Reframing professional boundaries in healthcare

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Introduction

Thesociologyofnursingcontinues to be dominated by its focus on the subordination of nursing in relation to the medical hierarchy. This is despite significant interventions through the professionalization of the nursing field and the expansion of their roles. In addition, other occupational groups employed in healthcare have also seen a shift in their roles as healthcare professionals. To assess the extent of medicines continued dominance we must first look at defining a profession and changes to nurse training with assistance from Eliot Friedson’s work (1970, 1986). This essay also makes reference to Svensson’s (1996) analysis of the negotiated order between nurses and doctors with relation to other social theorists such as Porter (1991) and Hughes (1980). Changes in gender status will also be assessed and finally conclusions will be drawn on whether or not medicine continues to dominate or whether there has been a levelling of the medical hierarchy.

We should consider the bureaucratic nature of a hospitalenvironment; this, according to Weber (1914) means that there must be an organisational hierarchy. Within a hospital, for example, this will be split into professional groups, between professional groups, between primary and acute care and between different medical specialities. Specialist expertise must be employed and there are an abundance of specialist workers within a hospital, both medical and technical. Impersonal rules are used and discipline enforced to maintain social order within the organisation. Salaries are often paid to their workers instead of wages, and there are definitecareerladders within the hospital. The bureaucratic nature of

hospitals limits freedom, autonomy and initiative (Turner & Stanley, 1995) due to the fact that those in managerial positions create policy and those in medical positions follow it.

Looking at Friedson's (1970) work we can distinguish key characteristics that produce a profession. Firstly there must be a body of specialised knowledge and this must be produced and assessed by those who are members of that profession. Secondly, there must be a monopoly maintained through the registering of all members, the restriction of employment to those only on that register, and competence assessments made only by those in the same field. The Formation of the Royal College of Nursing in 1916 led to a state registration in 1918. There must be autonomy in decision making and reviews of professional changes as well as a code of ethics to dictate the ideology of service to be carried out by members. There is an associated social status concerning professions and there is a definite " hierarchical divide between the knowledge-authorities in the professions and a deferential citizenry". The nursing profession has witnessed a change in the way that they become trained, now having to obtain a degree or a diploma that is recognised by the Nursing and Midwifery Council to be registered with the profession. This was through the ' Professionalisation project' which introduced training taken out of the working environment (Project, 2000) with a degree structure and status. There were distinctions made between basic care and clinical care and a development of a specific knowledge base. Specialist clinical roles were also introduced, and through furthereducationnurses can become a nurse practitioner or a prescribing

nurse. This has led to the nursing profession being recognised more adequately on the medical hierarchy.

The medical professions are definitely hierarchal in nature with surgeons and specialist doctors at the primary position. The “ Dominance of doctors was supported at various levels: over the content of their own work (characterised as autonomy), over the work of otherhealthcare occupations (authority) and as institutionalised experts in all matters relating to health in the wider society (sovereignty)” (Willis, 2006: 42). Their training is longer and significantly more taxing then that of lay therapists and occupational workers, meaning that they receive higher salaries and acquire status for their chosen professions. Nurses are seen further down the organizational hierarchy, however the professionalisation of the nursing occupation has meant that there has been a leveling of the chain of command. Now there is a ladder within the nursing profession, from nursing specialists, to staff nurses and then unqualified nursing support in the form of healthcare assistants and auxillary nurses. The Wanless review carried out by The Royal College of Nursing (2005), showed plans that the nursing practitioners could take over around 20% of the work currently completed by physicians. The leveling of the medical hierarchy is only going to continue with this and the introduction of the European Working Directive which will “ inevitably result in a handing over of responsibilities to nurses, as doctors are unlikely to be available all of the time” (Fagin & Garelick, 2004: 278).

Nursing roles have changed considerably over the past. Looking atdoctor-nurse interaction, specifically Porters (1991) study into the doctor nurse

relationship, we note that “ nurses reported feeling less subservient to doctors and experienced much greater participation in informal decision making”. The theory of a negotiated order between doctors and nurses was largely developed through symbolic interactionism to understand social order within organisations. “ Key changes in the health care context have created ‘ negotiation space’ for nurses, leading to the evolution of new working relationships with doctors” (Allen, 1997: 1). The negotiated order between doctors and nurses leads us to better understand the changing hierarchal laws within the medical and nursing professions. Svensson’s (1996) study of medical and surgical wards is the most “ appropriate theoretical framework for understanding patterns of doctor-nurse interaction” (Allen, 1997: 1) and proved that through continuous negotiation between doctors and nurses a social negotiated order has been produced. According to Strauss, social order is “ something at which members of any society, any organization, must work”. By way of explanation, negotiated order symbolises the progression of change, along with the relative nature of order and the persistent change of society. “ While there was a theoretical ideal of the independent nurse, and of nursing as a separate field of knowledge, during the early Nightingale era its connection with medicine in reality was qualified by the nurses’ subordination to the medical profession” (Svensson, 1993: 382). However, the hierarchal role of the nurse seems to have altered, “ the field of negotiation has widened; rules and norms that once were scarcely negotiable are now possible and legitimate to modify” (Svensson, 1996: 381). This is impart due to the social nature of their roles, they are in close contact with patients and therefore “ powerfully placed to

contribute to patient management given the centrality of ‘ the social’ to holistic” (Allen, 1997: 501). The nurse’s roles have been shaped through this leading to them coming to conclusions on medical diagnosis of patients and appropriately negotiating with the doctor. Nurses have a very significant role “ in certain respects as regards not only defining the rules for interaction on the ward, but also defining the patients’ medical status” (Svensson, 1996: 381). This can lead to us makings some positive determinations about the leveling of the medical hierarchy due to the increase role of nurses in the diagnosis of patients.

In relation to junior doctors, doctor-nurse interaction is again of a different nature. The nurses role had extended to guiding junior doctors in diagnosis. Hughes noted that nurses “ often prepare necessary equipment even before doctor has directed what treatment should be given” (Hughes, 1988: 11). This makes sure that thediagnosticdecision is not taken from the doctor but instead gives the less experienced a “ general indication of particular diagnosis” (Hughes, 1988: 11). Showing again a leveling of the medical hierarchy. Casualty nurses also have increased involvement in decision making when it comes to the diagnosis of a patient and relevant treatment. The fast pace, heavy work demands and urgency of potential treatment have all lead to a definite “ qualitative shift in nurse-medical staff relationships” (Hughes, 1988: 16). Nevertheless skills are not lost by the doctors and they still have overallresponsibilityfor the patient’s diagnosis and treatment, and so medical dominance is, at the same time, retained.

The changes togender equalitywithin the workplace have affected the medical hierarchy and expanded nurse's roles. Attitude surveys have shown that the public identifies ' alertness to the needs of others' (Oakley, 1984) as a characteristic of a good woman and a good nurse. Caring for people are seen as a women's job and caring is " portrayed as intuitive, instinctive and as something you're born with by virtue of your gender" (Smith, 1992: 2). The doctor-nurse relationship is " deep rooted in societies status differentiation, women's position in society and the biomedical orientation of care" (Digeall & McIntosh, 1978) and the " notion of a collegial, mutual relationship between medicine and nursing is a comparatively new one' (Dingwall and McIntosh 1978). The number of female medical staff has risen by 69% since 1998. The number of male medical staff increased by 31% over the same period. The improvement of women's social status within the workplace may have contributed to a leveling of the medical hierarchy.

Conclusion

Through the expansion of nursing roles and the increased interaction between nurses and doctors there has been a levelling of the medical hierarchy. Now, there are specialist roles for nurses to release some pressure from the doctors, but also given qualified nurses more responsibility towards patients medical care and diagnosis. There has not been transference of overall skills, and the status associated with being a doctor or a surgeon certainly still outweighs that of a nursing professional. Medicines dominance can still be seen, as those at the primary spot on the hierarchal chain are biomedically trained, however the expansion of nursing and occupational

roles certainly signals an overall shift in responsibilities and power. Nursing still relies predominantly on medical knowledge, however the professionalisation of the field was a further step for the recognition that nursing staff deserve.