Hospital medicine and nursing in the 1980s

Interaction between the professions of medicine and nursing

THE PAPERS AND PROCEEDINGS OF
A SEMINAR HELD IN THE ROYAL COLLEGE OF
PHYSICIANS AND SURGEONS OF GLASGOW
AND SPONSORED BY THE
NUFFIELD PROVINCIAL HOSPITALS TRUST

1983

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THE NUFFIELD PROVINCIAL
HOSPITALS TRUST
1984

NPHT EDITORIAL

The Trustees of the Nuffield Provincial Hospitals Trust are glad to support the initiative of the Royal Medical Colleges in Scotland and the Scottish Board of the Royal College of Nursing in raising important issues concerned with the interaction of the medical and nursing professions in hospital practice today.

For many years the Trustees have been seeking opportunities to encourage a more comprehensive view of hospital practice in which the two major front-line professions are concerned. The fact that this book presents an opportunity for raising a series of issues which are probably universal in their application—and certainly in the United Kingdom—indicates, amongst other things, the importance of exploring matters of health in a context where participants well known to each other can be relatively frank. It is extremely important to do so since many of the issues, because of the failures in communication, tend to be overlaid by narrow professional interests, which not infrequently obscure the end, which is improved care of patients.

Fundamentally, the book is a collection of the papers and notes on discussions which took place at a seminar held in Glasgow in May 1983 together with an analysis of the parts. The first four parts consist of the precirculated papers together with resumes of the discussions on the main topics, which were chosen as significant examples of where interaction between medicine and nursing reaches its greatest pitch in current hospital practice. The discussion on each topic has been condensed and there is no attribution to individual participants other than the writers of the papers and the Chairmen. The fifth part gives the short summing-up which was made by two participants at the end of the seminar. The sixth and final chapter entitled 'An analysis of the issues' is by one of the editors (ASD) and consists partly of reflections on the seminar and partly of a look to the future.

The Trustees join the editors in thanking Miss Molly Lobban for her advice in the editing of the publication and the staff of the Scottish Board of the Royal College of Nursing for preparing transcripts of the discussions. G.McL.

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PREFACE

PROFESSOR J. A. STRONG
Convenor of Organizing Committee

The Seminar at which the papers that follow were discussed arose from a series of steps taken carefully over many months by a few individuals, convinced of the need for a new initiative to bring together medicine and nursing to discuss some of their mutual problems. These individuals were able to generate in the three Scottish Medical Royal Colleges and the Scottish Board of the Royal College of Nursing a level of awareness of the need sufficient to ensure the formation of a discussion group, now intending to meet at regular intervals. This group consists primarily of the three Collegiate Presidents and the Chairman of the Scottish Board of the Rcn.

At an early meeting the group decided that the relationship between the two professions should be considered at an exploratory all-day seminar. The Nuffield Provincial Hospitals Trust agreed to sponsor such a seminar and arrangements were made for it to be held on the 19 May 1983 in the Royal College of Physicians and Surgeons of Glasgow.

This seminar was intended to reflect the belief by many in both the professions that the progressive divergence between the two disciplines has extended too far and lasted too long. It seems extraordinary that two professions with so much in common should allow this mutual isolation to persist. Explanations to account for this behaviour are readily forthcoming. Topics for the seminar were selected as a means of introducing the discussions to follow, intended in turn to improve the existing poor relationship.

The title for the seminar is inevitably selective. The possibility of including other branches of medicine and nursing, particularly as they relate to services in the community, was considered and excluded: it would have involved too diffuse a debate and too large an attendance for the type of meeting that we had in mind. Nobody is likely to consider the programme light in substance or concept, or

lacking in relevance to patient care. We hope therefore that our colleagues, amongst whom we number Obstetricians and Gynaecologists, Midwives, General Practitioners, Health Visitors, Psychiatrists, Mental Health Nurses and Community Medicine Specialists as members of corporate bodies, will not feel excluded. This seminar should serve to show whether there is a real rather than a contrived future in this dialogue. If the outcome is as fruitful as one would hope, then the atmosphere we aim to create will allow for expansion of the concept of an improved working relationship between medicine and nursing, extending into the specialities whose very existence as separate entities, however inevitable, has been responsible for some of the difficulties we need to discuss.

The representatives of the Scottish Medical Royal Colleges and the Scottish Board of the Royal College of Nursing look forward to a constructive outcome which we hope will help to develop more effective relationships between our professions in the future. Further, they would like to thank the Trustees of the Nuffield Provincial Hospitals Trust most warmly for the keen interest they have shown in the seminar, and to say what pleasure it gave them that Sir Edgar Williams, Chairman of the Trustees, Sir Andrew Watt Kay, and the Secretary of the Trust, Mr. Gordon McLachlan, were able to be present.

I

The effects of the new technologies

PAPERS BY

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INTRODUCTION

An obvious, if extreme, effect of new technology in medicine has been the need for and creation of highly specialized units—intensive care units (ICUs)—for the management of respiratory failure, renal failure, transplants, ventricular fibrillation, etc. The use of sophisticated machines which are expensive in themselves demands a concentration of expensive and scarce resources such as staff, equipment, and space; and, as a consequence of the care provided as well as the methods of providing it, new problems—medical, nursing, technical, and ethical—have been created.

TRAINING

The complexity of both technology and medical care demands a knowledge of the principles and practice not only of the types of disorder being treated but also of the mechanical and electrical appliances being used in that treatment, that is the staff require special training. The nurses in the units must understand the specific and specialized medical problems and also the nature of the support being provided, the interaction between machine and patient, as well as being skilled in the recognition and perhaps treatment of machine failure. However, it is important to recognize that the nurse must not be considered as a machine-minder. Her prime responsibility is still to the patient and, as the nurse should not be a functionary of the machine, so the machine must not be considered as a substitute for nurse availability. Monitoring gadgetry should rather add a new dimension to patient care.

It is important that the training should be very practical as well as theoretical and it must be continued, if for no other reason than that the state of the art in technology does not stand still. For example, in

the Assisted Ventilation Unit, the introduction of high frequency ventilation brought new concepts as well as new technology, and opportunities must be provided for the staff to keep abreast of, or even ahead of, new developments.

Training must also be widely based. Because of the disparate nature of the disorders treated and the appliances used in the various intensive care areas, were the nurse trained in one unit only, she would be less than fully effective in other types of unit. This would be wasteful, particularly in view of the fluctuating demand in the different units. But a widely-based training is also important because, even within one unit, a multiplicity of problems may occur, for example a patient with multiple injuries may require surgical, orthopaedic, neurosurgical, and metabolic support in addition to artificial ventilation and renal dialysis.

A consequence of the need for special training is that nurses, even qualified nurses, without that training may be of limited value in ICUs. One might go further and suggest that an untrained person in an ICU is a liability rather than an asset.

STAFFING

ICUs demand highly trained staff and also must have them in sufficient numbers. When a patient's life depends on sophisticated life support apparatus, it is jeopardized by anything less than a sufficient number of trained people to look after him. Both the number of people and their standard of training are important. The staff/patient ratio required is very high. Staffing difficulties are compounded by an unpredictable level of demand. It would obviously be advantageous if the various ICUs in one hospital were grouped together but when they are geographically separated one should at least be able to deploy trained staff between units as the need arises. This comes back to the question of a broadly based training course.

In times of shortage, there is an obvious temptation to have recourse to agency nurses to plug gaps. This is an expedient which has nothing to commend it. It is bad enough for an ICU to be short of staff but for those left to have to supervise untrained and perhaps uninterested temporary staff in addition to doing their own work is a recipe for frustration and disaster. There is no point in providing

money for new machines if enough is not provided for staff cover. It must be the business of the nursing administration to provide adequate trained staff when required, just as it is the duty of the doctors to keep the demands on these units down to a minimum for example by returning the patients to ordinary less intensive care at the earliest opportunity. It must be appreciated that the stresses of the job are considerable when the full staff complement is present; they can be intolerable in times of shortage.

Psychological pressures

Stress is inevitable because the work in ICUs is very demanding—medically, technically, physically, and emotionally. Intensive care lavished on an unconscious, moribund patient for week after week until his ultimate recovery or death imposes great strains on nurses and relatives (not to mention doctors) and a sense of let-down or failure if the patient should ultimately die. Not all nurses (or doctors) are equipped intellectually or psychologically for this type of work. In the absence of criteria to make a rational choice we must depend on self-selection but trainees and, indeed, established staff must be under continued supervision to detect signs of inability to cope with the situation. Opportunities must be created to allow transfer without recrimination to an ordinary unit should this be desired and perhaps a limit should be put on the length of time a person should spend working in an ICU. It is also very important to maintain morale by proper consideration for the particular stresses. This may be difficult for administrators who have had no practical experience of working in such units. Two situations in particular are likely to lead to low morale. One is staff shortage and fatigue, and the other is when several consecutive patients have died.

Ethics

Ethical problems may contribute to stress. New situations have been created by new technology. In particular, it has introduced serious, indeed fundamental, questions on life and death. The criteria for cerebral death, for instance, have caused heart-searching, though this particular difficulty has been largely resolved by general acceptance of nationally agreed signs. But other ethical difficulties may remain and some may find the 'beating heart donor', for

instance, a distasteful concept. Much more difficult than the question of the definition of death is the question of whether (and when) we should 'strive officiously to keep alive'. The ability to prolong the process of dying to an inordinate degree is surely still a pressing problem, one that has led to the demand for 'death with dignity'. The decision on whether to ventilate a quadriplegic patient going into respiratory failure, or to discontinue treating a patient with gradually progressive multiple organ failure, are problems upon which not all those involved will agree. Consultation is important between medical and nursing staff on these questions, as well as on treatment. The doctor must keep the nurse informed and aware and, for instance, decisions about whether or not to resuscitate should be made in advance of need.

ADMINISTRATION

In keeping the nurse informed, it would obviously be advantageous to have a full ward-round at a set time each day with all those involved. However, administrative difficulties may make this impossible. The involvement of specialists from different disciplines makes the question of joint ward rounds at any fixed time an ideal incapable of achievement; and even the nature of cover provided by the consultants in charge of the patients may rule out availability at specified times. This does not alter the fact that a full daily ward-round of those involved is a desirable practice.

NURSING DUTIES

Perhaps one of the most important potential problems of the ICU is the delineation of nursing duties. The responsibilities of the nurse have been increased, especially in the ICU and she is now involved in duties which her predecessors would not have considered to be within their remit. These responsibilities should be clearly defined so that there is no conflict between nursing duties and those of the doctor, who must recognize that the ICU nurse is usually very knowledgable and skilled. Nursing duties are still primarily basic nursing—keeping the patient comfortable (as far as is possible), comforted, clean, and nourished. They also include monitoring the

patient's condition (with the aid of sophisticated modern equipment) and carrying out treatments ordered by the medical staff. These will include drug administration and routine care as well as more esoteric measures when circumstances demand.

Drugs

An area of possible dispute has been, and still may be, in the administration of drugs by the intravenous or extradural routes. It seems to me that if the nurse has been sufficiently trained and the medical staff accept the responsibility for adequate cover, there is no difference in principle between these and other routes of drug administration. There is a heavy onus of responsibility, however, on the doctor who orders the drug to make his orders clear and to provide adequate cover. There is a danger always in *prn* administration. For example, if relaxants, or opiates are ordered *prn*, they may be given to 'settle' a patient on a ventilator when the reason for his becoming 'unsettled' might be a deterioration in his condition. Different practices may pertain in different units and some may feel aggrieved at not being allowed to carry out duties which are encouraged in another unit.

Records

Another possible source of trouble between nurse and doctor is the nursing notes. These should comprise a record of nursing only, for there are considerable potential legal hazards involved if they overlap areas of medical responsibility.

CONCLUSION

Although technology makes new and different demands and creates new opportunities as well as new problems, the basic separation of the responsibilities of nurse and doctor remains. Because of the challenges and the difficulties, it is more important than ever that mutual respect, rapport, and sympathy should exist between them.

LARRY MACKIE

The example of computing

Computers were introduced into United Kingdom hospitals over twenty years ago to what I believe could be described as much anxiety and speculation about how they could actually help patient care. We have travelled down a long road or ascended a high spiral, depending on one's perspective, since the 1960s. We have all seen dramatic changes and advances in technology, both in medicine and in the computing industry, from the very advent of the transistor circuits, in large cumbersome boxes, to the recent advances and developments of the micro-chip, housing in increasingly smaller boxes, more powerful computers. This changes the question from how a computer can help patient care to how does advancing technology affect the role of the nurse in providing patient care.

The time has long since disappeared when National Health Service computing could be described in a single paper. Like many aspects of life today, it has split into separate specialties with specialized facilities and requirements. We now see computer technology devised to measure body contours in radiology and routinely to interpret data from EMI scanners and Gamma cameras. Clinical laboratories have developed systems for monitoring and extracting data from automated analytical equipment. Systems are also being developed to provide facilities for functional budgeting and operational and strategic planning. New systems are being developed in parallel to these advances in technology.

Effect on nursing

Similarly we have witnessed considerable developments within the nursing service. Nurses form the largest single group of health care workers in the National Health Service. Because of this, we require to be aware of the need to respond to change and to understand the

principles of management. Every registered nurse is a manager in the sense of being concerned with decisions about how to relate available finite resources to the needs of the patient.

THE IMAGE OF NURSING

Over 100 years ago Florence Nightingale raised the public image of the nursing service as it existed then. She was strongly helped in this task by the catalyst of the Crimean War. Today nursing is undergoing another major change in image, influenced this time by high technology. In times of rapid change, we should try to preserve what is good in the old, while helping to develop the required skills for the new. Florence Nightingale, I suspect, would have approved of what we are now doing, as she was a woman with vision.

In order to appreciate how some of these changes came about, one has to look back to the effect of the Second World War. It was here that the picture began to alter. Registered nurses returned from the war with new and acknowledged skills, but these were practised covertly, with encouragement by doctors who recognized the impossibility of providing these services themselves.

While nurses were undertaking an astonishing range of skilled procedures, some nursing leaders of that time decided that nursing did not want to choose to make competence in clinical nursing practice the primary focus of demand for more recognition. Perhaps they were looking for a different avenue to professionalism?

SEPARATE PROFESSIONAL STATUS

Thankfully, in spite of this attitude, skill and knowledge were promoted as the foundation of professional status and an ideology was emerging that nursing is parallel to and separate from other health care disciplines. This concept became attractive to most nursing leaders and in the 1950s we witnessed nurses beginning to look at nursing problems with the help of research techniques. Nursing turned to the social scientists for this help, while doctors were on the whole discouraging of these efforts. Nevertheless the growing point for nursing research was firmly established.

The medical profession has established a near monopoly over the

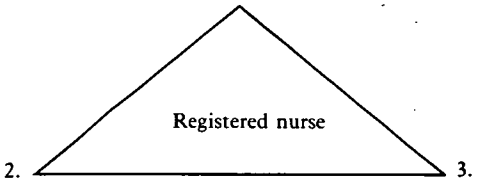
medical services, with control over allied paramedical professions and a strong political influence on government health care resource allocation. Despite the doctor's dependence on a reliable surrogate, he has until recently refused to acknowledge the registered nurse either as a member of an emerging discipline with an unique contribution to the nation's health or even as a junior partner within his authority. Nurses are often not allowed to make decisions to initiate nursing treatments which should be within their competence and responsibility.

HISTORIC JUNCTURE

We seem to be at a historic juncture in the convergence of other forces generated by advancing technology. Nursing is being required to pursue specialized skills which although adding to the extension of the nurse's role and practice, could, if we are not careful, fragment the essence of our profession.

Increased social awareness by the general public gives rise to increased demands for accessible health care. This has helped the nurse to emerge with a distinct role to play in health education.

The initial effects of changing technology, which began to have its influence predominantly upon nursing in the early 1960s, exert a triangulation of pressures upon the entire nursing profession.



2. Concept of patients' 'self-helpability'. Patients encouraged to do more for themselves. 'Self care'. Shorter periods of hospitalization. Shift of emphasis from acute to community resources. Changing demographic patterns.

3. Increased managerial role. Shorter working week. Accountability for actions. New nurse education programmes.

THE CENTRAL ISSUE

The central issue for nurses in this decade and beyond is the profession's need to resolve its conflict between achieving independence and recognition as a unique contributor to health care on the one hand and the growing movement on the other hand which, influenced by high technology, points towards an extended and specialized role for the nurse.

My personal belief is that this conflict between recognition of nursing and extended nursing roles will become one of the central issues for the future of nursing—how to cope with an ever increasing and ever developing technology and still maintain the nursing profession's contribution towards health care. One fears that rapid medical advances may force the registered nurse to assume a subservient position and relegation to the status of doctor's assistant, with second-in-line prominence as a health care giver.

I advocate that we must guard against being forced into extended roles and too much specialization, however exciting these may be. Nursing, itself, must decide whether and how to extend its role and at the same time assume accountability for the monitoring of that role. The advantage of extending and developing our role lies in the new value given to the core tasks of clinical nursing.

The practice of nursing brings few rewards in true prestige. The medical profession has expressed the belief that the better educated registered nurse tends to move up and away from the central tasks in nursing. Etzione (1) cautioned these sectors not to split away, but stratification appears to be accelerating. The nursing profession is fully aware of this factor and the Royal College of Nursing has identified a nursing structure that establishes a clinical career pattern (2).

The profession is also cognisant that it must not allow the achievement of 'professionalism' to be pitched higher than the level of nursing practice at clinical level. The registered nurse is the nurse who must be seen as the professional nurse. She is the one who assesses, plans and evaluates nursing care in a systematic manner to the identified nursing needs of the patient (3).

EDUCATION AND THE EXTENDED ROLE

Technology has inspired massive efforts to advance the level of nursing education at both basic and post-basic levels. The relationship between doctors and nurses will not be improved by any new laws providing for the extended roles, but these new roles may provide the missing link between nursing and medicine—namely, a legal means for the transfer of authority to nursing to make decisions about nursing care and nursing management of patients. However, advancing technology has the power to shape the future of nursing into something we may not want. One of the many paradoxes in nursing's evolution is this recognition that technology affords growth and development for the profession. Moves beyond many traditional boundaries and restrictions are being opposed by many nurses who feel threatened that they are expected to be accountable for their actions and they therefore reject the connotation that nursing has a separate and unique contribution to make (4).

THE NURSING ADMINISTRATOR

The nursing administrator needs to deal explicitly and consciously with the effects of new technologies. Creativity and innovation are two significant interrelated issues that affect a service's effectiveness and efficiency. Although both are interrelated, they are different concepts. To be creative is to bring something new into being. Innovation is the introduction of change. A new method of organizing nursing care is of little value until it has been introduced into the working environment. However, a new method cannot be introduced until it is created (5).

Technology throughout this decade will force nursing management to ask if it is as creative as it should be in:

(1) anticipating most opportunities to develop the role of nursing;
(2) solving complex problems;
(3) using human resources wisely and consistently;
(4) testing the validity and reliability of nursing care;
(5) developing manpower strategies for the next decade and beyond;
(6) monitoring and controlling the plan being implemented; and
(7) assessing results against stated objectives.

Every aspect of nursing can be approached in either a very conservative or a highly creative fashion. Nursing management must strive for the latter.

THE CHALLENGE OF TECHNOLOGY TO THE ROLE OF THE NURSE

Technology has posed a challenge for the contemporary nursing service to take a democratic and creative approach to management within the realities of the large bureaucratic National Health Service as it exists.

Hughes (6) has stated that doctors have more authority than they can effectively exercise, and the registered nurse, like the army sergeant, has more potential power than her title indicates. We know nursing is complementary to and overlaps with medicine and with other health-related professions. This must be seen as nursing's strength—the organization of direct patient care in partnership with other professionals and yet the maintenance of accountability within our own parameters of nursing care. No other profession can take responsibility for nursing care decisions.

Such professional freedom permits the registered nurse to make judgements that are independent of, can conflict with, and even refute those of her own and other professional peers. John Finch (7), Senior Lecturer in Law at Leicester University, reminds us that nurses often forget that they owe a 'legal' duty of care to their patients. The law requires the nurse to maintain at least a reasonable standard of nursing care.

LOOKING AHEAD

The shape of any nursing service in the future will be dominated by the demands of technology. A sharp reminder in our present times of high medical technology is the inescapable fact that the great improvements in health care over the past 80 years have mostly been due entirely to measures not associated with acute medical technology. Improvements in nutrition, industrial cleanliness, sanitation, education, and better housing have lifted the whole quality of life for the community and transformed expectancy of life as well (8).

Effects of technology

What technology does, is to allow people to forget that health is not a constant positive factor. Health is a perpetual balance of the individual with the environment and can easily be affected by a change in either. The dramatic powers of technological medicine cause people to forget to be fully responsible for their own health. We tend to rely upon technology to solve all our health problems.

A frightening effect in medicine could be what is termed the 'technological imperative'. This is the desire of the doctor to do everything he has been trained to do regardless of the cost and proven benefit. Halfdor Mahler, Director General of the World Health Organisation, summed it up:

> Health care workers consider that the best health care is the one where everything known to medicine is applied to every individual by the highest trained medical scientist in the most specialised institution. It is frightening, but expected, that when a specialist group is formed to perform certain functions it is evaluated and continues to be supported because of the number of such actions which are done, rather than whether the problem is solved (9).

CONCLUSION

I have attempted in this paper to focus upon the parallel development of changes within the nursing services and the growth of technology from the mid-1950s to the present day.

Nursing is strongly influenced by a 'triangulation' of pressures. This can be attributed to technological influences. At the same time nursing's contribution towards health is under-valued by the medical profession and by society as a whole.

The good nurse has a reverence for care. The better nurse is more critical of her care. She attempts to evaluate the outcome of her nursing care. To respond positively to advancing technology, the nurse can no longer hide behind the expression: 'But we have always done it that way'. Technology forces us all to respond with an acute awareness that change is dynamic and that to cope with change requires maturity. Tradition is the cement that binds our building

blocks together and allows us to move forward into the future with growth and development. It is not the excuse to stand still. 'We must preserve the very essence of nursing in a technological age' (10).

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DISCUSSION

Several times during the discussion, participants introduced points which related to care in the community rather than in hospital. In particular there are problems about hospital nurses from intensive care units following their patients out into the community without having any practical experience of how the community services operate. It became clear that, increasingly, technology will relate to care in the home as well as in the hospital. While discussion in this seminar was restricted to interaction between doctors and nurses in the *hospital* setting, it was re-affirmed that the distinction was too limiting and that future discussions must focus on the equally important field of professional relationships in the home setting.

It also became clear that the effects of newer technologies vary greatly with the type of unit. Interprofessional relationships are more critical in units with rapid turnover of patients and the need for highly specialized 24-hour cover than in smaller units involving just as much technology but with more continuity of care and slower turnover.

Although discussion was free-ranging rather than structured, the points made may, in spite of considerable overlap, be brought into focus under a number of headings.

Recruitment and staffing

A major question was how intensive care and high technology nurses are selected. The answer was that following some exposure during training they tend to select themselves. It is not practicable to arrange for all nurses to spend time in ICUs during their training but they are exposed to high technology in the wards and sufficient are attracted to ICU work for there to be a great number seeking appointments in high technology units. Motivation was discussed and it was agreed that novelty and high status are factors and that the actual gadgetry appealed to some. In spite of ease of recruitment staffing is a problem because the need is there 24 hours a day, 7 days a week and the demand does not have the same diurnal or week-end variation that prevail in less intensive units. There is no point in providing and equipping the units unless there is sufficient staff to provide the services and although there is no shortage of applicants there are problems in staffing.

These arise partly because specialized training is required and during that training recruits are more of a liability than an asset, and partly because of rapid turnover of staff. The rapid turnover is in part due to stress, which is discussed below, and partly because the frequent evening and night duty make it difficult for married women to reconcile for long periods the conflict of duty hours with their domestic and family commitments. 9 to 5 work in an outpatient department may not be as exciting as work in an ICU but it is more compatible with family life.

For this and other reasons there is merit in rotation to other duties and the view was expressed that it should be possible for a nurse to move laterally without loss of face or a feeling of failure. Indeed it may be desirable to move nurses before they request a change. The consensus was that staff nurses rarely stay in the more intensive units for more than a year at a time, although it was noted that senior nursing staff did not leave any more frequently than from other units. Because of the nature of the work and of training needs, a very high level of staffing is necessary. It did not seem that the physical environment had as much bearing on staff leaving as did good relationships and morale.

Training

It was agreed that it is desirable that in their basic training, nurses should have some theoretical and if possible practical initiation into what is involved in high technology and how it can be used to help not only the patient but the nurse's tasks. If however the nurse is to be secure in her role it is not fair to introduce her into a high technology area until she has had a good grounding in a more conventional ward setting.

In the past, mistakes have been made in using nurses as pairs of hands while they were learning but it is now realized that a more constructively organized training programme is necessary and that the staffing of units has to be at a sufficiently high level to separate care from training. It is important to train more nurses in intensive care than might seem to be necessary in order to allow the rotation which was agreed desirable. It is also necessary to make provision for continuing education to be available, both because of advances in technology and because of the return to nursing of married women after their child-bearing years.

As the years pass, children will have grown up in the high technology age and will have become familiar even at school with computers, monitors, and display units. Training in intensive care will then not be so difficult in that ordinary people will be familiar with advanced machinery.

The role of technicians

The work of technicians in an ICU was really outside the scope of this seminar but a few significant and relevant points were made. The technician has an important role in the maintenance of the equipment and in emergency breakdowns. The technician cannot however be expected to understand the physiology and pathology but the nurse and the doctor have to understand the basic principles and ordinary care of the equipment. Technical help must be available 24 hours in the day unless complete spare units are available. Even amongst technicians, specialization has become necessary, since increasing complexity precludes any one technician's being certain of rectifying every fault. The distinction was made between equipment used for diagnosis and that for treatment. Nurses have long been trained in the use of tools concerned with diagnosis but in a way the differentiation is artificial because some of the diagnostic equipment of the present day is even more complex than is the therapeutic.

Use of resources

There was a brief digression into the proper use of resources. One medical participant raised the fundamental issue of whether the National Health Service had not allowed high technology to lead it into diverting resources both of expensive equipment and of highly trained personnel into caring for small numbers when the problems of the handicapped, the elderly, and the chronic sick are much greater. The blame for any such diversion of resources was clearly on the shoulders of the doctors and involvement of nurses in these high technology areas should not be such as to divert them from their primary role. This subject was not pursued as it was beyond the scope of the seminar but arising from it was the question as to why modern technology is not being applied to the simpler tasks of patient care such as the use of modern means of recording patient temperature instead of the outmoded and inaccurate thermometer.

Psychological stress

The stress on both nurses and doctors of working in intensive care units is inevitable but doctors can get away from it more easily than the nurses can. In some ways ICUs, because the nursing work *is* intensive, are like production lines in industry but the boredom element so significant in repetitive tasks in industry is not a feature, though the technical nature of the work is thought to be a determinant. The point was made that married women staff have their own stresses at home as well and there is a conflict of loyalty. This may apply also to men but to a lesser extent. The question was asked about the evidence that there is extra psychological pressure in ICUs

over and above the stresses of nursing any acutely ill patient. It was stated that there have been several court cases world-wide featuring bizarre behaviour of people working in ICUs and although numbers were small they are perhaps significant in view of the relatively small overall numbers of ICU staff. A number of North American studies show that stress does relate to intensive care and that sadly it seems particularly to affect the best and brightest of staff. The jargon term 'burnout' has been used to describe a condition akin to battle fatigue in the Armed Forces. Interestingly, the studies have shown that the other type of nursing leading to stress burnout is that of patients with senile dementia. Obviously, different factors must be at work and the case was made by several participants for research into these important areas. It may be that patient care will begin to suffer before the effects of stress on a nurse are recognized by her colleagues. Changes in organization of nurse staffing should also be considered; one way in which organization might relieve stress would be for the nurse to move with the patient when he is improving and transferred to an area of less intensive care.

On the other hand, stress may not be primarily a nursing problem. It affects also the medical staff and it varies with the types of intensive care. In plastic surgery and burns units or dialysis units high technology is used but there is no great turnover of staff. Again, where the team is small, as in a neonatal unit, the problems are less. It would seem that where the doctors and nurses all know each other and understand each other's roles, conflict is less but where there are many different doctors coming into the unit, differing types of patient and different nurses on each shift, that is when stress arises. It had been indicated in Dr Masson's paper that a sequence of deaths in an ICU leads to a lowering of morale. This was not denied but the hospice movement is leading to alleviation of the taboo surrounding death. It is becoming easier to talk openly about death and bereavement and this will tend to diminish, although not to abolish, stresses related to these deaths in the unit.

Effect of technology on nursing

The introduction of new equipment, however sophisticated, should not be allowed to lead to any change in the fundamental nature of nursing. Nurses in ICUs must understand the specialized medical problems and also the nature of the support being provided by machines. They must understand the interaction between machine and patient and must be able to recognize and sometimes correct machine failure. Technology must be the servant rather than the master. All that the machines are doing after all is giving an objective measurement and helping doctor or nurse to do their primary task. The nurse is there to support the patient and she must feel secure in her primary role before being subjected to the addition of mechanical support systems.

It became clear in this session that further training, education; and research are necessary to allow rational alteration of ways in which ICUs are staffed, bearing in mind firstly the best care for the patient but equally, because they are mutually dependent, the stresses on nurses and their attitude to high technology. Once such information is available further discussion will be profitable.

COMMENT

T. J. THOMSON

It is clear from the wide-ranging discussion which we had that our choice of topic for this session was an appropriate one, and we have seen that the advent of new technology has far-reaching implications for doctors and nurses in the 1980s. Even after reading the prepared papers and following the points made in discussion, I am not sure that we have answered the questions concerning the effects of these on our professions.

It may be that some of us have been trying to assess the new techniques when our personal experience has been mainly of traditional diagnostic and therapeutic methods. How many of us have grown from childhood with micro-chips on our wrists, used electronic calculators at school, and computers in our homes? Perhaps not too many of us. Nurses and doctors of the future will have grown up accepting as routine much of what we today consider to be new technology. It is almost certain that this difference in perspective will modify the effects of the technologies on our professions in the future. When we repeat this exercise, as I am sure we should, the views of our young colleagues will be most welcome.

It has become evident in this session that there exists a wide variety of opinions on some of the basic questions which have been asked. Are nurses in Intensive Care Units especially subject to psychological stress? Do we have in the UK the 'burnout' syndrome as described in the USA?

We require formal data on these questions, and prospective research is indicated. Results of such studies would tell us whether nursing staff should work in Intensive Care Units for defined periods and whether rotation of staff to other units is desirable or necessary. Similar studies would guide our leaders and trainers as to the best methods of training staff for work in units using new technologies.

II

Policies for the long-term care of the elderly

PAPERS BY

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DISCUSSION

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INTRODUCTION

During the past 15 years, the elderly population of the United Kingdom has increased by 1·5 million and we can expect a further increase of half a million in the next 15 years. There will be no growth in the 65 to 74 year old age group, but the number of those aged over 75 years will increase by 28 per cent. This trend will lead to an increase in mean age, which will have major implications for the health and social services. Doctors, nurses and other health care professionals will need to equip themselves even more effectively to deal with the medical problems of old age and the disabilities of the very old.

Care of the elderly is predominantly a family function. In 1971, 95 per cent of the population over 65 years of age stayed in private households. While this proportion decreases with age it is evident that even among the very old, hospitals and residential homes only care for the minority (1). More than half of all adult admissions to UK hospitals are over the age of 65 years and the average length of hospital stay increases with age (2). Reducing the length of stay in the elderly age group is difficult and bed blocking in acute facilities often results (3). Present trends predict that by 1991, elderly females of 75 years or more will consume 60 per cent of hospital in-patient bed days and elderly males 30 per cent. One-third of acutely ill elderly patients admitted to general medical beds are admitted for largely social reasons and not primarily on medical or nursing grounds (4). Most elderly people who appear to block beds, particularly in geriatric medical units, are awaiting alternative residential care (3), but sadly the rapid increase in the number of very aged people has not been accompanied by appropriate expansion of local authority residential facilities (5).

The continually changing demographic pattern of old age suggests, however, that the impending crisis of large numbers of

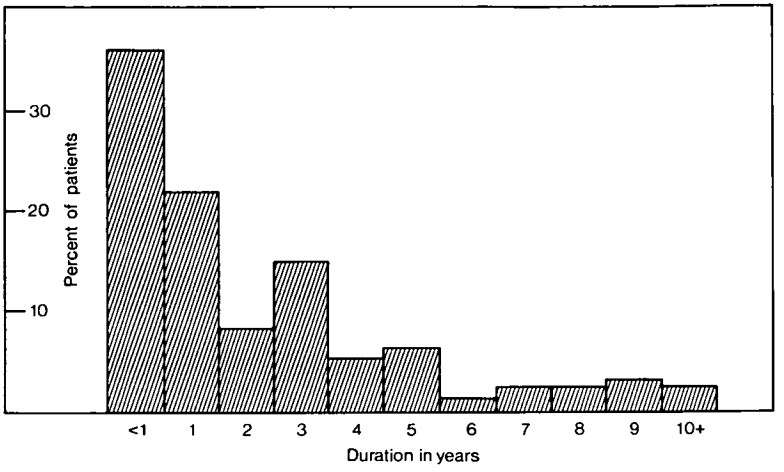

Fig. 1. Duration of hospital stay in 200 geriatric medical patients.

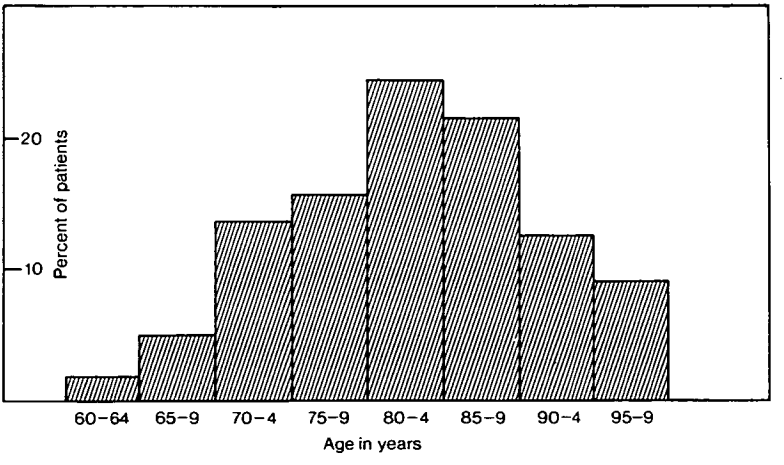

Fig. 2. Age distribution of 200 patients in a geriatric unit.

elderly disabled people requiring institutional care may ease by the end of this century (6). Nevertheless, the period of the next 15 years poses considerable problems for the health care system and efficient use of existing resources must be promoted. Care of the elderly is a demanding job and it requires special knowledge of the physical and mental problems of old age.

The incidence and duration of many types of disabling illness increase steeply with age (7). Many elderly patients are found in the medical specialty wards and also in the surgical, orthopaedic, and psychiatric departments of hospitals. It is clear that the majority of doctors and nurses who work in hospitals must share in the care of the elderly.

The majority of patients admitted to geriatric medical departments will achieve improvement to a level sufficient to permit discharge to the community, but between 10 and 20 per cent will require continuing institutional care (8). These patients will have a multiplicity of chronic problems with medical, social, and psychological factors, which are too complex to allow management at home (Table 1).

Table I
Main reasons for continuing care in hospital

Gross physical disability
Uncontrollable urinary incontinence
Persistent faecal incontinence
Permanent psychiatric disorder
Unsatisfactory social conditions

Over a four-year period in my own unit, 50 per cent of patients admitted were discharged, 35 per cent died, and 15 per cent required continuing hospital care (9). Despite this apparently low recruitment into continuing care, 60 per cent of our beds are occupied by patients who have been in hospital for more than nine months (Figure 1: representative sample of 200 beds in a geriatric medical service) and the average age of the elderly patient in continuing care is 83 years (Figure 2).

If facilities for community care of the elderly disabled are insufficient, significantly reduced by economic strictures or even maintained at their current levels, then the number of people requiring continuing institutional care will increase towards the end of the present century.

PRINCIPLES OF MANAGEMENT IN CONTINUING CARE HOSPITALS

These principles differ little from those in current assessment and rehabilitation practice (9):

1. Accommodation within an acceptable environment;
2. Maintenance of the patient's physical and mental capacity;
3. Maintenance of active therapy, including the treatment of intercurrent illness, to improve the quality of life;
4. Application of the principles of good terminal care;
5. Encouragement of relationships between patients, relatives, staff, and other visitors.

THE TEAM CONCEPT

The aim of the hospital health care team is to rationalize the available appropriate resources to return the elderly patient to normal activities and to maintain independence. Assessment, diagnosis, and treatment must be carried out in a coherent manner and progress must always be regularly reviewed. There can be few areas in medicine where the concept of the team is more important than in the care of the elderly. Much lip-service is paid to this ideal, but without it the management of the elderly patient readily becomes disorganized, haphazard, and inefficient.

There is no rigid formula for the composition of the team but certain members are essential (8) (Figure 3). The composition will vary according to the philosophy, resources, and special interests of the department. The team has three principal functions:

1. To plan an appropriate programme for the individual patient in the light of needs and potential;
2. To review at regular intervals progress, or the lack of it, and to attempt to identify the reasons for the latter;
3. To anticipate individual special needs which will contribute to discharge from hospital and even from continuing care facilities.

Regular review

All members of the team must meet for regular planned discussion to assess progress and, if appropriate, redefine goals. These case conferences are best held weekly in assessment or rehabilitation areas

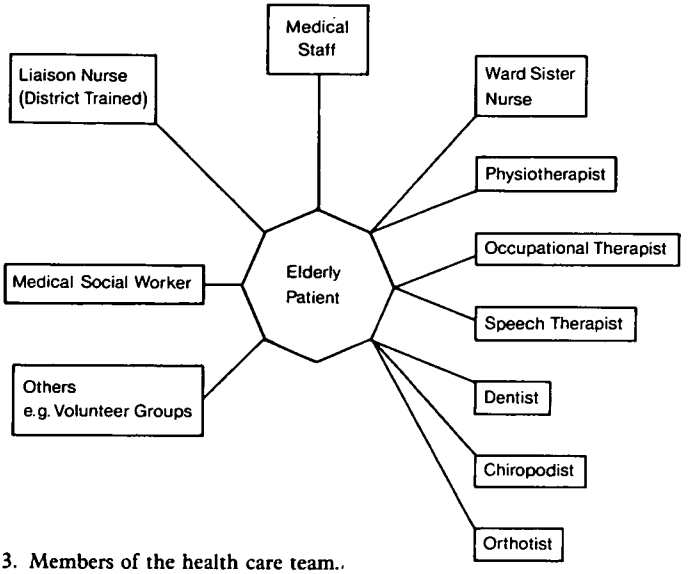

Fig. 3. Members of the health care team..

and monthly in continuing care areas. The case conference is best held after a medical and nursing ward-round and it should allow everyone concerned to exchange information and should explore and eliminate conflicting views on progress and objectives. The team's decisions must be guided by the patients' best interests.

Elderly patients requiring continuing care usually have multiple problems (Table 1), but these may change and the slower pace of management in the continuing care wards may promote readier adaptation to rehabilitation and unexpected improvement. If regular review is not carried out, such improvement might go undetected. Regular review helps to prevent the inaccurate complacency resulting from a tendency to regard all patients in continuing care as being permanently placed.

The doctor has the ultimate legal responsibility for the patient, as well as overall responsibility for medical management, but he shares ethical responsibilities with other members of the team.

The role of the nurse

In hospital, the nurse is the professional most constantly in contact

with the patient. Her role in the care of the elderly continuing care patient is dominant in two major respects. First, she is there to give regular reassurance and encouragement to the disabled person and, secondly, she can reinforce the technique being taught by her colleagues in the team, especially the physio-therapist and occupational-therapist. Without the regular feedback of the information that only the nurse can give, the team cannot function efficiently.

The nurse is also an essential gatherer of information. She is more likely to be told the patient's hopes and fears, and to observe pitfalls and impractical aspirations. Changes in mood may be more readily noted, and also changes in continence, sleep pattern, or food and fluid intake. The nurse also frequently acts as an essential interpreter of the team's hopes to the patient and relatives.

In continuing care wards, it is obvious that nurses make much the most important contribution, and there have been suggestions made that some at least of the continuing care institutions should be run entirely by nurses. Experience has shown, however, that if doctors, particularly senior doctors, are prepared to show that they are interested in the continuing care wards and value the work done there, then the morale of all concerned is improved (10). Medical skills are undoubtedly necessary to optimize the condition of patients in continuing care. Regular medical involvement must be seen as a necessity.

ALTERNATIVES TO FORMAL HOSPITAL IN-PATIENT CONTINUING CARE

1. *Augmented home care*

Selected disabled elderly invalids with acute or chronic illnesses may be suitable for home care if they can be left unsupervized at night, or if a relative is available to provide supervision (11, 12). The cost of such care is generally cheaper than in-patient care and schemes of this kind might reduce the need for additional continuing care geriatric medical beds.

2. *Minimum dependency hospital areas*

Low dependency nursing areas have proved effective in two hospitals in Glasgow. These wards provide care for those elderly

patients who are awaiting alternative residential accommodation. Formal nursing supervision of these facilities with immediately available medical cover must be ensured, however.

3. *Residential homes for the elderly*

Most residential homes for the elderly frail ambulant population are run by the social work department, religious bodies, or voluntary organizations. An immediate priority is for the criteria for admission to local authority homes and other similar establishments to be more clearly defined and more uniformly applied than is at present the case (6). Accurate medical assessment should be routine, before admission, as a substantial number of those admitted to old people's homes are likely to benefit from hospital treatment. The continuing trend of more frail, elderly residents who require increasing levels of nursing and medical care lends support to the concept that all institutional facilities for the continuing care of disabled elderly people should be under the supervision of the NHS.

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MARION L. SMITH

INTRODUCTION

The elderly are surrounded by myths and stereotypes, many of which are upheld not only by the general public, but also by health service workers closely involved in care of the elderly. A number of older people who do not experience difficulties attributed to old age see themselves as exceptions to this somewhat dreary picture. By the nature of such misconceptions we do the elderly a great disservice, tending to cast them as just another problem rather than a potential resource for resolving their dilemmas.

When considering care of the elderly we must remind ourselves that nobody is exempt from the changes associated with living and ageing. Old age is not a disease and many elderly require neither care nor cure services. What they do deserve is a quality of life which as far as possible ensures that whatever their health status they retain as much independence and dignity as they are capable of.

Although much progress has been made in care of the elderly much of it is not as good as we would wish.

If we wish the best for our future elderly then we should begin in the community, providing preventive and supportive programmes for the well elderly, helping them to retain health, and educating them to adapt to ageing. They should be taught to recognize the physiological and psychological changes of advancing years and to learn to accept such changes as part of the process of life.

In any proposals put forward there must be respect for the preferences of the individual. Remember that an old person may not think of herself as old and for her the biggest fear is that she will have to leave her home. In this respect it might be of help if there were greater flexibility of use of accommodation, allowing the elderly to move more freely from one type of care to the other. At all stages however, it is important that the patient be given the right of choice. To obviate too much movement, our aim should be to place

considerable resources on primary care in the community, providing a first class nursing, medical, and social work caring service.

One must always look to the need for change and this will come through differing expectation among our elderly. While some of the old stoicism still exists, it is diminishing and will continue to do so. Standards of care in the National Health Service, no matter how much they are criticized, give rising expectations and today's young—tomorrow's elderly—will have quite a different view of their future care.

THE ROLE OF THE NURSE

But what of the nurse?

In recent years changes in nurse education have been such that care of the elderly is now an integral part of nurse training and students receive a period of theoretical training followed by 13 weeks practical experience in areas designated for the care of the elderly. This step forward has greatly improved patient care and attitudes in general. Geriatric wards are no longer the ugly ducklings of the hospital service because the needs and potentialities of care are now recognized.

In the Rcn discussion document, *Towards Standards* (1), eight key factors were identified as prerequisites for the professional control of nursing care.

1. A philosophy of nursing

Nursing is a particular and identifiable approach to patient care which is distinct from that of medicine—or any other discipline. It is a value system in which the patient is central, as a whole person, and as a unique individual. Nursing's aim is to define goals with and for the patient, towards the achievement of maximum independence in daily living. To achieve this must be the essence of nursing practice, the matrix of nursing education and the *raison d'etre* of nursing management.

2. Knowledge and skills

There are three main skills which require to be developed: decision making, communication person to person, and skill in written documentation.

3. Authority to act

The extent of a nurse's authority to act is of crucial importance. Nursing takes place in large complex organizations where many people are involved. Nurses must be clear as to the extent of their responsibility and this must be matched with the authority to discharge it.

4. Accountability

The degree of accountability is linked to the degree of authority vested in the individual. The nurse should plan nursing care, make decisions and judgments on the nursing care, and control change. Nurse managers must push accountability downwards and nurse practitioners must not look 'up line' for direction nor across to other disciplines—such as medicine—for 'cover'.

5. Control of resources

To achieve the best possible match between needs and resources is the responsibility of every nurse and appropriate training in control of resources must be available.

6. Structure and management

The function of nurse management is not to control practice but to enable good practice to be achieved.

7. Medical-nursing relationship

The nurse should have a clear understanding of the distinction between medicine and nursing. Doctors and nurses should work as a partnership to achieve the best outcome for the patient.

8. Management of change

Innovation and change can be threatening as well as challenging. They should be achieved gradually and allow for periodic evaluation.

Should these guidelines be followed then standards of care must improve.

PATIENT CARE

Along with the advances in nurse education has come a different concept of patient care.

Prior to the implementation of the Nursing Process, patient care evolved as task orientated.

The nursing care plan now looks towards:

Assessment of the patient's need and identification of the resources available to meet the need.

Planning care: orientating the patient towards promotion of creativity and independence.

Documenting the plan.

Evaluating the results.

This approach looks at the patient as an individual with his own special needs rather than a person in a hospital bed with nursing needs. In any plan there must be respect for the preferences of the individual. People vary in their desire for activity and company.

Busy with procedures and daily routine, those who care for the elderly must be taught to look at their patients. To my mind 15 elderly paients is the maximum number which should be under the care of one ward team. In the day-to-day sameness of an institution efforts have to be constantly made to provide the residents with relevant information about time, place, and person.

Another important aspect in providing care is the design of the patient's environment. Avoidance of too clinical an environment is essential in long-term care. Care is needed in choice of floor coverings.

Dining space and day space should be separated to allow for change of position and there should be adequate facilities for interviewing relatives.

Adequate toilet facilities should be near all areas of patient care, with space to allow the nurse to transfer the patient. All toilets need to have well placed supports. Good, well ventilated bathing areas are also essential.

CONCLUSIONS

I have taken nursing standards and the nursing process as my main themes in this talk because I think they are the biggest factors in the

future care of the elderly. If we improve standards we improve care. While we recognize that we are all an integal part of a patient care team, if our colleagues appreciate our aims and standards, then our working together should be enhanced.

It is my belief that planned interdisciplinary education for various professional health service workers, based on joint learning experiences, would be conducive to more effective collaboration among health service practitioners and would end in better care reaching the patient. Such education would not only provide information but should promote a better mutual understanding of the specific professional roles of the varying members of the team.

Care of the elderly is not a series of jobs to be done but a series of roles to be discharged. The patient should be the centre and origin of all activity undertaken. He should not be the passive recipient of smothering care, but should be part of a consultative process of a well integrated group who really care.

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DISCUSSION

Needs

Discussion started with recognition that 'the elderly' are not a homogenous group with the same care needs. Those who are physically disabled or mentally disturbed need full professional health care, but others 'just' need a home providing the shelter of an appropriate environment. While concern was expressed as to the possible effect on the elderly who are only physically handicapped, being placed in the day-long company of mentally confused people, it was also pointed out that the physical and mental status of the aged are not static. Changes in condition can cause a change in care needs at any time and the elderly therefore face the continuing threat of having to leave surroundings to which they are becoming acclimatized.

There was some follow-up of a point made in Dr Williams's paper, that one-third of the elderly are admitted for social reasons. Shortage of hospital and other facilities leads to general practitioners emphasizing fragility and playing down the confused state of their patients in order to gain the requisite sympathy for patients to gain entry to care somewhere. Standard procedure is often bypassed because they are brought to hospital emergency departments by ambulance. It was thought that perhaps GPs and relatives are too ready to seek hospital admission, without sufficient enquiry as to the feasibility of home care by community staff. Although community services for the acutely ill are patchy in Scotland, some of the elderly were said to be 'blocking' hospital beds when they could be in the community, while some in local authority homes need to be in hospital. Several present considered that such misplacement of patients is often due to the separation of health and social work services and it was suggested that there should be one co-ordinating body. Difficulties were said to arise because health professionals and social workers do not have the same view of needs. Dr Williams's concern about residential support facilities being outwith health care, was shared by participants, who expressed anxiety about the drastic reductions taking place in the community services despite the increasing number of the elderly in the population. It was difficult in view of the limited nature of the seminar to maintain discussion purely on the hospital aspects of the subject.

Whether or not services should be provided by one body, the need for co-ordination had become clear, especially at a time when resources in both

services are strained. Many of the elderly are now in their eighties rather than their seventies and it was agreed that proper planning for their care depends on obtaining accurate information as to what the needs are. It was suggested that this could be best achieved if the elderly person has a 'say' in what services are needed and, in effect, co-ordinates the team.

Team relationships

Harmonious team relationships are a feature of geriatric care, as propounded in the opening papers of the session, and it was remarked that it might be worthwhile to explore the application of this concept to other fields of care. This in turn raised the issue of doctor-nurse relationships, with reference to statements in a Royal College of Nursing publication (1) to the effect that nurses, in caring for the whole patient, may have goals different from or even in conflict with those of doctors. A medical speaker dismissed this as nonsense but it was held that the Royal College's intention was to indicate that there may be specific nursing goals that are distinct from medical goals. There was general agreement that in the round medicine and nursing share ultimate objectives.

It was stressed that to avoid patients receiving conflicting information, there must be collaboration between doctors and nurses. A reminder that one definition of 'collaboration' is 'consorting with the enemy' evoked laughter that lightened the atmosphere. It was suggested that health professionals would be less likely to regard each other as adversaries if there were better understanding of the respective roles and this might be fostered by more shared professional education. There was some dissension about the need for role identification because one view is that to give professional credibility, too much time, thought, and energy are expended on this instead of on establishing relationships with one another. Nevertheless, there was some support, especially among the nurses in the audience, for a need to identify and appreciate each other's professional contribution to care, before the optimum can be achieved in relationships.

While there was general agreement that a team must have a leader, there was some debate as to who this should be. It was suggested that the patient should be team leader and perhaps co-ordinator of his or her own care when a speaker questioned the diagram (p. 29) presented by Dr Williams in introducing his paper. It was pointed out that although medical staff appear at the top of this, it is conceivable that at certain times someone else might be a more appropriate leader as a judge of particular requirements—a social worker, a nurse, or possibly a patient's relative. A hospice administrator said it was especially important to recognize this in supporting the terminally ill, when allowing the patient to set the pace for the professional team could also influence the family's reaction to subsequent bereavement.

It was suggested that conflict could arise from the assumption that the doctor is always the co-ordinator, who decides what the nurse should do, although physio-therapists and occupational-therapists are also apt to define the nurse's role. There were disclaimers by doctors that they make all the decisions but a consultant put a counter-view. He saw the patient as being at the core of the team but not its leader. While the patient could be consulted, he advocated the doctor as being the most useful leader of the hospital team although, interestingly, he saw the district nurse as the leader in the community, rather than the general practitioner. Other doctors claimed local team successes as a result of collaboration with the ward sister and effective discussion that prevents antagonisms arising.

Professional accountability

Contending that it is the doctor who has to appear in court if anything goes wrong, Dr Williams maintained that it was the doctor's legal responsibility for the patient that led to the philosophy in Glasgow and Edinburgh that the medical consultant leads the team. This raised the issue of professional accountability. Nurses emphasized that they are legally responsible and accountable for their own professional nursing activities and examples of court cases confirming this were cited.

Specialization

During the discussion the issue of specialization in medicine and nursing was raised briefly. A doctor recognized that some specialization is the effect of research, which is now making an impact on nursing similar to that which occurred in medicine thirty years ago. A nurse contended that care of the elderly in all its facets should be an entire specialty and that those with mental disabilities should not be transferred to another field of care. A medical comment that nurses are against specialization caused a nurse to express concern about medical misunderstanding of specialization in nursing. It was remarked that a good deal of medical and nursing specialization has arisen from technological developments which seem to be regarded as more important than other aspects of the patient's need for care. The topic of specialization in nursing was explored more fully during the final discussion of the day, but a doctor expressed the view that caring for the elderly can be more stressful than working in areas of high technology. 'We need special people to nurse them', he said: and no one quarrelled with that.

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COMMENT

H. M. CROMPTON

It became clear during the discussion in this session that making satisfactory provision for the long-term care of the elderly is a complex matter. The whole problem is compounded by the lack of understanding between professional 'carers' of many disciplines as to each other's role, contribution, and responsibility. Even the fact that a particular professional's role and responsibility may be different from time to time was not recognized.

Similarly, there remains a lack of definition of the needs of the dependent elderly and any acknowledgement that those needs may have to be met in a variety of ways at different periods of time for each individual. The provision must span the whole range of services from purely medical to purely social, with a facility for movement along the line at any point as necessary.

Flexibility and co-ordination would seem to be the corner-stones of any system of care that is established. This would probably be relatively easily achieved; more difficult to establish would be the 'trust' required between the various professional groups that would make any system fully effective.

III

Changing clinical practice in nursing

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NOTES ON OPENING DISCUSSION

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DISCUSSION

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INTRODUCTION

Over recent years much has been written and spoken about changes which are taking place in nursing but much of this debate has been ill-informed, has dealt with isolated topics out of context, and has frequently had strong emotive overtones. This has led to considerable misunderstanding and entrenchment of attitudes at the expense of considered discussion about the underlying purpose and aims at which the change is being directed.

TERMINOLOGY

Some of the confusion has arisen from the use, by nurses and others, of the phrase 'the nursing process' without fully understanding what this phrase means. The term has lost its meaning and should be dropped because there is a danger that the quite legitimate antipathy directed towards some of the peripheral issues may mean that the central themes are not addressed.

Stated very simply, the aim of change and the two main themes embodied within the term 'nursing process' are:

(a) the introduction of a systematic approach to the planning and execution of nursing; and

(b) the promotion of self-care as being the purpose of nursing.

These two issues will now be debated in more detail.

The systematic method being promulgated is not unique to nursing: rather it is the same logical and methodical approach used in any decision-making process, be that in pursuit of professional or personal goals. Essentially it involves assessing the need for action; identifying what has to be achieved by the action, i.e. the goal; describing in detail the plan which should meet the need and achieve

the goal; ensuring that the plan is implemented; and finally, evaluating the effectiveness of the plan in achieving the goal identified when the need for action was assessed. Whilst not expressed in this explicit form, the analogy with medicine would be taking the medical history; making the diagnosis; giving the prescription; and reviewing of progress. An analogy with personal decision-making would be the application of the same logical approach to buying a car—assessing the type of car, what it is to be used for, how much you can afford, etc: looking at the range of models which are available within these limits; buying the car; evaluation is constant and may ultimately dictate your next purchase. Thus I reiterate, the method is not unique to nursing but application of the method to nursing raises other fundamental questions—assessment of what? planning of what? And it is in this area that much of the confusion and misunderstanding is concentrated.

THE ROLE OF NURSING

What is the role of nursing and what is the appropriate business of nursing in today's Health Service? *Care* is not the sole prerogative of nurses—all health care professions have this aim, but inevitably with the growing range of disciplines involved in health care there will be overlapping areas which could lead to some conflict and division of effort to the detriment of patient care.

There is a need for recognition and understanding of each profession's potential contribution to health care—in particular to recognize that each profession has areas of competence superior to any other group and that there will be areas of shared and/or equivalent competence. Only with this recognition will it be possible to utilize effectively the skills of each group which through teamwork will lead ultimately to the provision of the best standard of care for the patient.

The nursing workforce is, however, by far the largest single group of employees within the Health Service (1). If the most economic and efficient use is to be made of this group, and if appropriate education and training programmes are to be developed for this group, the purpose and aim of the nursing function must be clearly understood and expressed, and not left to assumption or interpreta-

tion which may in turn be based on an individual's own perception from within a confined context.

The Report of the Committee on Nursing (Chairman Professor Asa Briggs) was published in 1972 (2). As a direct consequence the (Scottish) National Nursing and Midwifery Consultative Committee (NNMCC) published a paper in 1976 entitled *A New Concept of Nursing* (3) which reflected that Committee's view of nursing within the context of the Briggs Report. As a corollary to that work, and in the belief that there is a cohesion and unity in nursing which permeates all aspects of health care regardless of clinical speciality or disease, the NNMCC in 1981 outlined a statement of principle on *The Role and Function of the Registered Nurse* (4).

It is the issues arising from the implications of these publications which are central to the present debate in nursing in Scotland.

What is nursing? Over the years, nursing has reacted and adapted to the changing demands created by advances in medical knowledge, new technology, and the dramatic effects of improving chemotherapy. As these changes have occurred the nursing role has followed medicine in its pursuit of cure, and *nursing* has in many instances become synonymous with many of the tasks associated with the diagnosis and aspects of treatment of disease. This disease model has been perpetuated in nurse teaching, where the signs, symptoms, and treatment of disease and nursing procedures associated with them, have formed the basis of nursing curricula. The organization of nursing at ward level has tended to confirm this view where work has been organized in a 'task-centred' manner and where the tasks themselves are often ranged within an artificial hierarchy of 'skills'. The discussion about the extended role of the nurse bears witness to this approach where extension of the role is often described in terms of carrying-out some activity either normally undertaken by someone else, or some activity associated with new technology.

While many of these activities will continue to be undertaken quite appropriately by nurses, to define *nursing* in terms of tasks alone is quite wrong. Perhaps unfortunately from this point of view, the vast majority of nurses receive their basic training within the acute hospital sector and it is from this cadre of people that staff for all other specialties—apart from mental illness and mental handicap—emerge. In some cases further statutory training is required before the nurse can practise, for example health visiting, but

important here is that certain attitudes and consequent expectations are created right from the outset.

Essentially therefore our aim at present is not to undermine this aspect of the nurse's role but (a) to improve the performance in it and (b) to refocus attention on that other important component of the nurse's function, namely, the meeting of fundamental human needs.

Improving performance

With regard to the former, i.e. improving performance in meeting the medically prescribed activities of nursing, it is believed that nurses should document their activities much more specifically and thereby improve communication. The quick turnover of patients, increasingly complex treatment regimes, the shorter working week of nurses, and the increasing use of part-time staff all combine together to place effective communication in serious jeopardy if formal written mechanisms are not established. Another aspect to be considered, in the acute field particularly, is that in the majority of instances where activities are ordered by the doctor and carried out by the nurse, the doctor will not always know how the nurse achieves what has to be done. Thus there is considerable responsibility on nursing staff to identify the best practice to achieve the aims. It is therefore important not to see this as a conflict but to draw a distinction between the doctor's rightful role in *prescribing* a procedure and the nurse's rightful role in identifying the best way of *carrying out* the procedure.

Meeting human needs

With regard to focussing attention on the nurse's function in meeting fundamental human needs, this is perhaps the area where the greatest change is taking place. In an acute environment, nurses will undertake activities on behalf of the patient which he would normally undertake for himself if he had the necessary strength, will, or knowledge (5). In this situation, such action by the nurse is normally only of a temporary nature and the patient will soon, once the disease process is resolved and by his volition, regain his independence. Where the disease process leaves the patient with a permanent incapacity or has any effect on his ability to live a

'normal' existence, active intervention by nurses on a permanent basis and without any focus or structure will lead the patient to increasing dependence.

Virginia Henderson (5) suggests that an important aspect of the nurse's function is to '... help him (the patient) gain independence as rapidly as possible'. The promotion of self-care is therefore the underlying theme being enunciated to nurses at this time. In reality and in respect of meeting fundamental human needs, the nursing role being advocated is a therapeutic role aimed at making patients as independent as their mental and physical states will allow, as distinct from a custodial role where the *status quo* is perpetuated.

The dividing line between knowing when to push a patient towards independence and when to accept that he will be dependent is very thin and it is in this area of decision-making that we see the role of the professional nurse. For example, failure to recognize that an elderly person who is incontinent of urine may have this problem as a result of immobility rather than because of functional failure could lead to a quite inappropriate nursing intervention resulting in the patient remaining incontinent. Application of a systematic approach to planning nursing is going to be a prerequisite to the promotion of self-care because if we do not identify what we hope to achieve by nursing we will not know where, if, and how we have achieved it.

Two components of nursing

The crude division of nursing into two components, i.e. caring for the person with acute illness and exploiting fully an individual's residual ability, is undoubtedly an over-simplification of a very complex situation. Whilst we would always advocate that the nurse cares for the individual patient regardless of his medical diagnosis or of the medical speciality in which he is receiving care it is recognized that the balance between these two components of nursing will be influenced largely by both the disease and the medical specialty. For example, the nurse caring for the patient admitted in severe diabetic coma will be functioning in the short-term at least, almost entirely to the dictates of the medical condition, whereas the nurse caring for the individual admitted to a long-stay geriatric unit will be concentrating almost entirely on developing the individual's ability to live as normally as possible. There are many shades between these

two extremes and whilst one aspect may predominate in a particular clinical area, the awareness of the other must never be lost.

We must avoid at all costs the relegation of patients' living needs to unimportance by assuming that all that is required of nursing in this area is that of the surrogate relative. It may well be that many of the caring staff will not have a formal training requirement but if nursing is to meet its goals in these areas such staff will always be working within a plan of action prepared by a professional nurse. If this role of nursing is not recognized the long-stay field be it for mental or physical care will revert to one of custodial care, with the consequence of poor calibre staffing and a very unsatisfactory lifestyle for patients.

EDUCATION

Much education is going to be required to bring about a change of attitude, to provide knowledge to underpin practice, and to introduce systems of working which will facilitate good communication and planning. A recent editorial in the *Nursing Times* (6) was introduced as follows:

> Nursing's claim to be a research-based profession is as unfounded now as it was 10 years ago. Despite a decade of great activity and much promise, nursing practice in 1983 is still largely rooted in traditional guesswork and doctors' orders.

Hard hitting? Yes, but regrettably true. And even in areas where research has been undertaken the profession at large is often unaware of it and only very few actually take account of the findings. Part of the difficulty is that many of the research studies have been undertaken by students in pursuit of an academic qualification, with the consequence of small unrepresentative samples. It is postulated, however, that one of the underlying problems in connection with this is that nursing practice has been 'handed down' and not taught or developed from any sound theoretical base, with the result that the need to question or review practice is not stimulated.

An example of this difficulty can be cited with regard to nursing action to prevent pressure sores. In years gone by, when patients were nursed in bed for longer periods than happens nowadays, nurses were taught to turn the patient 2-hourly to prevent bed sores

and to try to get the patient up to sit as quickly as possible to reduce the risk of bed sores. It would appear that it was the bed that was seen to be the thing that caused the sore, whereas we now accept that it is pressure, regardless of the support surface on which the patient rests. Of course, in the old days patients did not normally sit out of bed if they were incapacitated, so in fact it was not the sitting out of bed which was important in prevention of pressure sores, the main factor was the improvement in the patient's general condition which made it possible for him to sit in a chair. So while this practice, created upon a faulty base, was all right as long as none of the other parameters altered, it would not stand up when patients who were ill, disabled, and helpless were put into chairs. Thus many of these patients developed pressure sores as a result of sitting in the chair and, equally disturbing, the nurses were quite happy to leave them sitting because they had been told it was good for the patient. So for these patients, who formed a new group of chair-fast patients, the nursing routine was probably to turn them 2-hourly while in bed and leave them alone while sitting. The dangers of this have only been fully recognized in recent years (7).

I believe this example embodies much of our fundamental problem, i.e. often doing the right thing for the wrong reasons, which makes it intellectually difficult to adjust practice to take account of changing circumstances.

Attitudes

Nurses are taught by nurses within nursing, and students acquire many of their attitudes and much of their knowledge from the ward sisters who have themselves acquired attitudes and knowledge from others and from experience. The value of the experience is in principle unquestionable but if experience merely means the perpetuation of practice without evaluation, without additional learning, and from a knowledge base which is itself suspect, professional standards can be neither set nor measured. Thus a treadmill effect develops and procedures are performed by rote rather than according to the dictates of the needs of the individual patient.

Education is going to be the cornerstone to progress; this must take some organized form (8) and not be left to chance. Ward-sisters are the focus of clinical nursing and some kind of reorganization

within the nursing structure is going to be necessary to permit appropriate reward to those who choose to stay directly within the clinical environment. Length of time in post cannot be the sole criterion for advancement at clinical level and some mechanism will have to be found to permit progress in this area.

Many ward-sisters leave their posts to 'get a break'. The need for this arises from the continuous unremitting pressures placed upon them by the demands of the service. They should not have to leave to gain respite or to look for new challenges. It should be possible for them to develop within their own situation. It is all too easy to accept gratefully the advantages which we all know will accrue from having a good ward-sister—*but at what cost to the individual?*

THE SALMON STRUCTURE

Alleviation of some of these problems was undoubtedly behind the recommendations of the report on the Senior Nursing Staff Structure (9) (the Salmon Report), where attempts were being made to recognize the need to encourage a closer look at practice; the need for a greater awareness of research; the importance of continuing education; and to facilitate a clinical career structure for nurses. Pilot studies were established to review the effectiveness of the proposed structure (with accompanying education) in meeting these aims. Unfortunately, however, before the pilot studies could be evaluated, a report by the Prices and Incomes Board (10) decreed full implementation of the recommended structure across the country. As a result, the accompanying education programme for new post holders was neglected and while job titles changed, old jobs were perpetuated.

Hierarchical management

It is inescapable that with a large workforce like nursing, hierarchical management will be necessary to ensure both adequate cover on the wards (with all the ramifications entailed in this) and to supervise the training and education of students. The hierarchy should, however, be facilitating rather than restricting and a point often lost in the present hierarchy, which is focussed on management and education, is that while a nurse moving into these areas must be

clinically experienced, the additional skills required to function are not actually clinical skills. Therefore the experienced ward-sister may well have clinical skills beyond those of nurses in the hierarchy. The assumption that being in the hierarchy automatically equates to having superior clinical knowledge does cause division amongst nurses which will only be overcome with the development of a clinical career structure.

Another problem associated with implementation of the 'Salmon structure' has been in many cases the heedless application of a standard structure to an amorphous organization. In practical terms this has in some situations resulted in the existence of unnecessary levels of management. This issue is currently being reviewed in Scotland, with one report available (11) and another awaited which will form the basis of a discussion paper to be issued later this year to all interested parties in the National Health Service in Scotland.

CONCLUSION

In conclusion, the foregoing outlines very briefly the changes in clinical nursing practice and some other current issues. As already stated, much of present practice arises from ritual rather than from action guides for nursing, supported by good research. Part of the reason for this is that it is only in recent years that the need to question this ritualistic approach has been recognized. Although there are now people who are developing the necessary skills to participate in research, much of nursing does not lend itself to scrutiny using a hard science model. We are therefore only at the beginning of change, and have to be careful not to undermine what is happening at present or appear to be hypercritical of staff who are doing their jobs as well as they can within the limitations of resources and available knowledge. However we must continue to strive to obtain a more meaningful knowledge base, to have greater understanding about the direction of nursing, and to create an appropriate environment in which good nursing can be practised if quality of nursing care is to be assured.

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NOTES ON OPENING DISCUSSION

(I) R. G. MITCHELL

I very much enjoyed Miss Clark's presentation, with its stress on the interdependence of nurses and doctors in the care of patients. I feel sure that a greater appreciation by doctors of the aims of modern nursing practice as she has outlined them would do much to increase mutual confidence and understanding. This recognition of the nursing profession's unique contribution to health care is an essential prerequisite of co-operative teamwork but I believe that there are other factors in the equation which are at least as important.

Good professional relations depend not only on mutual understanding of objectives and methods but also on compatible personality characteristics and the will to make relationships effective. Working conditions may be conducive to successful collaboration or inimical to it. We are living at a time when people, and especially the young, are very conscious of rights and less sure about responsibilities—and this is not just in the health professions but throughout society. Increased attention to hours of work, time off duty, payment for work done, and total financial reward have had the dual effect of enhancing awareness of professional status and diminishing the contribution the individual makes to patient management as a whole. In the hospital ward, this has given rise to shared and therefore intermittent responsibility for care, and loss of the feeling of day-and-night involvement with the patient, which was so professionally satisfying and compensated for long hours on duty. Nursing and medical staff no longer live in hospital, with the close commitment to the ward that this implies.

The former one-to-one relationship between doctor and nurse has been replaced by a much more complex interplay of roles between many professions with multiple points of contact. There is little doubt that this has strengthened the team approach which is so necessary in an age of increasing specialization and advancing technology but the cost has been some sacrifice of continuous personal accountability. Other changes have increased pressures on hospital staff. The demand for consultant involvement outside the acute ward—in administrative work, outpatient clinics, peripheral clinics, teaching and so on—has necessitated a greater number

of consultant posts and so more consultants in the wards, each with fewer beds; the increased number of ward-rounds imposes a heavy burden on nursing staff in many hospitals. One consequence has been a lessening of emphasis on attending all rounds, when there are so many other important things to be done. This has made the presence of the ward-sister less indispensable and she is now often not present on ward-rounds, which would have been unthinkable not so long ago.

In recent years there has been an increase in awareness among junior hospital doctors, in part at least due to the greater responsibilities and clinical experience they are now given as students. Too often an over-confident house officer will dictate to comparatively young nursing staff in a way which would have quickly earned him the censure of the ward-sister in days gone by. Now the sister is less matriarchal, frequently less experienced, and not nearly so often on duty; moreover, her dominating sway over her ward has been diminished by the presence of other professionals not responsible to her for their work, such as therapists, social workers and, in children's wards, play-leaders. Indeed, in children's wards also the continuous presence of mothers has changed the sister's role: she cannot be so authoritarian and so lays more stress on collaboration. All this means that the sister is no longer pre-eminent in the ward and her authority has been further undermined by the introduction of the Salmon Report recommendations. Many nurses have adjusted to these new conditions and find them quite acceptable, but others find being a ward-sister less satisfying and more frustrating than formerly. They may have to struggle with inadequate nurse staffing levels, and this at a time when the greater complexity and intensity of some types of treatment has led to a need for more rather than less nursing care. Thus a recent survey by the British Paediatric Association showed that half the children's hospital units in the UK have nurse staffing levels below the minimum considered acceptable. In such circumstances the strain on nursing staff becomes very great, morale suffers and it is hard to recruit staff. Some re-organization of the ward-sister's role is urgently required.

Other aspects of hospital work also cause problems. Whereas formerly the 'chief' or consultant in charge would confer with the sister and agree on such matters as extra beds, who should go home to make room, what should be done to control infection and so on, now there are several consultants of equal status, none of them feeling an obligation or indeed a competence to decide about the extra beds 'because they're not my beds'. While this greater democracy may be an advance from the doctors' point of view, it can be a source of frustration and loss of motivation to the nursing staff. It is not surprising that all these difficulties may be reflected in some deterioration in attitudes to medical staff.

These then seem to me to be some of the reasons why relations between nurses and doctors are giving rise to concern.

Nothing in my remarks conflicts in any way with what Miss Clark has said

but rather reinforces her view that competent teamwork leads to the best standard of care for the patient. All I have done is to add that the deceptively simple word 'teamwork' conceals a web of interdependent relationships of which mutual understanding of purposes and aims is only a single thread, albeit an important one. I believe that the increasing complexity of professional interaction and of hospital organization has made it more difficult to establish and maintain good personal relationships, and all too easy for them to deteriorate when slight incompatibilities of outlook become magnified under stress. Important though the hard science approach to nursing undoubtedly is, it must be tempered with warmth, good humour, and common sense.

(II) G. B. SHAW

I enjoyed Professor Mitchell's comments and I find myself very much in agreement with the detail of the various points of apparent conflict. I am choosing my words carefully because, like him, I greatly enjoyed Miss Clark's paper which, to my mind, clarified a number of the issues. It allowed me a much greater understanding, for example, of what Miss Clark now calls a meaningless term, 'the nursing process'. She is correct when she states that in the writings of some nurses its explanation engendered 'quite legitimate antipathy' in the medical profession.

I am sure she is also right, however, to have insisted that a change in the outlook, work programme, and training of nurses is necessary. It is perhaps unfortunate, although it may indeed have been necessary, that the method of introduction of such essential and often really quite harmless changes should have upset so many doctors.

I think it may be worthwhile to consider why so many of my colleagues are alarmed and, in doing so, attempt to ascertain whether a greater degree of mutual trust and co-operation is possible—as I am certain it is. If mistakes have been made and somewhat hostile attitudes adopted, it is well to define them. I am in no doubt that there are faults and failings on both sides.

It is a fact that doctors have taken the nurse's presence and tasks too much for granted. Although there are honourable exceptions, many doctors have expected things to continue now as in the past—an understandable weakness which fails to take account of a number of facts: the increasing technology and role of both medical and nursing procedures in diagnosis and care; the stresses and strains of greatly increased patient turnover; the problems raised by the different pattern of the working week; the complexity of and involvement of nurses in intensive care; the nursing load of many

medical research programmes; the rapid advance of medical as distinct from nursing knowledge; the introduction of several paramedical professions to the wards; the increasing numbers of consultants and junior staff, and at the same time the disappearance of the stabilizing influence of the consultant in administrative charge to whom senior nurses could relate. I am sure there are many other factors but these alone constitute sufficiently good reasons why the nurse, concerned about her role and her abilities to fulfil that role in patient care, might justifiably seek to redefine both her role and status. Perhaps she did need to jolt her medical colleagues into a new awareness.

Why were they so surprised and, in some cases, enraged?

I am going to put forward some of the reasons, as I see them, why a perfectly legitimate reassessment of the nurse's role caused so much upset.

In the first instance—and I am going to say this first so that we can put it behind us—no-one can completely exclude or conceal the role that the feminist movement had in this. Nursing, a predominantly female profession, confronted a predominantly male medical profession which was accustomed to allocating the role of essential tasks in patient care to the nursing staff. It is not wrong to say that the feminist movement had some influence in providing the words, phraseology, and spirit of the nursing challenge to such a role. As not infrequently in such matters, the case may on occasions have been slightly overstated and this has been to some extent instrumental in provoking a degree of male reaction. It will be interesting to see what will happen in this respect as more senior nursing appointments are held by men, and the medical profession continues to be infiltrated by women.

Another factor which has obviously greatly influenced our nursing colleagues is the activity on the other side of the Atlantic. I am not convinced that the problems of the UK nurse are identical with those of American nurses, nor that their solutions are always our solutions. But unfortunately, the more vocal advocates of change here and in the USA strongly suggest that we should follow their path. If you glance through the titles of the nursing journals one word, in many variations, keeps cropping up in relation to nurses—'profession', 'professionalism' or even 'professionalization'. According to McCloskey (1), an American nurse academic, nursing is listed by American sociologists as a semi-profession, or an aspiring profession which has been aspiring for full recognition as a profession for decades with little success. I am not one to take sociological opinions at face value in any event but I had always thought my nursing colleagues in the UK became a profession about 1860. It suggests immense lack of self-confidence that this should now be in question. I can, however, understand that nursing is challenged by many other groups in health care seeking professional status and that the nursing tasks therefore required redefinition; but nurses should not feel that it is necessary to re-establish the fact that they are a profession.

Another reason for our misunderstanding is somewhat curious. It is because, to some extent, it is an area where the doctors feel less adequate

than they were. I refer to the simultaneous reorganization of our two professions—almost in opposite directions. Nurses have, if anything, tightened up their hierarchical structure in relation to management, whereas doctors, in accepting the rather vague concept of the division and abandoning the consultant-in-charge system, have considerably weakened their voice at managerial level. This results in many doctors believing that nurses at least seem to be rather more influential in management. This is no fault of the nurses. At the same time, arising out of the Salmon rearrangement, there can be no doubt that a number of very experienced nurses disappeared from the wards into management and although improvements are now taking place, medical staff did feel for a time that that most valuable and constant colleague, the ward-sister, was not quite what she had been. It may or may not be regarded as fair criticism, although I think it is very relevant, to say that some of the writing in the papers on the nursing process seems to be rather divorced from ward life and practice as I recognize it.

Acknowledging that only the nursing profession can plan for its own future, I hope that we shall nevertheless see some consultation and discussion when changes are to take place in areas of joint responsibility. In Virginia Henderson's (2) excellent little booklet of 51 pages, with which I can find few points of disagreement, it is perhaps disappointing that the word physician occurs only five times and that on at least three of these occasions the mention has critical overtones. In other documents too, the phraseology, if not calculated to antagonize, is occasionally at least perhaps injudicious. As I said to begin with, I am sure we must see beyond these petty irritations and I must say Miss Clark's paper today has greatly heartened me. I personally welcome the concepts of greater nurse involvement and improvements in nurse education—always provided that it is fully relevant and avoids the worst excesses of the educationalists. As to research, I agree with Miss Clark that for the majority this should be operational research or audit, but more fundamental research should be carried out by academic and scientifically trained nurse research workers.

Originally research into techniques should perhaps be a principal task of the academic side of nursing. The practice of nursing, the day-to-day routine of the ward and of the bedside, should remain in the control of the nurses in the wards and one would hope that, in conjunction with medical colleagues, there would develop a useful and productive dialogue towards understanding and improving the team approach to the better care of our patients. The patients, we must remember, are the principal concern of us all and if we look after them, the professional standing of both disciplines will look after itself.

> A nurse on occasion may be more aware of the needs of a patient than a doctor, and the relationship between nurses and doctors should be

based on respect for each other's area of expertise within the framework of ultimate responsibility.

I am quoting from the BMA's *Handbook of Medical Ethics* (3). It seems to me to state in a single sentence what I am trying to say.

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DISCUSSION

Introduction

In introducing her paper, Miss Clark explained two of the ways in which nurses are attempting to change their clinical practice:

(i). by the introduction of a systematic approach to the planning and execution of nursing; and

(ii). by recognition that promotion of self-care is the main purpose of nursing, that is, that nursing should aim to make the patient as independent as his physical and mental state will allow.

There is a need for a great deal of planning and education if these goals are to be realized, and of course, the service must be kept going at the same time. To illustrate the scale of this problem she gave some statistical details. The Scottish nursing workforce, which in 1975 numbered 52,540, by 1982 had risen to 61,922, an overall increase of 18 per cent. It was gratifying to note that the largest increase was shown to be in the number of qualified nurses:

	1975	*1982*	*Per cent difference*
Qualified	24,246	31,022	+ 28
In training	11,096	12,644	+ 14
Unqualified	17,198	18,256	+ 6
Total	52,540	61,922	+ 18

The hierarchical nursing staff structure has frequently been accused of being top-heavy. Published figures (1) show the inaccuracy of such claims. Of the total workforce of 61,126 in 1981, 2·7 per cent were noted in the statistical returns as being administrative, that is:

Hospital administrative staff	1,370
Community administrative staff	226
Chief area nursing officers, divisional nursing officers, area nursing officers	75
	1,671

Of this number (1671) approximately 1000 were employed in the grade

of nursing officer and many of this grade have a major clinical involvement, the administrative component of their responsibilities being divided between the nursing service and the wider administration of a hospital during unsocial hours, that is after 5 p.m. and at weekends.

Miss Clark's stimulating paper should have dispelled some misconceptions about the nature of professional nursing but the discussion period proved disappointing. Some mutual difficulties were explored but there seemed to be rather less common ground between medical and nursing participants and less meeting of minds than had been apparent earlier. The frank remarks of the opening discussants should have been matched by equally frank examination of the issues they raised, some of which are clearly at the heart of what are said to be deteriorating relationships between doctors and nurses. Unfortunately, some participants in both professions adopted what seemed to be a preconceived stance, so unaffected was it by either the circulated paper or the contributions of the opening speakers. Undoubtedly, if better understanding is to be achieved, these matters should be addressed at a future joint meeting.

Organization of nursing staff

Initially, discussion centred more on the changed nursing staff structure than on changing clinical practice in nursing. It was clear that many doctors present cherished memories of a much earlier decade, when less complex hospital care and a longer working week ensured that the ward-sister was readily available to meet all needs.

One doctor opened by questioning whether introduction of nursing line management based on the recommendations of the Salmon Report (2) had undermined the ward-sister's position to the point where she feels insecure. She is now unable to make decisions without referring to a senior officer and ancillary workers are no longer under her supervision.

Another doctor took the argument further in a series of statements. The requirements of Exchequer audit lead to continual review of the nursing manpower. Cash limits necessitate nursing management having to account for the number of nurses on the establishment and their deployment. Nurses are trying to determine more precisely what their role is, to account to government for expenditure and to explain both to their medical colleagues. These developments threaten the nurse's clinical freedom and are destructive of previous relationships. He concluded by asking 'What methods are used to determine these issues? Who controls the clinical area? Where do the patients come in? And who reconciles any difference in view between "clinical nurses" and nursing management?'

Nursing practice

A chief area nursing officer sought to bring the discussion to clinical practice in nursing. She reminded a professor that when during training she attended his lectures he had emphasized that the ward-sister practised individualized patient care. This is still what nurses are trying to do but now they are also trying to record what they do. She pointed out that there are two- or three-times more doctors in the wards today than there were in the past, as well as two- or three-times more nurses to whom information has to be conveyed.

Another professor responded that individualized patient care demands continuity and efforts are being made to achieve this in medicine; for example, many young doctors are opposed to proposals for one-in-three rotas. He considered that there is greater emphasis in the south on patient orientation, rather than task orientation, and declared provocatively that continuity of care by nurses does not exist in Scotland. The rest of his comments concerned conditions of service common to the UK: not only does the sister no longer live at the end of the ward but the full-time nurse is only on duty for 37·5 hours out of the 168 in a week. Information about patients therefore has to be communicated between a number of registered nurses; they cannot emphasize the nursing contribution but can only complement the medical contribution. To maintain high standards it is sometimes necessary to pronounce a practice to be unacceptable but at the moment this is not done.

Asking leave to raise a note of controversy, a senior nurse declared that although this conference was being held for the deliberate purpose of understanding each other, some had not listened to what had been said. Reminding the audience that a delusion is a belief held against all evidence to the contrary, she wondered if doctors had a cultural inability to understand the social and demographic reasons for the changes in availability of nursing staff, clearly explained in Miss Clark's paper. Some doctors were persisting in their delusion that these unwelcome changes were the effect of the Salmon Report.

Problems in acute care

A chief area nursing officer said that Professor Mitchell's opening contribution to the discussion had highlighted the development of specialization within the medical profession. This causes particular concern in medical wards, where there can be four or five nursing teams trying to carry out different responsibilities in caring for 30 to 36 patients. One-third of the patients in these wards are long-stay, a third are emergency admissions, the remaining third being there for specialist care requiring considerable technological input. No charge nurse could co-ordinate the amount of

information generated by all the different disciplines, and particularly by medical teams. The enormous pressure cannot be sustained for more than four or five hours at a time and ward sisters escape it by leaving the service.

Elaborating this theme, she pleaded for better allocation of beds, saying that most Health Boards have a policy to alleviate overcrowding in the mental handicap and psychiatric services. As a result, in some of these wards beds have been reduced from around 50 to a reasonable charge of 24. There is now a serious need to examine the situation in the acute services. When a new consultant appointment is made, of a haematologist for instance, he has his own medical team and looks for beds for his patients in the medical ward. How they can be looked after and how many new specialties the medical ward sister can cope with has to be considered. Professor Mitchell recognized that the medical team's many activities in the morning include out-patients and day-patients, but in the afternoon nurses also have to contend with an avalanche of doctors with whom to exchange information. Introducing more nurses into the ward team only makes communication more complex and there is a limit to the co-ordination the ward-sister can achieve.

It was acknowledged by a doctor that it is not fair to expect the medical ward-sister to cope with both long-stay and acute patients. The constructive question was asked as to how the medical profession can best help to provide solutions to the problems described.

Some solutions?

The chief area nursing officer who had first raised the issue considered that many of the difficulties arise from the mix of patients in large wards which have 36 beds, as well as extra ones—smaller patient sectors could relieve the situation. A doctor agreed that wards are the wrong size. Smaller specialized units are preferable, staffed by nurses with specialized preparation, but he had the impression that the nursing profession wanted to keep large wards.

A nurse suggested that one solution lies in primary nursing, making one person responsible for planning the care of a patient. This implies different professional thinking but doctors are inclined to think in terms of 'my ward', 'my ward-sister', and 'my patients', although he does not own the nurse or the patients.

Miss Clark responded to a medical request for more information about 'primary nursing', explaining that the term describes delivery of nursing care by an individual nurse assigned to an individual patient. This nurse is responsible for the overall assessment of need, planning of action, and the evaluation of the effectiveness of the plan she has made for the patient. As it is not practicable for this nurse to be present throughout the 24-hour period, others will carry out the details, reporting their observations to her, together

with any change made in the plan during her absence. She will then make such adjustments to it as may be necessary.

One of the Presidents expressed sadness about the defensiveness shown by both medical and nurse participants during the discussion. He suggested that one solution to the problem of fitting a quart into a pint pot would be to use five-day wards. His own experience of such a development, initiated and planned by a ward-sister, had improved hospital efficiency considerably.

The last words on the problems in the acute services were left to Miss Clark, who admitted that she did not know the answers. There are 21 shifts to be covered each week and every full-time nurse only covers five. Patient turnover is rapid; five-day beds might help. One fact was clear to her—doctors and nurses must continue to talk to each other if a practical solution is to be found.

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COMMENT

R. H. GIRDWOOD

My comments on this subject are put forward from the point of view of one who has just ceased to undertake clinical work after having been involved in hospital practice for 48 years, including experience as a medical student and as a war-time RAMC officer. This experience has been enjoyed in a number of countries.

The problem is that medicine, using the term in its broader sense, has advanced more in the past fifty years than in the whole of the preceding history of mankind, and the nursing and medical professions have not yet been able to come to grips with the resulting challenge. The ward-sister of the past, who sometimes preferred not to have any off-duty, did not require to have any real scientific knowledge, and was able to benefit the patient by ensuring that a high standard of nursing compensated to a certain extent for a lack of potent therapeutic agents. The structure of most of our hospital wards was designed for the practices of the past and the ultimate in the way of a totally unsuitable environment for good medical care is an old-fashioned 30 beded ward with a mixture of general acute medicine, long-stay patients who cannot be discharged anywhere and, in the same ward, an active special interest as complex as modern haematology with difficult treatment regimes and numerous intravenous drugs.

Until such situations are corrected by overall planning, it is essential that the medical and nursing staff in such units act together as a team, and that the medical staff ensure that modern developments are explained to those who seek information, while taking an interest in the welfare of the patients as individuals and knowing about their family problems. We should not be too despondent. At the time of my exit from ward practice, I marvel at the high quality and dedication of the nurses and of the house doctors. We must continue to meet in order to plan better for the future and to ensure that the two professions do not drift apart. I am sure that my colleagues will agree when I say that the Royal Colleges are delighted to co-operate in joint ventures to improve mutual knowledge and understanding.

IV

Current problems in communication and in mutual understanding

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DISCUSSION

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INTRODUCTION

In every generation there are men and women who are manifestly born ahead of their time and who in consequence live out their lives half a century or more in advance of their fellows. Their ability to anticipate and communicate forthcoming changes is worthy of greater recognition and action. By now the need to anticipate change should be well understood. That this is not the case is evident day in, day out, in the protests of those to whom all change, all progress is seen as a blight on a glorious past. This resistance to inevitable change gives rise to many problems in both communication and mutual understanding.

COMMUNICATION

Communication is a vital and complex human activity, as complex in fact as human beings. It is hardly surprising therefore that few people have a clear understanding of what it is all about. Communication is a chameleon word, that is, one that changes its meaning with every person who uses it. Dictionary definitions would lead one to believe that communication is a simple matter of transmitting, imparting and sharing information by means of the spoken or written word or some mechanical means. Words, however, mean different things to different people and there is a considerable area of communication that has little or nothing to do with words; for example, body language.

Unless we can appreciate precisely what communication involves, any discussion of the means of making it more efficient is largely a waste of time. Involved in the process are skills and techniques, systems of communication and attitudes. 'True communication lies not so much in the physical passage of information, as it lies in the

will to communicate and in the desire to know whether the communication is serving the needs of those who seek it' (1).

Current problems in communication

Hospitals exist to provide care. Each recipient and each provider of care is an individual. As individuals, each relates best with the individuals he/she finds it easiest to communicate with. It is therefore important to be aware of and alive to the fact that 'I can't hear what you say because of who you are' is the way many people in hospital manage to avoid communication with one another, be they patients, relatives or staff.

Vertical communication

In nursing we endeavour to overcome the problems by means of channels of communication which serve individuals with common interests, the importance of sharing information being constantly emphasized. A Royal College of Physicians of Edinburgh Report described vertical communication in the nursing profession as generally satisfactory (2). However, in the more recent report of a study of nursing line management in Scotland, problems of communication were frequently cited and were stated to be diverse (3). In response to a question on divisional structure, 13 per cent of the 2869 nurses who completed and returned a questionnaire chose to comment on problems of communication (4). Only about half of those who attended the workshops associated with this study had received the correct information (5). Since the organizations which represent nurses had agreed to the need for a study and had been informed that a series of planned workshops would be organized, this is indeed surprising. Clearly, some nurses were no more aware of the information circulated by their organization than they were of the information circulated by nurse managers. Participants freely acknowleged that such faults as existed were not attributable solely to nursing management.

Horizontal communication

Communication sideways with other professions and trades in the National Health Service was more difficult than communication

within nursing (6). 'Many problems of communication and decision-making involved other disciplines in the Health Service' (7). 'The fact that doctors had a non-hierarchic structure also created problems of communication with other types of management structure in the hospital. Because each doctor was an individual it was difficult to obtain any common view or agreed policy statement from them' (8).

The increasing complexity of both communication and decision-making, and the consequent need for new systems of organization for both medicine and nursing was foreseen twenty years ago. In the chapter on 'Communications', the Joint Working Party's Report on the Organization of Medical Work in the Hospital Service in Scotland stated, '... the changes we have considered, many of which are already operating in an experimental form, must lead to radical alterations in the outlook of the medical and nursing professions ...' (9). 'The medical staff are not alone in having the type of organization which fails to meet the new requirements of hospital practice. Nursing organization is similarly geared to the requirements of a type of hospital practice which is rapidly disappearing' (10).

The Salmon Committee's Report on Senior Nursing Staff Structure (11) was published during the course of the Joint Working Party's meetings and this may have prompted their comment 'Co-ordination with the activities of the nursing services is likely to increase in importance and complexity. There is need for discussion between the medical and nursing organizations within a hospital to ensure that each is fully aware of the pressures on the other and the probable trend of development' (12).

Florence Nightingale stressed that reports are not self-executive. It is we who read and discussed these reports in the 1960s and failed to implement recommendations timeously who, amongst others, are responsible for current problems in communication and mutual understanding. Furthermore it is we who read and discussed the reports of the Integrated Health Service (13, 14) who, amongst others, will be to blame for the problems of tomorrow if we do not act in unison now at all levels in our respective structures and organizations. We are partners in care. To quote the Committee on Nursing, 'The vital need is for the two groups to communicate their professional knowledge and skills even more closely and consistently as integration proceeds' (15).

MUTUAL UNDERSTANDING

At the beginning of the decade, attention was drawn in the medical press to significant changes in the medical role. 'The role of the doctor in society has been overtaken by high technology and by teamwork' (16). Currently there is much debate about the nature and implications of teams. More teams and greater teamwork were foreseen twenty years ago and have been mentioned in a succession of reports. A description of the type of leadership required is quoted in the report of the Joint Working Party on the Organization of Medical Work in the Hospital Service in Scotland (17). 'Leadership is the skill to give form and expression to the feelings of the group, to represent rather than to command, to find new levels of synthesis which evoke agreement and satisfaction in the group.' It is the acquiring of this skill which ought to be being discussed and not who is to be the leader. Improving the level of collaboration depends so much on understanding, communication and attitudes.

Access to information

The more people who are involved in patient care, the more there are who must have access to personal information about patients. The Highland Health Board Staff Handbook states,

> All information regarding patients which members of staff learn in the course of their duty must be regarded as confidential. This includes the fact that certain patients are receiving treatment at all. Any member of staff who knowingly communicates, or in any way makes public information about the condition or treatment of a patient, or about his affairs, without authority will be liable to disciplinary action. (18).

Health Boards' staff handbooks should all contain a similar statement and each member of staff should have a handbook. In an age when there is concern generally about confidentiality, people are entitled to this assurance.

Such assurance has to be balanced with a need for clinical information to be readily accessible to health professionals, in the interests of complete patient care. These mutual needs are recognized in a King's Fund Project Paper,

> The advantages of enabling members of a team to make their full contribution to the care of a patient are great. We therefore take the view that every professional member of a team should have the clinical information upon which comprehensive care and treatment can best be based. In return, equally high standards in the maintenance of confidentiality must be expected of all those concerned (19).

Understanding between the professions

How is understanding between our two professions being furthered? That there is a need for an ongoing dialogue between doctors and nurses is without question. That a retracing of steps is required should also now be without question. Further reading and discussion of the reports mentioned in this paper are required. It is imperative that the thinking behind the recommendations be made known and understood by both present and future doctors and nurses. There must be a striving towards an understanding of each other's objectives and the time needed to achieve this should not be underestimated.

Time spent ironing out misunderstandings stemming from differences in terminology would be time well spent. The publication of a glossary of terms, with cross references where applicable, would assist both communication and understanding. The glossary would, of course, require to be updated as new terms come into use.

If there is to be greater understanding and less resistance to inevitable change in future, what steps should be taken now to prevent a repetition of the misunderstandings of the past twenty years? Increasingly there is evidence that need for multidisciplinary education exists and should be met. The question is, at which point in a doctor's or nurse's career should this education be introduced? There is a case for introducing it in the basic preparation but it is difficult to match medical and nursing curricula at a specific point. What is important is to ensure that behavioural sciences are included in the curricula and that communication skills and techniques, communication systems, human relationships and attitudes, and the management of change are covered in like manner. Objective-setting and evaluation should be undertaken on a multi-disciplinary basis, preferably by experiment in multi-disciplinary education in the early post-registration period.

CONCLUSION

You can't drive a 1983 car with a whip in one hand and reins in the other. My premise is that resistance to inevitable change gives rise sooner or later to problems in both communication and understanding.

> I realise you believe you understand what you think I said but I am not sure you realise that what you understand is not what I meant (20).

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SIR IVOR BATCHELOR

CONTRAST BETWEEN THE PROFESSIONS

Towards the conclusion of our meeting today it may be useful to place some of the problems which we have been discussing, in a wider context.

They arise out of the interaction and rivalries of two professions, sharing a humanitarian orientation and a common task of service to the public, but in structure and membership differing widely. Medicine is still a male-dominated profession, nursing female-dominated. Medicine is an all-graduate profession; nursing includes a great range of different talents and abilities, performing tasks which range from the most sophisticated to the domestic. Those who practise medicine usually devote their lives to it; nursing is a profession with a much more mobile and often transient membership; medicine has an ancient tradition; nursing developed its consciousness as a profession only in the last century. Medicine is a dominant profession, nursing an emergent one.

I have called medicine a dominant profession: many nurses would call it a domineering one. Their resentful attitude has been provoked by much insensitive behaviour on the part of doctors, and fuelled by the contemporary fires of Women's Lib. Many nurses want to get away from the doctors' shadow, to feel and be independent professionally, no longer hand-maidens. 'My sister' on the ward has come to sound a good deal too proprietorial; and doctors may be referred to as the 'medical fraternity', with sisterly venom. If you want to scrutinize the process of professional attraction and repulsion, a good place to go just now is general practice. There, 'practice nurses' employed by general practitioners are by many other nurses in the community considered to be 'black-legs': they have sold the pass and are doing doctors' work instead of nursing. A particularly teasing aspect of the situation is that many of the 'black-legs' are not only complaisant but happy, feeling that they have

escaped the attentions of a nursing hierarchy too prone to restrict the scope of their professional activities.

The doctors' stance

The most influential hospital doctors have been those who are most concerned to exploit the advances of science and technology, in order to open up new frontiers of diagnosis and treatment. They work in, and are concerned above all with acute medicine. Their aim is cure or substantial alleviation of illness and disability, and they believe that this is the kernel of what the NHS is all about. They ensure that the money available for development in the NHS in so far as they are able to determine this, is spent in the general hospitals, particularly the teaching hospitals. They have been at least reluctant, and sometimes determinedly opposed, to spending money on longer-stay services, particularly geriatric and psychiatric; and have in fact succeeded generally in preventing these services gaining a larger slice of the national cake. Rehabilitation hasn't greatly interested them; and they have been notably slow in recognizing that nearly all illness has a psychosocial context of considerable significance. In order to preserve their part of the NHS, they would be willing that long-stay provision and care should be transferred from the NHS to the social services of the Local Authorities.

The nurses' stance

Nurses have reacted against this, with an emphatic insistence upon care. Care to them is a cardinal aspect of any Health Service. Care is the nurse's job; diagnosis and cure the doctor's. Nursing is *the* caring profession. There is much firm ground under the nurses' protest, and one guesses that they have the public on their side. But I think that they have matched the general hospital doctors' narrowness of attitude with an exclusiveness and stridency of their own.

Of course care is an essential principle of action and devoted gift of the nursing profession, but it is sometimes difficult to find the word nursing detached from care in the nursing literature. In this it has tended to become part of the jargon of salesmanship—Securicor Cares, Safeway Care, Volvo the Truck People Care, NUPE (is it?)

Cares. The antithesis between care and cure has been pushed too far, in an effort to differentiate the two professions and to stake out professional territories. It is impossible to accept a definition of medicine which doesn't include care, and I cannot see why nursing should not consider diagnosis and treatment as aspects of its role. A nursing profession which insisted too much on care, if taken strictly at its word, could be limited to the enrolled nurses' functions.

RELATIONSHIPS

Clinical research

Poor relationships between medicine and nursing have been exemplified in the field of clinical research. Some doctors have assumed a dismissive attitude, declaring themselves unable to conceive of such a thing as nursing research; it must be medical research they say, which is being talked about. It has also been for far too long customary for doctors to use nurses in clinical research, as observers and technicians, with little or no acknowledgement of their contribution. Nurses have rarely been identified as co-workers with doctors, in applications for grant support and in the publication of research findings. In reaction to this, and inhibited by the doctors' over-insistence on their clinical responsibility, nurses have neglected the area of clinical investigation, to research nursing education, manpower problems, and the structure of their services.

Here both professions and their patients have lost out. Doctors could do much to help to train nurses of ability in the discipline and techniques of clinical research, by making them co-workers in some of their projects. Patients would gain from the daily work of nursing being subjected to critical scrutiny, rational development, and evaluation. Doctors would benefit in their clinical endeavours from a better quality of nursing practice, and in clinical research from the collaboration of better trained observers.

Structure

Doctors cannot understand why nursing is structured as it is, into so separate administrative, teaching, and research cadres. They cannot understand why clinical nurses, who form the largest and as they see

it the most important group, are paid the least. They resent the propensity of nursing middle management to interfere and say 'no'. They see nursing as far too hierarchical.

Nurses see doctors as too often arrogant, individualistic, and irresponsible in their use of their privileges of independent practitioner status and of clinical judgement. Nurses see their hierarchical structure as a way of monitoring and of preserving and enhancing standards; while doctors seem to them to do little obviously to scrutinize their own standards, and appear often to resist the development of a clinical audit even by professional peers.

Nothing, it seems, will persuade the medical profession to give its administrators due status and credit. From medicine's ranks arises a shrill parrot-cry that administrators are incompetent, that the NHS has too heavy a bureaucracy which should be cut back to provide more money for patient care. Small wonder that it has been a vocal critic of the Salmon structure in nursing, and frequently an ill-informed critic. No doubt there have been weaknesses in the Salmon structure; it hasn't got the status of the clinical nurse right and it was introduced too quickly, without widespread trials and before a good quality of middle management could be ensured. But doctors in their criticisms largely ignore the major problems which the nursing profession has in coping with a huge work force, deployed on shifts 24 hours a day and seven days a week, trained and untrained, students and part-timers, in post today, gone to get married tomorrow, having to meet deficiencies here, there, and the next place, and cementing together the heterogeneous work of a highly complex organization.

Doctors cannot understand why the teachers of nursing don't practise it, and why the practitioners of nursing don't teach in the Colleges and Schools of Nursing. There is certainly something seriously wrong here in the structure of nursing and the way in which the profession carries out its educational responsibilities. But there is an aspect of this which should elicit the sympathetic understanding of doctors. The nurses wish to ensure that those who teach have both the necessary ability and confidence, by having been trained to do so. We may think that they are over-anxious and exaggerate the amount of preparation necessary. It is, however, in part the explanation of what may seem the extraordinary under-employment of ward-sisters and charge-nurses in the delivery of nursing education.

Terminology

Doctors' hackles sometimes rise when nurses apply the terms 'practitioner', 'specialist' and 'consultant' to differentiate members of their clinical ranks. It suggests to them nursing hubris. 'Practitioner' is however a neutral enough term; and a profession which should have a specialist grade and has chosen to sabotage it by dubbing it sub-consultant, is in no position to throw stones. Doctors should take a relaxed attitude to differentiations of functions and names which may be thought to pay them the compliment of imitation. They should wait to see how it works out. Clinical roles in nursing above grade 6 (the ward-sister) have had a slow and uncertain development, but if nursing expertise and clinical responsibility in nursing can thus be fostered, these experiments should have the support of doctors.

CONCLUSION

The professions of medicine and nursing have now and will continue to have a great deal to teach to each other. I think that the most immediately important lessons are these. The message from nursing to medicine is first and foremost a spiritual one, to have wider sympathies and a more tender heart, and to preserve the comprehensive concept and initial idealism of a National Health Service. The advice from medicine to nursing is perhaps more quotidian: to value more highly in the structure of the profession the clinical nurse; to bridge securely the gulf between teaching and practice; and, by firmly resisting the self-assertive pressure for autonomy of some of its specialist groups, to remain united as one great profession.

DISCUSSION

Who will be surprised to read that the discussion in the session on 'Communication and Mutual Understanding' was the most diffuse of the four? There was no shortage of comments but the queries were not all answered and on many of the subjects there was no unanimity. One point, however, on which there was universal agreement was that there is a need for on-going dialogue to promote better understanding and that this should gradually involve more discussants including, in particular, younger members of the professions.

Miss Hood, in introducing her paper, said that leaders in the professions had in the past exhorted us to advance in tandem and that we had largely failed to do this. Better understanding is necessary in the face of inevitable change. Divergence has been too great and lasted too long. She made a plea for constructive thought and action.

Reasons for failure

Communication is always easier where units are small. It has always been better in small hospitals than in large. There has always been a tendency towards larger hospitals and in these there has been a move away from the 'firm' system towards the larger 'divisional' pattern without proper appreciation of the communication problems, and more especially without the introduction of means to counteract the difficulties. Further, with reorganization of the professions there has been a change in the channels of communication and the more channels there are, the poorer the quality of communication. The hierarchical structure of nursing may have made vertical communication within nursing easier but it increases the problems of horizontal communication with the much more autonomous structure in medicine. As will be elaborated below, the rapid increase of specialization—particularly in medicine but also in nursing—has carried with it certain problems, not only of communication but of the mutual understanding of the specialized roles in the two professions. Certainly, changing patterns in patient care has been a factor in altered relationships but probably not the principal one. Another feature of the Health Service which has

adversely affected understanding amongst all the professionals involved has been increased unionization.

Education

Surprisingly, little was said about the teaching and learning of communication skills but there was considerable discussion about education and teaching within and between the professions. Starting from the point made in Sir Ivor Batchelor's paper that medicine and nursing have a great deal to teach each other, several points emerged. It was suggested that medical students would benefit greatly from learning under an experienced ward-sister. This used to happen more in the 'firm' system and when students were attached for longer periods than in the present rotational type of medical curriculum. An increasing number of medical undergraduates do a spell of nursing during vacations or before they embark on the medical course and this is thought to be a valuable experience that tends to change the whole attitude of embryo doctors. The nurses however considered that only certain tasks could be learned by working with a ward-sister for a short period, not an understanding of what nursing is. At least one doctor also showed concern about this approach to a profession that requires three to six years study before qualification. What about three months of doctoring for nurses? Perhaps this is not practicable but nurses should join in medical teaching—both sides would gain from the association.

The matter of doctors participating in the systematic teaching of nurses was discussed. It appeared that this long-established practice had in some Colleges of Nursing become less common but it was agreed, although with at least one nursing voice in dissent, that quite apart from the content of any such tuition, the practice was desirable in the interest of mutual understanding and it was agreed that there should also be greater stress on the role of nurses in the formal teaching of medical students. Should nurses be teaching doctors and medical students about nursing skills or about other matters often neglected in the medical curriculum?

There was some discussion about the advantages of student nurses and medical students being taught jointly. It was generally agreed that in theory people who were going to work together should learn together but the point which had been made by Miss Hood was accepted, that to match basic curricula at specific point is impracticable. It was stressed rather that each category should learn the importance of communication and of integrated health care, and also that bedside multi-disciplinary case discussions are effective not only in improving patient care but in promoting inter-professional relationships.

It was interesting and perhaps significant that there was no discussion on the matter of nurse teachers not being involved in practice.

Specialization

Triggered by a question as to what nurses feel about their role in the specialized fields that have emerged in medicine, there was quite lengthy discussion about specialization in nursing. It was suggested that doctors put pressure on nurses to specialize because the specialist in medicine finds it convenient to have working with him nurses who have become specialists in his field of interest. Against this has to be set the need for mobility amongst nurses. As was noted in the first session, nurses in intensive care units have to have periods away from intensive work and the same may apply even in less intensive work situations. So if nurses specialize too much, mobility is impaired; in particular, return to nursing after childbirth has to be taken into account.

The term 'hyper-specialization' was used, although 'super-specialization' is perhaps the better word. It was agreed that the arguments about super-specialization do not apply to the major fields of care, such as psychiatric nursing which might well require nurses who make their whole career in it. Apart from such subjects the nursing profession in Scotland believes that nurses should be generalists but that many of them will develop knowledge of, and expertise in, special interests, and in respect of these interests will be consulted by other nurses both in hospital and in the community. The example of stoma care was taken but it was noted that the same principles would apply to other subjects. Several doctors commented on the great service to patients given by nurses who had developed special expertise in stoma care.

The concept of a nurse consulting another of equal, or even less seniority was a novel one to the doctors but its logic was fully accepted. A trend to super-specialization has taken place in the USA and to a lesser extent in England but the nursing view in Scotland is that this leads to fragmentation of care. It is better for the patient if the nurse already looking after him seeks advice from a colleague but continues the care herself rather than relays of nurses, one for instance attending the stoma, another giving chemotherapy, and another advising about balance between fluid and solid intake. It may be necessary for some nurses to be relieved of part of their general case-load in order to develop a special interest but it is important that such an interest should be chosen by the individual and not be imposed from above by senior nurse administrators.

Doctors asked if all nurses wish to remain as generalists; it was agreed that some nurses do wish to become super-specialists and that this may be appropriate in a few major hospitals in the cities but this would not be the case elsewhere. Doctors also expressed some anxiety that if nurses become too specialized they would begin to take over the medical care of patients in addition to their proper responsibilities for nursing care. Other doctors disagreed that this is happening and another indicated that equipment may

be lying unused because the nursing staff do not have the specialist knowledge to bring it into action.

The philosophical point was made that it is wrong to assume that an individual in the team should require to have all the skills. Each person has different skills and they need not threaten but enrich us. Holistic care does not mean that the different skills of varying people should not be brought into play at different times to meet the needs of the patient.

It was agreed that further discussion was needed on the place for the specialist nurse. This part of the discussion led naturally to the matter of teamwork.

Teamwork and leadership

Sir Ivor Batchelor in introducing his paper had emphasized that the whole subject of working in multi-disciplinary teams would require discussion on another occasion. The relationship between nursing and medicine might need review in the light of changing circumstances but with other professions being introduced more closely into patient care, the subject of teamwork and leadership has become very important. In discussion there was emphasis on the planning of patient care programmes and in these, dietitians, physiotherapists, occupational-therapists, and others often have an important part to play. We all continue to learn from the contributions of others to these discussions. The subject of leadership of the team was rather avoided but it was tacitly accepted that although the doctor would in most cases be the natural leader there would be times when a different professional would be expected to take the lead. The point was made that in some senses the patient is the leader because although others may intervene this does not mean that the individual is stopped in his particular journey in life. It was accepted that the patient's interest is the essential feature but it is arguable how often he wishes to take a lead in decision-making, even though he retains the ultimate sanction of acceptance or non-acceptance.

The future

There are many elements which require further exploration, including some which had barely been mentioned. Thus Sir Ivor had indicated that interaction of medicine and nursing in the field of psychiatry was in some ways a rather different matter which deserved attention.

It was suggested that the wider membership of the professions had been indifferent to the problems, some of which had been discussed during the present session. For example, the Royal College of Physicians of Edinburgh had in 1976 set up a number of working parties to consider inter-professional relationships. The other professions were fully represented and recommendations were published in a series of reports. It was disappointing

that these had not made more impact. This raised the question of how to ensure that the present seminar would stimulate wide interest. It was suggested that the discussion should be taking place amongst younger members of the professions. This was agreed but the convenor of the organizing committee defended the decision that unless the leaders of the profession were seen to be involved in the first place, discussions would never get off the ground. It was not denied, however, that a next step would be to involve both younger people and the other professionals engaged in health care.

More studies are needed on mutual understanding between the professions. There is still confusion about the terms and language used. Miss Hood emphasized her call for a glossary of terms. Doctors felt that they had been remiss in not involving nurses more closely in clinical research. Apart from other advantages, working together in the advance of knowledge leads to better relationships.

In summary, the discussion showed no lack of communication but brought to light some deficiencies in mutual understanding.

COMMENT

SIR JAMES FRASER

Communication has been defined as the act of imparting information and it is fundamentally a one-sided affair. To be really worthwhile and to have any place in developing mutual understanding it has to be a two-sided exercise with, on the one hand effective, relevant and informed communication, and on the other hand an equally well informed but a sympathetic reception of this information. Such a process is not new but it is an essential if there is to be any hope of co-ordinated team activity by several highly specialized groups or even individuals and never more so than in the care of patients.

During the past few years there may have been an increasing divergence of interests between the nursing and the medical professions, possibly as a result of the increasing complexity and the specialization of work on both sides, but the pitfalls and the dangers that can arise from it are now fully recognized. The choice of title of this session is evidence of this recognition while the formal papers and the open discussion have presented varying points of view and they may have taken the first steps to identify some of the circumstances where opinions differ radically. Equally these points of view have been given a sympathetic hearing by the 'opposition' and the consensus has undoubtedly been an apparently eager will to change.

Of infinitely greater significance however, is the means by which these attitudes towards co-operation can be expanded and can be induced in the two professions as a whole. It has been proposed that a first step could be a greater integration during the early formal training of nurses and doctors but progress will only be made by many and wide discussions on the lines of these sessions and in as many centres throughout the country as possible, both to continue the learning process to all levels of staff and to increase the dialogue. It must be appreciated, however, that a lasting improvement will in many cases require a fundamental change in attitudes and these are hard to alter. It will eventually be up to all individuals on both sides to recognize that an improvement in co-operation and a better degree of mutual understanding between nursing and medicine does not diminish the status of either profession and can only be of benefit to patients.

V

Conclusions and future action

PROFESSOR A. S. DUNCAN
Recently Vice-Chairman
Lothian Health Board

MARGARET G. AULD
Chief Nursing Officer
Scottish Home and Health Department

PROFESSOR A. S. DUNCAN

You will note that in this last brief part of the programme we are not observing the conventional politeness of 'ladies first'. In the original draft we had the speakers the other way round but for this important occasion I suggested that the nurse should have the last word. Miss Auld readily agreed!

It is a happy chance for me that we should be summing up together because for a number of years, (twenty years ago, Margaret Auld and I worked together in the same obstetric wards) both she and I believe that we were practising then much of what we have been talking about today. But, since that time, there have been changes in both professions and also very great changes in demography, technology, and the whole relationships with society. It is the very fact that the attitudes of society to the health professions and to health care have changed that makes it all the more important that the providers of health care should understand and act upon the changes in each other's attitudes and roles.

When we were discussing plans for this seminar we were well aware of two things. First that many more professions than nursing and medicine are involved and secondly that hospital medicine and nursing is only one part of the work of these professions but we felt we had to focus down a bit so as not to have too diffuse a discussion. I would earnestly hope that one part of future action would be to extend the dialogue to work outside hospitals and to our interaction with the other professions concerned in health care. In the choice of topics too we had a long list of suitable subjects. Others would have been equally good but I think the ones selected have been sufficiently varied for most of the points of principle to be ventilated.

In the session on 'New technologies' I was interested in the psychological pressures on nurses in ICUs. How long to keep them there and where they should go next? We did not have discussion on the desirability or otherwise of keeping nursing and medical records

separate. If they are separate it must be because the responsibilities are separate and it may be to the advantage of each profession to keep the responsibilities separate.

Mr Mackie said that the medical profession has established a near monopoly over the medical services and I was interested to compare this with Sir Ivor Batchelor's point about medicine being dominant but appearing domineering. Two other of Mr Mackie's points particularly impressed me—'How to cope with the new technology and still maintain the nurse's contribution to health care' and secondly his quotation about accountability. Certainly responsibility must be linked with accountability and with authority.

In the next session Dr Williams reminded us of the all important demographic changes and I was impressed that the *average* age of patients in geriatric units is now 83. It is in the care of the elderly that the team concept is best illustrated. I remember Katharine Whitehorn saying 'I don't like the phrase "working as a team" because teams usually play *against* someone and in health care I know jolly well who that is'. Sister Prophit gave the definition of the word 'collaboration' as meaning 'consorting with the enemy'. Dr Williams, in his nice diagram has given the lie to any criticism because the patient is shown as being part of the team and that is surely how it should be. As Professor Altschul said—'whoever is at the top, the patient is central'.

Miss Smith made the good point that old age is not a disease. In this session it was particularly unfortunate that for very good reason we restricted the subject to hospital care for nowhere else is the role of community care so important.

From the doctors' point of view the session on changing clinical practice in nursing was the key one. On the whole, nurses know about the changes in medical practice and organization but doctors are singularly ignorant and ill-informed about certain matters in nursing organization. Proper interaction of the professions is only possible if each understands the attitude, role, and aspirations of the other. Miss Clark's paper fills this gap for us. Understanding is only the *first* step but it is an essential one. She reminds us of the doctor's rightful role in prescribing a procedure and the nurse's rightful role in identifying the best way of carrying it out.

Dr Gavin Shaw has already quoted for us the statement from the British Medical Association *Handbook of Medical Ethics*—'A nurse may on occasion be more aware of the needs of a patient than a

doctor and the relationship between nurses and doctors should be based upon respect for each other's area of expertise within the framework of ultimate responsibility'. (Para 6.10.) Dr Matthews spoke for all when he dismissed any question of conflicting goals. On attitudes there is to me no doubt that hierarchy tends to diminish individual initiative. Miss Clark highlighted the deficiencies of the Salmon Report and gave us a look into the future. She raised a number of queries and we must not expect changes overnight. We must understand the objective which is to strive to keep all that has been good in nursing but to add on to it a new dimension based on more meaningful knowledge. In the following session we talked about specialization and super-specialization—this needs further discussion.

Sir James Fraser wondered if the session on communication and mutual understanding should not have come first rather than last. It was kept to the end because it is so important—the whole seminar might have been devoted to it because most other things hang on proper communication. Miss Hood sets out the problems and their importance. The quotation from Revans about the will to communicate is particularly apt. Miss Hood tells us that *we* must all accept responsibility for any failure and that it is *our* responsibility to improve matters and *that* is the object of the seminar.

Understanding even between doctors is not all that good. The Trust is concerned about that also and will shortly be publishing the report of its working party on Doctor to Doctor Communication.

Sir Ivor refers to 'the most influential hospital doctors' and there is no doubt that some doctors see their own specialty as being a cut above others and that doesn't aid mutual understanding. One cannot make progress *in vacuo* or in the abstract and Sir Ivor gives us good practical examples of ways in which interaction can be fostered: the concept of care and cure; clinical research; in structure, the importance of the clinical nurse; teaching arrangements—teachers who do not practice are foreign to clinical medicine and we also believe that engagement in research is important in the maintenance of competence of teachers—a lesson perhaps for nurses and nurse teachers. And finally he makes points about terminology and the two telling messages to each other which he spells out in his conclusion. I believe these are very important messages to go away with.

Our remit is 'Conclusions and future action'. I hope there cannot be any real conclusion because there must be continuing action. The

first step is to give wider publicity to today's discussion and this the Nuffield Trust with its very long-standing interest and initiative in this subject has agreed to do for us. The second is that the Discussion Group of Presidents and Chairman in Scotland from which the idea of this seminar stemmed should continue to meet regularly and be seen to be fostering better understanding and interaction. The third is a point which I made at the beginning, namely that the dialogue be extended, for example in relation to planning for the elderly, to those working outside hospitals, to the younger doctors and nurses, and also to our colleagues in other professions who share with us the privilege of participating in health care.

MARGARET G. AULD

I cannot pretend that, throughout my long working association with Professor Duncan, I have always had the last word but I am very grateful for being given it on this particular occasion.

To complement his summing-up of the specific contributions made by the speakers today, I should like to comment in more general terms. I greatly welcomed the initiative of the Presidents and Chairman of the Royal Colleges in bringing together members of the medical and nursing professions to discuss matters of mutual interest and concern. Indeed, the Fellows of the Royal College of Nursing—a group to which I am proud to belong—await with great interest the outcome of this exploratory meeting because they too believe it is important that representatives from the two largest professions concerned with health care should meet.

Many nurses in Scotland were saddened by reports that discussions between medical and nursing personnel elsewhere had exposed considerable conflict and acrimony, with no discussion about ways of resolving the difficulties. Of course discussion should highlight areas of potential or actual conflict—as indeed our discussion has done today—but I would like to think that we have exposed the differences and similarities in our professional practice in a constructive, rather than destructive, way.

Communication, or lack of it, has been mentioned more than once as being a considerable problem; the use of professional language may not only be misunderstood by patients but between and even within our own professions. There is no doubt that better understanding could be promoted through some joint education; people who work together should undertake at least some of their learning together.

As one of the people involved in the planning of the seminar, I am surprised at the emphasis that has emerged on the nursing problems that are apparently seen to be amenable to solution by the medical

profession. It would have been interesting to hear rather more of some medical problems which the nurses present could have debated. I have also noted the difficulty we seem to have in listening to what each of us is saying. Or is it that we listen but do not hear? Both our professions seem to have adopted a particular stance on most, if not all, the topics raised today and the opportunity for real debate was largely missed. It may well be that in future meetings, having got our prepared and/or expected statements out of the way, we can get down to a meaningful dialogue and reach greater mutual understanding.

Many references were made to the hierarchy in nursing. The effective organization of large numbers of nurses makes some kind of hierarchical structure inevitable. We are well aware of the problems a hierarchical structure creates and, in Scotland, we have started some research in an attempt to identify areas of difficulty with a view to finding solutions and, if necessary, making changes. There must equally be problems in a profession with a flat structure, such as the medical profession, and it would have been interesting to hear about these.

We in nursing also have problems associated with increasing medical specialization because of the need it creates for specific education in such specialisms. Whether nurses should follow the example of doctors into ever more narrow specialism is very debatable, particularly as the central core of all nursing care is common to all specialisms. We need to study the development and use of performance indicators to assist us in determining standards of nursing care. The problem of setting standards of performance is, I am sure, shared by the medical profession and it would be helpful to both our professions to share and learn from our separate but closely related experiences.

One very important, and highly relevant, point made by all the presenters, and by those who spoke in the debate was the clear recognition of the importance of the patient in the scheme of things. Time and time again as both doctors and nurses discussed—sometimes hotly—such issues as leadership of the team, who is responsible and accountable for what, we were reminded of the *raison d'etre* of all our planning and efforts—the patient.

There is no doubt in my mind that today's meeting has been the pathfinder for other such discussions. The need for more and greater depth of discussion of the particular issues raised today has been

clearly demonstrated. The format of future meetings should change with a spread of representation from those practising at the bedside to the planners of the service.

It is interesting to note how often our discussions strayed beyond the boundaries of the hospital-based services into the community and membership will certainly need to be extended to those working in the community services. At the same time I would make a plea for some continuity of membership so that the original aims of this meeting are not forgotten.

As Professor Duncan has rightly said in his summing-up, there can be no conclusions but further meetings of the Discussion Group of Presidents and Chairman to plan future seminars must be the way forward. I believe that discussions between the two professions of medicine and nursing will become increasingly important as difficult decisions about the maximum use of scarce resources become more imperative and more formidable. The need for teamwork and collaborative decisions on the management of practice, which is inevitably dependent on resources, will become increasingly urgent. Such meetings could provide the locus for mechanisms for joint planning to be drafted.

VI

An analysis of the issues

PROFESSOR A. S. DUNCAN

Recently Vice-Chairman
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PROFESSOR A. S. DUNCAN

The original intention was that this chapter should be a summary of the seminar. In the event, in writing, it became an analysis of the main points at issue, based on the papers and on the discussions. The reasons for this change are several: *first*, an immediate summing up by two participants is already featured (pp. 85–93); *second*, the discussions were deliberately not structured and, as a result, there was considerable overlap and a number of important issues were discussed in more than one session; *third*, the first two sessions were devoted to specific subjects chosen out of many suggested, and they represent examples of specific areas where interaction between the professions may present differing features, while the subsequent sessions were more general and central to the theme; *fourth*, and perhaps most important, there were a number of forthright statements and challenges in the pre-circulated papers which were not explored in discussion except in a rather oblique manner and it seems helpful to bring these out again in order to identify areas of misunderstanding or conflict which need to be resolved between the professions. As a starting point Sir Ivor Batchelor's paragraphs on the contrast between the professions (pp. 73–5) are relevant. The end-point of the analysis is that which Miss Auld made in her summing up (p. 92), namely that whatever disagreements appeared during the seminar we were agreed on 'the *raison d'etre* of all our planning and efforts—the patient'.

BACKGROUND TO THE SEMINAR

In attempting to analyse the issues involved, the limitations of the seminar must be remembered. The seminar was always intended to be exploratory in nature and some of the limitations were advantageous—the small number of participants, the fact that it did not purport to extend beyond the Scottish scene and so could be more

circumscribed and the fact that the members were mostly well known to each other. These advantages had to be counterbalanced against the disadvantages of lack of representation of more junior staff and, more particularly, of doctors and nurses working in the community. At a time when much emphasis is rightly being laid on close interaction between hospitals and community services it was found difficult and in some cases frustrating, to restrict discussion to hospital medicine and nursing. It would not have been proper, or constructive, however, to allow the discussion to extend to community services in the absence of doctors and nurses working in the field. This dilemma was highlighted during the discussion on the care of the elderly, and perhaps that was not a very good topic to choose in the circumstances. By the same token and for reason of numbers, the medical participants were restricted to medicine and surgery but it is hoped that the similar problems in other disciplines and specialties will be featured in wider discussion of the principles which were raised. Again, at certain points in discussion the absence of social workers and of other health professionals proved to be a deficiency but in this initial seminar the scope was deliberately restricted to medicine and nursing in hospital in order to limit the numbers and concentrate the discussion.

As stated in the preface, the seminar arose out of meetings of a Joint Discussion Group which was established following an informal meeting in February 1982. The core members of this Group were the Presidents of the three Scottish medical Royal Colleges and the Chairman of the Scottish Board of the Royal College of Nursing. The Group was unanimous that there is a need for closer collaboration at national level in Scotland between the nursing and medical professions. It resolved to meet regularly as a group and to initiate such other activities as might seem desirable to help to achieve the aim. Having agreed to hold an exploratory seminar and having secured for it the support of the Nuffield Provincial Hospitals Trust, the Group first accepted the desirable limitations of size and therefore of overall subject. Before decisions were made, other subjects were seriously considered: quality of care; health promotion; communication (as the entire subject); records; the interface between hospitals and community; ethics; manpower problems; and terminal care. These are mentioned here partly to show the type of topics that the Group felt might be conducive to discussion on interaction and partly as suggestions for future exploration.

The final choice of four subjects was determined by the belief that communication is central to all interaction, that misunderstandings have arisen because doctors are unaware of changes and reasons for change within nursing, and by an idea that it would be good to choose two specific examples of health care, one at each end of the acute/chronic spectrum. As will be detailed at the end of this chapter, participants tended to concentrate on the subject rather than on the interaction of the professions within that subject. In one of the summaries (p. 87) it was suggested that relationships between the professions twenty years ago, in some units at least, were satisfactory and that deterioration has been due to changes in demography, technology, and attitudes within society. On the other hand, eight weeks after the seminar one of the participants wrote—whether or not as a result of the seminar, 'I am not convinced that relationships ever were as rosy as some people seem to think—memory tends to play tricks.' (1). Whichever view is correct, the Group was convinced of the pressing need to improve professional relationships between medicine and nursing, which leave something to be desired even at the purely clinical level and certainly fail to be effective away from clinical areas. The first objective which the Joint Discussion Group set itself at a meeting in August 1982 was that of 'avoiding the danger of medicine and nursing going their separate ways'. It is with that perspective that the issues raised at the seminar should be considered.

CONTRAST BETWEEN THE PROFESSIONS

At no time in the seminar was the view expressed that nursing should not be regarded as a distinct profession or that it should be part of medicine. Some of the interaction and rivalries to which Sir Ivor Batchelor referred (pp. 73–7) would be lessened if the professions were merged. It is arguable whether medicine and surgery are to be regarded as separate professions but the parallel is not valid since nursing has quite different arrangements for recruitment and training and its own pattern of career structure. Nevertheless, as nurses are called upon to do more and more tasks which were traditionally in the doctor's province some of the distinction may become blurred. The important issue is not the blurring but that functions which are distinctly nursing may be left undone—or done

by the untrained—if registered nurses become too involved with quasi-medical tasks. The Scottish Home and Health Department in a 1979 Circular (2) recognized the need to prevent such a possibility—'Medical and Nursing Staff have, however, the prime professional responsibility for respectively ensuring that it is appropriate for a doctor to relinquish a particular task to a nursing colleague and for an individual nurse to undertake it'. At the seminar Mr Mackie (pp. 8–15) issued warnings about rapid medical advances leading to nurses assuming a subservient position and becoming relegated to the status of doctor's assistant. He explained that in times of change nurses must preserve what is good of the old while developing the required skills of the new and was emphatic that no other profession can take responsibility for nursing care decisions. He was critical of the medical profession 'which has established a near monopoly over the medical services' and it is questionable whether it was the politeness of the occasion which induced him to introduce the words 'until recently' into his assertion about doctors refusing to acknowledge the nurse as a member of a separate discipline rather than someone within the doctor's authority.

Misunderstandings between the professions and arguments about the borderlines of responsibility will be considered in the next section but it must be stated here that there are still many doctors who consider themselves to have an innate right to be responsible for the total care of the patient and it is small wonder if nurses resent assertions that the nurse's first duty is to carry out the doctor's orders and the second to relieve the patient's discomfort (3). The stage at which nursing becomes a separate academic discipline is rather a different matter which is considered later in this chapter but there is no real doubt that nursing is and should remain as a profession distinct from medicine (p. 9). The issue of accountability is important and not always understood by doctors. Nurses are accountable for the *nursing care* they give. The press has reported a number of instances in which nurses, midwives, and health visitors have given evidence in fatal accident enquiries and have been held responsible for their actions. Widely reported investigations into more than one sad case of child abuse or neglect resulting in death have unambiguously recognized the health visitor's professional responsibilities for surveillance of child health. Similarly, the Health Service Commissioner when investigating complaints examines nursing records and determines whether nursing actions or omis-

sions contributed to the matter under enquiry. And in order to protect the public, disciplinary measures taken by the statutory body which regulates nursing, midwifery, and health visiting practice can include removal from the Register if these health professionals fail to give a satisfactory standard of care.

In contrasting the professions and looking at the changing clinical role of the nurse it is important to distinguish between the expansion of her nursing role and delegated medical care. But as Miss Clark stresses (p. 45), to view nursing in terms of tasks alone is quite wrong. She draws the 'distinction between the doctor's rightful role in *prescribing* a procedure and the nurse's rightful role in identifying the best ways of *carrying out* the procedure'. She goes on to explain the important role of the nurse in meeting fundamental human needs and the responsibility of the professional nurse to decide on the dividing line between leading a patient towards independence and accepting that he will remain dependent.

This concept of nursing as a methodical sequential activity geared towards fulfilling complex but definable human needs is described in a Scottish Report (4) prepared by the National Nursing and Midwifery Consultative Committee. This document may not have been circulated as widely as it should have been and if more doctors were to read it they would more readily comprehend the nature and purposes of nursing as understood by nurses.

No one argued with Sir Ivor's contrast between the professions (p. 73) but there was some discussion on the extent to which the differing characteristics of the two professions lead to misunderstandings or even conflict. The concept that doctors are concerned with cure while nurses are responsible for care is over-simplistic. There is no doubt that doctors in the middle of this century swung towards cure in that they had available more scientific means of reaching a precise diagnosis and that for the first time they had effective pharmacological and surgical means of therapy. More recently, however, while still developing new techniques towards cure they have swung back towards the more holistic approach necessary for total patient care. This attitude, a response to demographic change, has been fostered by public opinion and by political pressure. At the same time nurses are sharing in the great technological and pharmaceutical advances towards cure while still retaining their traditional role of care enhanced by better understanding and greater professionalism.

INTERACTION AND MISUNDERSTANDING

Between the meetings of the Scottish Joint Discussion Group in August 1982 and December 1982 there had appeared in the medical and nursing press, reports of a meeting in London of the British Medical Association's Central Committee for Hospital Medical Services at which representatives of the Royal College of Nursing had been invited to speak about the College's discussion documents *Towards Standards* (5) and *A Structure for Nursing* (6). It was the *British Medical Journal* report 'Changing relations between doctors and nurses: CCHMS critical of Rcn's discussion documents' (7) which more than anything else crystallized the view of the Joint Discussion Group that better dialogue was necessary between the professions and that an exploratory seminar on interaction and relationship between the professions was not only necessary but urgent. It was noted that the report concluded with the statement that further meetings would be sought between the CCHMS and the Rcn but the Group felt that discussions in Scotland, with its advantage of smaller scale, would be helpful to the general debate. In that the Group was already established between the medical Royal Colleges and the Scottish Board of the Rcn, it was agreed that it should be the Joint Discussion Group and not any other which should plan an exploratory seminar and seek sponsorship from the Nuffield Provincial Hospitals Trust.

The *B.M.J.* report made sad reading because it brought to light general misunderstandings, confusion in terminology, the impression of conflict of goals, and failure of communication. These four subjects were all discussed at the seminar and the issues are analyzed below under these headings. It is disappointing to find that almost a year after the *B.M.J.* report the Joint Consultants Committee (8) has been discussing the same matter without reporting any evidence of greater mutual understanding.

General misunderstandings

Discussion at the seminar showed that doctors and nurses have different concepts of nursing. Mr Mackie's paper (pp. 8–15) and Miss Clark's paper (pp. 43–52) unequivocally give the nurse's view whilst Dr Masson's (pp. 3–7) and Dr Williams's (pp. 25–31) show a

quite different perspective. The doctors seemed to see nursing as a series of tasks mostly related to basic care and comfort and the carrying out of medically ordered treatment. Nursing claims to be, like medicine, a unique mix of skills and disciplines and the nursing view, gradually being supported by nursing research, is that patient outcome can be affected by nursing assessment and by decisions taken by nurses about nursing care. Doctors both in these papers and in the ensuing discussion did not seem to accept this and regarded nursing aspirations more as a spin-off of 'Women's Lib' rather than as signs of enhanced professionalism. The nurse fully accepts that there are medically prescribed tasks which it is her duty to carry out but would see a difference between, say, taking a blood sample as part of a patient's total care and devoting a whole clinic session to taking blood samples. In the past, nurses accepted that much of their work was carrying out tasks allocated by doctors. While this remains part of their duties, the new dimensions outlined by Miss Clark (pp. 45–8) are of increasing importance.

The question of ultimate clinical responsibility has already been discussed and it is clear that nurses bear the responsibility both for carrying out the doctor's prescribed treatment accurately and also for planning, implementing, and evaluating nursing care.

It is not surprising that misunderstandings take place in view of the many contributing factors enumerated by Dr Shaw (pp. 55–8). There are faults on both sides but the differences will be solved only if they are brought to light and discussed frankly. There was more discussion about doctors' misapprehensions about nursing than of the converse but it may well be that nurses do not fully understand the impact on medical practice of the changes of the last decades. Dr Shaw added to his list the suggestion that in some respects doctors feel less adequate than they were, having given up their traditional hierarchical structure and seeing nurses increasingly influential in management.

Dame Catherine Hall in her recent Kathleen A. Raven lecture (9) said

> The medical profession reacted adversely to the introduction of the Salmon management structure which it saw as elevating management and downgrading clinical practice, particularly the role of the Ward Sister. It is therefore surprising and appears inconsistent that the medical profession is now showing resistance to developments in nursing at the level of clinical

> practice. It is imperative to overcome the present strained relationships. The two professions are complementary and inter-dependent and so, unless understanding between them can be achieved, development in nursing can be impeded.

It might be added that without mutual understanding, all forms of health care will be impeded.

It was good to see the quotation (pp. 57–8) from the BMA's *Handbook of Medical Ethics*—'A nurse on occasion may be more aware of the needs of a patient than a doctor and the relationship between nurses and doctors should be based on respect for each other's area of expertise within the framework of ultimate responsibility'. It was heartening to see that the letter given pride of place in the *B.M.J.* of 9 April 1983 (10) was from 18 nurses and that it too featured this same quotation.

Confusion in terminology

The term above all others which has led to misunderstanding and even friction has been 'the nursing process'. It was well that Miss Clark (p. 43) accepted that there had been legitimate antipathy to the term and suggested that it should be dropped. In so doing, however, she pressed that the two central themes embodied in the concept should be retained: a systematic approach to the planning and execution of nursing and the promotion of patient self-care.

'Primary Nursing' (pp. 62–3) is not a term familiar to all doctors or even to all nurses who may confuse it with the primary health care to which community nurses contribute in close collaboration with general practitioners. The concept—planning of nursing care by an individual nurse for an individual patient and its delivery by a group of nurses answerable to her—carries practical difficulties which some nurses are trying to overcome. Implementation of such nursing practice would certainly increase continuity of care and consequently add to patient and nurse satisfaction but would consultants be prepared to seek information about patients from each team of nurses instead of expecting the ward-sister* to be always on hand as the only channel of communication?.

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*The traditional title was much used throughout the seminar, and is therefore used in the proceedings, although it has been replaced by the term 'charge-nurse' to include male nurses.

The use of the terms 'consultant' and 'practitioner' in relation to nursing has been criticized as aping or even usurping medicine but at the seminar it was pointed out (p. 77) that doctors have no monopoly of these terms and that their adoption by nurses is in fact a compliment to medicine provided they are used in the proper context. Nurses could therefore derive relatively comparable professional status from appropriate experience, depth of knowledge, skills and matching graded qualifications as in any other profession.

Apparent conflict of goals

The report *Towards Standards* (5) was published by the Royal College of Nursing and there has been considerable adverse comment on some of the wording. The sentence 'Doctors and nurses must both recognize that their goals for a patient may differ or even conflict' has come in for particular criticism. The nurses at the seminar agreed that the words were ill-chosen but stressed that they were more liable to misinterpretation when taken out of context. Miss Clark (pp. 47–8) expresses the Scottish view when she writes about two components of nursing. There may be nursing objectives in patient care which may be distinct from, but should not be in conflict with, the medical objectives provided it is the long-term good of the patient that is the goal. Mr Mackie (p. 13) in saying that no other profession can take responsibility for nursing care decisions makes the point that 'such professional freedom permits the registered nurse to make judgements that are independent of, can conflict with, and even refute those of her own and other professional peers'. The issue here is the extent to which differing judgements are matters to be distinguished from differing goals. Some clarification of such points was given during discussion in the second session (p. 38) but there are demarcations which remain unresolved especially within the clause 'framework of ultimate responsibility'.

Failure of communication

In that this question was considered sufficiently important to designate a whole session of the seminar to the subject, nothing much need be said here. Scrutator (11) of the *B.M.J.*, in commenting on the meeting mentioned above between the CCHMS

and representatives of the Rcn said that the one thing which was apparent was the 'chasm in communication between the two professions on this vital subject'.

Miss Hood (p. 68) refers to vertical and horizontal communication; both are important and each has its special problems. As was mentioned in the summary (pp. 89–90) the Nuffield Provincial Hospitals Trust has long been concerned with communication and is adding further publications to its already well-known contributions to the subject. It is recognized that barriers to good communication include historical factors, hierarchical factors, and jargon. The barriers have to be broken down and it is strange that in the discussion there was no follow-up of Miss Hood's point about the teaching and learning of communication skills.

STAFFING STRUCTURES

The subject of staffing structures was not on the agenda for the seminar but hospital doctors when they meet nurses never fail to criticize the Salmon Report (12). Doctors feel that the status of the ward-sister has been downgraded and that the only way for nurses to get promotion and greater financial reward is to enter administration and give up clinical nursing altogether. This is a distortion of the situation but it is generally acknowledged that some unfortunate interpretations of the report need correcting. A number of the issues were raised at the seminar. Miss Clark (p. 50) and Sir Ivor (p. 76) both indicated that the Salmon structure had been introduced too quickly—the report was overtaken by another and the pilot trials were not evaluated. But all is not bad. In 1980, at the request of the Chief Area Nursing Officers and the Scottish Home and Health Department, a study of middle management in nursing in Scotland was begun. The first phase was a widely distributed questionnaire; the second phase was a series of workshops held throughout the country; finally a discussion paper based on the results of these enquiries will be distributed to the profession. The study has not yet been completed but as Miss Hood points out (p. 68), the workshop evidence suggests that there is little dissatisfaction among nurses at any level about the framework of their staff structure. However, it would seem that in some places unnecessary levels of management may have been introduced; the Salmon Report did not say that

appointments had to be made at each level nor that nurses had always to refer up the line for decisions—a practice which is the subject of complaint by doctors.

Professor Mitchell (pp. 53–5) spells out many of the reasons why the changes in both nursing and medical staffing arrangements have led to problems and these were further ventilated during the discussion at that session. The Salmon Report is often blamed but if the increased hierarchical pattern in nurse staffing made essential by a large work force with a high proportion of part-time and unqualified personnel has contributed to friction, so has the the abolition of the 'firm' system in medical staffing and the greatly increased number of consultants all of equal status, often working in the same ward, and all equally demanding of the ward-sister's time. So the trend in the two professions has tended to diverge and it is small wonder that it is taking some time to adjust. Further changes will take place. The government has agreed in principle to increasing the number of consultants and reducing the junior staff—will the nurse be as prepared to call the consultant for advice as she is to summon a junior doctor and will the consultant be prepared to be as readily available as is the junior doctor? The government has provided money to evaluate three experimental schemes in England designed to further the professional development of newly registered nurses. Announcing this the Health Minister, Mr Kenneth Clarke said (13) 'I share the widespread concern of most nurses about some weaknesses in the career structure of their profession. Many nurses would like to see more opportunities and encouragement to develop their full potential in the clinical setting of the wards'. In Scotland discussions are under way to consider how professional developments can best be furthered at every level. Statistics given by Miss Clark in discussion (pp. 59–60) show that doctors have an exaggerated idea of the proportion of nurses engaged exclusively in administrative work but there must be financial recognition of clinical expertise and the opportunity to gain promotion without leaving the clinical scene.

The Royal College of Nursing's document *A Structure for Nursing* (6) proposes a structure based on four key principles—the accountability of the individual nurse, the key role of the ward-sister, professional development through continuing education, and promotion dependent upon fulfilment of specified criteria of accreditation. The suggested structure is still very much a matter for

discussion, not least because many in Scotland consider it more sensible to adapt the existing structure than to introduce another. However, the nursing profession in Scotland whole-heartedly subscribes to the principles of this report, implementation of which would go a long way to meeting comments made at the seminar, including the suggestion that hierarchy diminishes initiative. Doctors often come forward with suggestions for an improved structure in nursing (for example, Gibberd (14)). The problems for the nursing profession of the staffing structure in medicine are not so often ventilated and as Miss Auld states in her summary (pp. 91–2) this seminar was no exception, apart from Professor Mitchell's analysis to which reference has already been made.

SPECIALIZATION

Discussion of specialization, which recurred throughout the seminar, related almost entirely to specialization in nursing. Perhaps specialization in medicine was taken for granted but it should be remembered that specialization in medicine as we know it today is relatively new. The pattern of development from generalist, to generalist with a special interest, to specialist, to super-specialist is an evolutionary one. The advantages to patient care have to be weighed against the disadvantages. In the British system of health care the disadvantages have been largely offset by the greatly improved training and competence of general practitioners who have come some way towards taking the place of the generalists in the consultant practice of the past. In other countries where the patient goes direct to the specialist the disadvantages of super-specialization are greater.

It may well be convenient for doctors to have nurses working with them who have become super-specialists in the same field as their medical colleagues. We were warned (p. 80) that whereas there may be a limited place in the larger centres for such an arrangement, it would not in general be in the interest of nursing and therefore ultimately of patient care. It would be well, however, for nursing planners to pay heed to what has happened in medicine in the last two generations and to see what lessons there may be for nursing. In specialist units, doctors begin to look to nurses to take over tasks previously exclusively in the doctor's province. Some nurses may

think it adds to their status in the eyes of colleagues and of the public but too often it is a departure from what nurses at the seminar saw as the real role of the nurse. However if the nurse is not to do this work who is? Will another breed of paramedical emerge like the physician's assistant in the USA? Should there be an extension of the training of technicians to do specific tasks in the operating theatre or the ICU without any responsibility at all for nursing care? There are certainly some tasks which are important and specialized but which do not require the long and varied training to which the modern nurse is subject. How would nurses react to the introduction of such an individual into technical patient care? Some answers to these questions may lie in another Scottish Report *The Role and Function of the Registered Nurse* (15) that is perhaps too little known. In this document the function of the qualified nurse and midwife both in hospital and in the community was reviewed by the National Nursing and Midwifery Consultative Committee.

STRESS AND BURNOUT

The subject of stress not surprisingly featured chiefly in the discussion on the impact of the new technologies. It was interesting to be told, however, that the other area in which stress is prevalent is in the nursing of patients with senile dementia. The chairman of that session in his comment (p. 21) called for research to ascertain the extent of the burnout syndrome in the UK. It has certainly been recognized in the United States (16, 17) and has been defined as 'a debilitating psychological condition brought about by work-related frustrations that result in lowered productivity and morale' (18). One of the participants, Sister Prophit, in an interview by *The Scotsman* (19) on her appointment to the Chair of Nursing Studies in Edinburgh, said that this subject is one of her special research interests and indicated the high incidence of the syndrome amongst health professionals. Certainly if ICUs are the danger areas and if we follow trends in the USA there is cause for concern. It is reported (20) that there is a 4 per cent annual increase in ICU beds in the USA. In 1981, 4665 new ICU beds were introduced at a capital cost of $320m. It is interesting that in medicine it is psychiatrists and not specialists in intensive care who continue to have the right, because of the stresses of their speciality, to apply for early retirement on full pension.

EDUCATION

Although the subjects of medical and nursing education were not part of the formal programme for the seminar, education is so fundamental to practice that it is not surprising that it was raised on a number of occasions.

Learning together

The concept that if people are going to work together they should learn together is always attractive in theory but for doctors and nurses it was accepted as impracticable in the basic training except perhaps in the behavioural sciences (p. 71). Experiments in Norway and elsewhere have confirmed this but nursing and medical curricula at all levels need to include education in inter-professional as well as inter-disciplinary thinking and practice. We should also aim at greater nurse participation in multi-disciplinary bedside teaching. At a meeting of the Discussion Group, although not at the seminar, the possibility of a joint diploma between medicine and nursing was mentioned but not explored. It would seem that the most likely starting point would be at postgraduate level and open to graduates in nursing and graduates in medicine. If sufficient common ground were found in some special field to make such a diploma viable a great boost would be given to closer co-operation. Exploration of the possibility of such shared learning is already beginning in Departments of Community Medicine and particularly in the field of health education. Apart altogether from a joint diploma for graduates, shared education at post-registration level merits exploration and experiment.

Learning each other's disciplines

Even if it is not practicable for nursing and medical students to train together, it is important that they have proper insight into the real issues of each other's professions. This question was discussed (p. 79) but the subject would merit separate debate. As Professor Altschul points out (21) doctors do not know how to nurse and 'good relationships between doctors and nurses . . . can only develop when doctors are prepared to learn from nurses what it is they can do and accord them the same kind of respect which nurses have for doctors and for the work they can do'.

Doctors and nurses as teachers

The completely different approach of the two professions to the role of the teacher was commented upon (p. 76) but the matter was not taken up in discussion. Medical clinicians would be horrified if their teaching were not combined with practice whereas in nursing it is not possible to reach any senior position in a college of nursing and midwifery while still engaging in practical nursing. This also is a matter which demands further debate. The difference is historical in origin and there are faults in both systems. University teachers, not only in medicine but in general, have, unlike school teachers, little or no training in teaching methods and skills. University students, including medical students, have been critical of this fact and that their teachers are appointed more on the basis of their research achievements than on their interest or ability in teaching. Since the publication of the Hale Report (22) some greater emphasis is laid on what is called 'staff development' but there has been no radical change. The argument has run that a school teacher requires to be taught how to teach but when students come to University they have already been taught how to learn and their higher education should consist more of self-learning and being given the opportunity to acquire further knowledge and experience by guidance and by access to resources rather than by instruction. That is the theory but in practice much of medical education is didactic and too often presented by people who have not been taught even rudimentary teaching skills.

On the other hand, nurse education has followed more in line with the teaching profession and in discussion papers about courses for nurse tutors we read such phrases as 'The kind of preparation which would fit a nurse teacher to take her place beside other teachers would be along the following lines...' (23). That same discussion paper, reviewing the opinions of students in a nurse teachers' course, records the impression that 'to many of them teaching done by a ward sister in the course of her duties was not fundamentally the same process as teaching in the classroom'. But this was in the 1950s and brings us back to the fact that the differences are historical. The nurse tutor had to establish her status and in any case she would not have found a place in the ward alongside the old style ward-sister who either literally or at least metaphorically lived on the ward. One of the differences has been that, unlike the medical model, to become

a nurse tutor involves, after a prerequisite period of clinical practice, two academic years of study followed by examinations. The way student nurse training and education are organized contributes to the difficulties. Geared as it is to providing a steady input to manpower in the wards, intake of students occurs three or four times a year and the curriculum includes long periods of service. These arrangements make considerable administrative demands on tutors and are extravagant of teaching time; despite improving student/teacher ratios even the best staffed colleges have not reached the recommended establishment. It is to be hoped that links between colleges of nursing and midwifery and hospitals will become closer, as discussed in the next section. There is precedent in many walks of life and, for example, in specialties of medicine, for separate professional entities to be established in order to achieve status by recognition before returning to the parent organization for mutual help in keeping abreast of advancing knowledge and changing practice, and for closer co-operation in research.

Joint appointments

The principle of joint appointments between university and hospital has long been established in medicine and more recently has also applied to nursing in centres where academic units or departments of nursing have been established. Financial arrangements vary from the formal to the 'knock for knock' agreement but the important thing is that the benefits of the research and advance of knowledge from the one side and the practical experience from the other can be shared to mutual advantage. One problem of any wider scale development of this principle in nursing as opposed to medicine is that in nursing there is at best one university department of nursing in any one centre and very large numbers of nurses in hospitals, whereas in medicine there is a much lesser imbalance of numbers. In nursing, therefore, to facilitate the sharing of expertise and experience, joint appointments between college and hospital could be encouraged and the numerical disparity would be less. There is strong popular support in the nursing profession in Scotland for the idea of joint appointments but although experiments have been and continue to be made it is difficult to structure them so that they achieve their full potential. Some ward-sisters lecture episodically in colleges of nursing and midwifery while retaining full responsibility for a ward.

Some lecturers in the colleges are attached to specific clinical areas to which they make episodic visits without having responsibility for a particular group of patients but there are different patterns of responsibility and accountability. In Scotland attempts to bridge the gap between education and service are made by clinical teachers—registered nurses with at least two years clinical experience and who have qualified as clinical teachers after following a one year's course in a college of higher education.

The profession is trying to get to grips with the organizational difficulties. Development of special interests through research could benefit the clinical scene. Links with those caring for the chronic sick could be especially rewarding because it is possible to show that good nursing intervention does make a difference to patient outcome.

As we have seen, it was important as a stage of evolution for the colleges to separate themselves from the hospitals but has not the time come when gradually those who teach should also, as a matter of course, be practising? Some of the existing staff of colleges would welcome the opportunity of a period of leave from teaching in order to regain clinical skills. Some of the younger teachers who have had recent nursing experience and university or college of education experience, including development of special interests through research, could surely bring those interests and skills back to the clinical scene. The greater turnover of staff in a unit due to the shorter working week and other factors will make it easier now than in the past to bring in an additional number of staff at any given level. Of course, there would be administrative problems of time-tabling and of salary scales but these should be overcome if the mutual advantages of the system are recognized and if this principle, already accepted in a number of posts, were to be extended as being the norm. The possibility is being examined of promoting one qualification which will prepare teachers to work both in the clinical setting and in the classroom.

Although the matter was not raised at the seminar there is no doubt that these fundamental differences between medical and nursing education are a hindrance to interaction and further discussion is required.

Academic departments of nursing

Having included in this chapter the subject of formal education,

although it was not discussed in detail at the seminar, brief mention must be made of the development of nursing as a university subject. As already noted the status of a separate profession does not necessarily carry with it that of a separate academic discipline. As recently as in 1964 the Robbins Report (24), which has been hailed as a most important landmark of higher education in our time, stated in the very first chapter:

> We received evidence about training for nursing and some of the occupations associated with medicine. Since this does not form part of higher education as we have defined it we have not specifically considered this wide area of opportunity for girls. But we are aware that at certain points contacts with universities and colleges are now being established.

In fact the Nursing Studies Unit had been established in the University of Edinburgh in 1956 and had become a full university department in 1963. The original proposal (by Professor F. A. E. Crew) was that the unit be established within the Faculty of Medicine. In the event it was set up in the Faculty of Arts and, when in 1963 Social Science split from Arts, Nursing Studies went with Social Science. This is not the place to enter either into the history or the rights and wrongs of that decision. Briefly it can be said that not all of the medical professors were persuaded that nursing represented a sufficiently distinct body of academic knowledge to justify a separate entity but it was the nurses who favoured Arts, either because they sensed some antagonism in Medicine, or because in a Faculty other than Medicine they certainly did have a sufficiently distinct body of knowledge to justify recognition. In Medicine they might well have been smothered whereas in Arts and later Social Science, the Department has been able to develop not only its own research and teaching but important links with other departments. The Professor of Nursing Studies is, however, a full member of the Faculty of Medicine as well as of Social Science.

Sir Harold Himsworth used to say at the Medical Research Council that in the development of a new academic discipline there must first be research and then postgraduate teaching and only then, undergraduate teaching. There is no doubt that it is nursing research and postgraduate teaching which over the last two decades have brought to the profession the fresh look which has replaced the 'But we have always done it that way' attitude to which Mr Mackie refers

(p. 14). In contrast to the Robbins Report, the Briggs Report (25) only eight years later said 'There should be no more argument about whether such (i.e. university) courses qualify for awards than would be the case in relation to any other university course in any subject'.

Degree programmes of nurse education, validated by CNAA, are offered by various institutions of higher education as well as by universities.

Continuing education

In both the examples chosen for the seminar, new technologies and care of the elderly, the papers and discussion underlined the need for continuing education in both professions. Changing attitudes consequent upon demographic change and society's priorities are just as important reasons for continuing education as are the rapidly developing technologies in diagnosis and therapy. A doctor or nurse not working in acute medicine will within a couple of years be out of date as regards the technical innovations but in the same way, the remarkable advances in the care of the elderly and of the mentally handicapped are not seen by staff working elsewhere and the service as a whole will only benefit from changes in one part of it if there is an effective programme of continuing education.

The need for continuing education applies equally to medicine and nursing. In nursing, ways of meeting the need possibly linked with eligibility to practise (as it is for midwives), are being explored by the new statutory bodies which in July 1983 took over the work of nine professional and training bodies—the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the four National Boards. A Report *Continuing Education for the Nursing Profession in Scotland* has been produced by a working group chaired by the Chief Nursing Officer of the Scottish Home and Health Department. It proposes a framework of continuing education and professional development and the principles outlined have been accepted by the National Board for Nursing, Midwifery and Health Visiting for Scotland.

RECORDS

There seems to be little doubt that patients' records will be computerized to a greater or lesser extent. It is therefore timely that thought be given as to whether it is in the interest of the patient that the nursing record be combined with the medical record or kept separate. The circulated papers seemed to favour separate records but the matter did not come up in discussion. Dr Masson (p. 7) is emphatic on the grounds of separate legal responsibility. Miss Clark (pp. 43–4) does not specifically indicate a separate record but in describing the systematic approach to nursing she speaks of 'describing in detail the plan which should meet the need and achieve the goal'. Certainly separate history taking is part of the nursing process as described in *Towards Standards* (5). If we accept that there may be nursing objectives which may be separate from, although not in long-term conflict with, medical objectives, then it is reasonable that these should be set out but should not the history be complementary and part of the same documentation, whether manual or computerized? There is no reason why they should not be in a different colour or typeface for ready reference but it is difficult to believe either that it would be in the patients' interests that two separate histories be kept or that the nursing notes would not be of interest and importance to the doctor and vice-versa in that each is based on information obtained in response to quite different questions. Just as the medical history and record of prescription should be available to the nursing staff, so the nursing care plan could with benefit be made more readily available to the medical staff. In the discussion in session 3 (p. 61) it was stated that nurses still practise individualized care as in the past but now in addition they try to record what they do. Good, but need it be in a separate record? The idea of Problem Orientated Medical Records (Weed, 26) has not spread in the UK as much as it might have done but it supplies a good prototype of a combined record.

TEAMWORK AND LEADERSHIP

As would be expected, the chief discussion of this subject came in the session on the care of the elderly but there were references also in the other sessions. Participants were familiar with the recent literature

on the subject and in particular with the King's Fund paper for the Royal Commission on the NHS by Batchelor and McFarlane (27). The spirit of the discussion reflected the sentences in Jean McFarlane's summary of her section of that paper:

> Health problems are not just medical problems. Each member of the team is responsible for his own actions and 'leadership' does not confer the right to direct other members of the team. The style of leadership required is that demanded by the co-ordination of the work of colleagues. It is not the leadership of the coachman with a team of horses and a whip but rather that of the team game, where whoever has the ball leads the action.

There are many matters still to be resolved in multi-disciplinary work. It was observed that it seems to be more successful in long-term than in acute care. Is the difference in the type of care or is it that there is no conflict because doctors don't feel threatened and nurses feel more confident? It is certainly worthwhile to bring the fruits of lessons learnt in the care of the elderly to the scene of the acute ward. There is no doubt also that the size and mix of units affects the chances of effective teamwork. Let it be recognized that there are separate and parallel but discrete roles for doctor and nurse. In looking at Dr Williams' diagram (p. 29) all were agreed at least on the central position of the patient.

WHAT IS BEST FOR THE PATIENT?

This section follows naturally on the last. Repeatedly during discussion, emphasis was laid on the best interests of the patient. It is easy, however, to pay lip-service to the objective and not to give it full attention when staffing structure, specialization, teamwork, etc. are being re-examined. The great majority of complaints to the Health Service Commissioner relate to failure of communication rather than failure of care and there is no doubt that the complexities of teamwork and specialization leave loopholes for communication faults. Inadequate staffing is also a problem and as Dr Masson indicates (pp. 4–5) there is no point in providing more modern machines unless there is staff to run them efficiently. Even well-meaning attempts by the public or by charities to raise money to provide some new and fashionable technological innovation are

misplaced unless there is prior consultation with the health authority to ensure that there will be staff and money to use the equipment when it is purchased.

If older patients are asked about the health service their chief complaint is that they miss the old one-to-one relationship with a particular doctor (whether in hospital or outside it) and that they never know which nurse is going to be giving them care. Much of this deprivation stems from changes within society, with the shorter working week, the demand for leisure time and other factors which have led to radical changes in our way of life. The clock cannot be put back but in health care of all things a real effort must be made to provide as much continuity of care as possible. There may be a distinction between what the patient would like and what is best for his health care. Patient satisfaction may be a very different matter from quality of care. Historically the patient looks upon the doctor as the leader of the team and most of us like to know who has overall responsibility. There is, therefore, a natural tendency among doctors to query the motivation of the nursing profession in its pursuit of professional status distinct from medicine. It is up to nurses to demonstrate to the public, as well as to doctors, that they have an independent although complementary contribution to make in the care of the patient and to accept that professional developments in nursing do not of themselves compensate for diminished continuity. It is up to doctors to support their nursing colleagues in the presentation of their case and in the achievement of their professional aims.

Not only should we be saying 'what is best for the patient?' but 'how can practice be improved for the benefit of the patient?' and 'in what way will any planned professional interaction improve patient care?'.

FIELDS FOR CLOSER CO-OPERATION

It is easy to speak in the abstract about greater interaction between the professions but during the seminar several specific areas of activity were mentioned which would not only be productive but would be non-controversial and therefore good starting points towards a new attitude of co-operation.

Clinical research

Dr Shaw (p. 57) stresses the point that where nurses are fully involved with doctors in clinical research there is generated 'a useful and productive dialogue towards understanding and improving the team approach to the better care of our patients'. Sir Ivor Batchelor (p. 75) is critical of the way doctors have used nurses in clinical research as observers and technicians. He emphasizes the mutual benefit of a different and more fully collaborative approach.

Quality assurance

Both in a general way and also in more specific projects to assess quality of care, the full participation of nurses in the planning and in the execution of the study adds an important dimension. It is good to note that a number of publications in this field have included nurses amongst the authors but too many studies are still mounted without nurses being involved in the all-important planning stages.

Joint evaluation

Rather on the same lines, full advantage is not always taken of the different viewpoint of the nursing profession in the evaluation either of a patient's progess or of a new procedure. The elements of nursing which make it a profession distinct from medicine have already been emphasized and as a result of training and attitudes it is only natural and proper that the nurse will look at problems in her own way with the nursing objectives in mind. Both professions should take advantage of the different outlook in their joint efforts for the agreed ultimate goal.

Health education

There were several mentions of health education although the subject is perhaps more readily related to the community than the hospital service. Whatever the context, it is agreed that health education as part of general medical or nursing care is just as important and sometimes more effective than when undertaken as a separate exercise. Conflicting education is bad and hence discussion and agreement between the two professions on health education matters is important and a useful field for co-operative effort. Much

health education is haphazard and prior agreement on policy is important. A large part of health care is given in the hospital setting, much of it by nurses. Because patients are receptive to their advice it is widely accepted in Scotland that hospital nurses have an active part to play in health education and this topic is now an identified part of their curriculum.

Ethics

Medicine and nursing each have their own code of ethics although the codes coincide in most areas. Allowing always for differing stances of individuals there is renewed recognition that the ethical aspects of patient care are important in investigation, in treatment, and in research. They should be discussed openly and recognized as being an integral part of medicine and nursing rather than something separate to be considered only under certain circumstances. If such discussions worked more effectively the need for pressure groups from outside might be less apparent. Nursing should be represented on research ethical committees and in the teaching of medical ethics to medical as well as nursing students. Here again the slightly different slant given to a problem by a nurse adds a new dimension to the discussion. Dr Masson (p. 6) in describing care in the ICU emphasizes the importance of prior agreement and knowledge by all concerned of decisions in respect of artificial ventilation and other support systems in severely brain-damaged patients.

Other fields of co-operation

A start has been made, notably by the Royal College of Physicians of Edinburgh (28) in ensuring that nursing and other professions are properly represented at medical meetings at national level on clinical and professional subjects. It is increasingly commonplace for nurses not only to be present but to participate fully at unit or hospital meetings but too often at national level discussion has been the poorer for lack of nursing input. Reciprocally, the Scottish Board of the Rcn has recently invited medical participation, not simply as guest lecturers but as full members of discussion groups. This trend is to be encouraged and it is the intention of the Scottish Joint Discussion Group to foster such participation.

Taking this a bit further it would be appropriate if the Rcn were represented on the General Medical Council—admittedly in recent years a nurse has been a nominated member but when 33 members are appointed by Universities, Royal Colleges, and Faculties, it would be a very proper step to include the Royal College of Nursing as an appointing body. Similarly if the College were purely concerned with professional matters, it might open the way for representatives of the College to sit as observers on the Councils of the medical Royal Colleges and their Faculties. Inter-collegiate links of this type exist now between some of the Royal Colleges and an extension to nursing would not only recognize the contribution of nursing to medicine but would lead to useful and constructive input to the deliberations of those bodies.

RETROSPECT AND PROSPECT

It would ordinarily have been interesting to compare the objectives with the achievements of the seminar. But the seminar was exploratory and so had no very clearly defined objectives other than to further the aims of the Scottish Joint Discussion Group in the field of co-operation and interaction between medicine and nursing. In the same way the achievements will not be measurable until some time has elapsed, until the discussions have been more widely publicized and until it becomes clear whether this initiative is followed up and whether it does indeed lead to improved relationships. Better understanding is only a first step but it is an essential prerequisite to better interaction. As has been noted, both the circulated papers and the discussion tended to concentrate on the subject matter of each session rather than on the way in which professional interaction takes place or should take place within that area of activity. Both doctors and nurses regrettably often appeared to be talking, perhaps as a result of preconceptions, along parallel rather than converging lines. This point is made in the report of discussion (p. 60). Later in the same discussion there was some plain speaking: a senior nurse wondered if doctors had 'a cultural inability to understand the social and demographic reasons for the changes in availability of nursing staff'. Perhaps the programme was cast as if nursing had all the problems and was looking to doctors for solutions. At some future meeting it might be salutory to include

some items which relate to doctors' problems (p. 92) which may be amenable to nurses' solutions.

It could be rewarding too to air some of the problems for nurses arising from practices determined by doctors alone: for example, admission policies, scheduling routine use of operating theatres, investigation and treatment of in-patients in out-patient beds, and the allocation of beds that can give rise to uneven nursing workload and demands on nursing time. It might be thought that these uneven pressures on nursing staff are amenable to local discussion but the frustration frequently expressed by nursing staff about lack of joint review suggests that doctors in general are unaware that their unilateral decisions have implications for the nurses' volume of work and the nursing care they give.

On the other hand, a professor suggested in discussion (p. 61) that problems are created for doctors by the expectation that ward-sisters should conform to clinical shift rotas. This prevents their always being on hand when doctors need them, fixed medical scheduling necessitating ward-rounds being made on weekday mornings. Nurses have commonly taken the view that as *providers* of clinical care, ward-sisters need to be on duty at different times of the day. But perhaps their clinical management function has been insufficiently recognized. If they are seen to be 'key' *managers* of clinical care, then sisters need to work 'managerial' rather than 'clinical' hours, that is, they must be on duty in the mornings, when the information flow is greatest, to plan, delegate, and make an input into medical decision-making. Nurses must solve this dichotomy realistically, preferably in joint discussion with medical colleagues.

Professor Girdwood (p. 64) reminds us that medical progress has been so rapid in the last fifty years that the medical and nursing professions have not been able to come to grips with the resulting challenges. Perhaps also the choice of hospital medicine was from some points of view not the best. One of the aims of the exploratory seminar, with its limitation of numbers, was to be sure that some of the most influential members of the professions were included. This was probably the correct place to start. The President of the Glasgow College (p. 21) suggests in the session on the effects of the new technologies that some of us were trying to assess the atmosphere of an ICU from a personal experience of more conventional diagnostic and therapeutic methods. In the same way, it may be that some of us were thinking too much of the old traditional relationship of

medicine and nursing and not enough about the new professional achievements and aspirations of the nurse or the new problems of medicine.

Be that as it may, a start had to be made somewhere and as has been emphasized all through from Professor Strong's Preface onwards the hope and intent are that the dialogue will be continued and will be extended to other specialities, to other health professionals, and to other age groups. The intention is that such further discussion should be stimulated by the publication of these proceedings and that it should take place at local, regional, and national levels in Scotland. The other Royal Colleges and the various UK bodies in medicine and nursing have executive committees or other formal representatives in Scotland and we would hope that they would add their weight to this inter-Collegiate initiative.

It is worthwhile looking again at the conclusion (p. 51) of Miss Clark's paper and at what Sir Ivor Batchelor says (p. 77) about what the professions of medicine and nursing could teach each other.

The Joint Discussion Group in Scotland will continue to meet and will encourage and promote the various types of activity which have been mentioned in this chapter. Above all, it will seek to avoid the very real danger of medicine and nursing drifting further apart and going their separate ways, and will endeavour to ensure proper understanding and interaction between the professions in the best interest of patient care.

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