in is around the consequences of this form of economic relations. What I have sought to establish is that it has negative consequences for all types of nursing activity. Its generation of social inequality undermines the health of the population; its reckless pursuit of profit subverts the sustainability of curative interventions; its ownership and control of health services pollutes therapeutic relationships; and its requirement for a disciplined workforce can compromise care that supports its employees. Given Marxism's identification of the socio-economic mechanisms that lead capitalism to have such adverse effects upon nursing care, if nurses aspire to control their work, then applying a Marxist lens to the issues they face would be a sensible approach to take.

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