Pacific Doctors and Nurses: Union or Divorce Towards the Year 2000?

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Introduction

Doctors are taught to talk just like parents where "negligence becomes random human error, callousness becomes scientific detachment, incompetence becomes a lack of specialized equipment - and malpractice a technical problem."[1] This completes the institutionalization of the home (hospital) with the father (doctor), mother (nurse), and children (prodigies).

The Socialization Process

From the beginning educational requirements have been used to provide an identity. Florence Nightingale established the reigning educational requirements for nurses.[2] She provided the conceptual framework that allocated nurses to the servant role. On the other hand, the doctors have used the same educational model to maintain the station of master. Inherent in these educational requirements were exclusiveness, upward mobility to a new social status, segmentation for easy control, specialization to prevent evaluation of total services, and adjustable entry requirements with no job differentiation.

The educational models were formalized, and it formed the basis of legitimizing the professions. The social atmosphere was suitable for a takeover of the responsibility for health, because the new economic order preoccupied all. There was a vacuum in the new urban society for a health caretaker. The barber- surgeons took the initiative then recruited their nurse maid to assist. They learned through trial and error to identify the knowledge to be controlled and used for socializing their offsprings. The control of this knowledge became the basis of professional power.[3]

The Socialized Products

After passing through such educational systems, doctors and nurses were socialized to an exclusive profession - the medical profession. However, the system failed to delineate roles and functions. Thus overlap, duplication, competition, and subsequently internal conflict started to raise questions about the marital bliss. It was now obvious that the honeymoon was coming to an end. However, the nurses were still relegated to being doctors' handmaidens because professional sexism remained a social norm; nurses had a lower educational entry point to the socialization process; and, subsequently, lower remuneration for their efforts.

When conflict was brewing, the doctors quickly recruited the top nurse and called her matron. She was given honorary doctor status and shared their tea. She exerted the doctors' authority in the name of the nursing profession. She enforced the uniform and the headwear, presumably to keep the bacteria away. She ensured that nurses were to speak when spoken to, and when wishing to address more senior nurses, they were required to stand three feet away with their hands behind their back.[2] In the meantime, doctors refused to wear uniform and wear white coats to keep the bacteria away. But being in control, the coat became a status symbol rather than a militaristic uniform - like those of the nurses.

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The Coming of Age of the Partnership

The advent of unisex and feminism demanded a sharing of the knowledge with each other. Knowledge of medicine is no longer the prerogative of the few. In addition, consumerism demanded that users of service must also have this exclusive knowledge. This is expressed through concepts such as patient education, patient rights and self-care. The need for recognition of the individual necessitated the formation of a new plane in the doctors and nurses relationship. The current rethinking and revision of the meaning and purpose of health, disease, and health services have also led to a reexamination of the doctors and nurses partnership.[4] This averts a legal separation and establishes a need for reaching a new equilibrium in the tasks performed.

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At this stage, it is time for the partnership to be equalized, the overlap and duplication to be remedied through a clear definition of role, with doctors and nurses practicing their trades in horizontal and complementary spheres rather than through the vertical autocratic model. To achieve this, the doctors and nurses must define clearly their objectives and strategies with proper participation of the consumers of their services.

In practice the doctors still hold political control of the health industry. The nurses on the other hand have used the new freedom of knowledge to understudy doctors with the hope of outstudying them: a bid for high specialization and ultimate takeover of the relationship. The subsequent competition has left consumers unattended, to an extent that alternative medicine and new cadres of medical workers have entered the arena. The health consumers are no longer accepting of a service reflecting the power struggle. Therefore, doctors and nurses have begun to lose credibility. For the sake of their own livelihood, if not for the consumers' sake, doctors and nurses must therefore quickly reexamine and reconcile their differences. This can only be done through demystifying their body of knowledge and activities, thus resurrecting wholistic humaneness into the science and art of health care.

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The Pacific Way of the Partnership

The state of doctors, nurses, and their hospitals in the Pacific is now characterised by: male-female role differentiation, the doctor-nurse partnership being perceived as a caring duo, an increasingly sophisticated and knowledgeable public, an expansion and diffusion of information, and rapidly changing social attitudes and aspirations. Firstly, the doctors and nurses must accept these social norms. Secondly, they must accept that the central goals of health care involve the slowing of the aging process, prevention and early treatment of disease, and elimination of pain. Only then can they start sensible dialogue for the development of a relevant and appropriate educational system for the region. From a resource allocation viewpoint, the doctors and nurses must achieve these goals with a balance between the amount of care and the most economically efficient way to deliver the caring. After all, society has many other uses for its limited resources, and perhaps more important ones, than health services.

For the doctors and nurses of the South Pacific to reach a common understanding, a certain amount of 'marital' give and take must be exercised. Firstly, both must become health professionals with an autonomous organization to cater to joint needs rather than being doctors and nurses with divergent interests. Secondly, the health service and health care have enough scope for the doctor to be master of one area and the nurse the master of another. This will come about if they recognize that health and health service is highly political, not just technical and professional. Both must take separate portions of the health service while leaving the door open for rounds of exchange and free flow of expertise. This will allow for an overview to prevent fragmentation, and the opportunity to keep the marital quilt warm.

The complicating factor entering at this stage is technology. The doctors and nurses must make a conscious decision about their involvement, relating this to a clear, humane and consumer-oriented objective. The choice may then be to forfeit technology and concentrate on what originally gave the professions distinction - people. This means a new highly specialized and almost robotic technocrat must be developed under the tutelage of the doctors and nurses. This will free both doctors and nurses to continue to function as generalists with primary health and basic medical care skills.

Such an arrangement means that the nurse be provided with skills previously confined to doctors—that of diagnosis, therapy, and of course the proverbial stethoscope. This type of self sufficient, clinical decision making nurse, trained to be independent of doctors has been called a nurse practitioner. This arena of care will provide an unlimited sphere of activity unperturbed by doctors and open for full vertical mobility. Therefore the job can become an independent expression of the nurses' capacity, not just an adjunct to the doctor's hospital service. Both doctors and nurses must train and become efficient managers if health service is to remain their domain. Their coming together then becomes a matter of mutual agreement, not that of a servant responding to the call of a master.

Conclusion

Doctors and nurses must reach an agreement on the basis of mutual respect, not as master and servant, in order to have a happy union. For such a union, they must cope with the diversity of health and its determinants. Only then can they genuinely talk about a consumer- oriented service, that is a service designed and delivered according to the people's needs. Compassion and skill must be the hallmark of the strengthened and equal partnership, only then can we talk of a health caring service. If I may be allowed the presumptuous privilege, I suggest that a model of independent sharing and improved management must be the guideline for developing educational objectives to achieve a socially acceptable and professionally compatible union towards the year 2000.

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