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Nurses and doctors ... and patients

A Forum discussion group hosted by Dr Eilif Liiisberg was formed from a few of the participants at a WHO nursing conference in Geneva. Subjects discussed were the status of nursing and changing attitudes to patients.

Dr Liiisberg—Before we start talking about international nursing and the nursing profession, maybe each one of you could say in just a few words what the current situation is like in your country regarding nursing. How is nursing considered as a profession? What are the problems the profession is facing? How do you relate to primary health care? How is it in Bahrain, Dr Al-Gasseer?

Dr Al-Gasseer—The major challenge facing us is Bahrainization. Only 27% of nurses are Bahraini. The majority are from India, Sri Lanka, and the Philippines. However, there have been certain achievements throughout the years, and just recently the nursing and midwifery regulations became law. We now have more control over recruitment to the profession. We have been able to achieve these things because of the strong joint commitment between the education and health services in Bahrain. We have only one nursing institution on the island, but it has organized meetings to study the demands and needs both of the nursing staff and of the community. I believe that that is the main reason for our achievements; we have managed to get the support of the government for nursing because of the increased awareness of the part nurses can play in reaching Health for All.

Dr Liiisberg—When I was in the Middle East 25 years ago working in refugee camps,
nursing was not considered a very attractive profession. Has that changed in the last quarter of a century?

*Dr Al-Gasseer*—Yes. The nursing situation has been progressing slowly but surely. In the 1970s only a few people were taking up nursing. I was one of seven graduates in my year. This year we were oversubscribed. We had over 350 applicants for 130 places.

*Dr Liisberg*—So the nursing profession is now considered something for people to go into, and there is a future in it?

*Dr Al-Gasseer*—Yes, and there is a career educational ladder, which is a big achievement. That means the nurses can look forward to eventual promotion, especially the Bahrainis. They may start as practical nurses, followed by a degree; then they can go on to post-basics, or midwifery, or community health, or psychiatry, and they can go for a B.Sc. degree, and so on.

*Dr Liisberg*—Thank you. Dr Sorvetula, what is the situation in Finland? There, I imagine, nurses are in a very strong position. In the Scandinavian country I know best, nursing is a strong profession.

*Dr Sorvetula*—I am happy that you have got that impression, and I hope it is true. But, if not have the status of a profession in my country. That is one side of the picture. On the other side is the fact that we have a body of very well-educated nurses, strongly committed to serving the people. But we don’t have—and it’s a sad truth—any official or public support, so the future of nursing in my country is entirely in the hands of these committed nurses. I am afraid we simply can’t use the word “profession”. If we succeed, if we do what nursing is supposed to do in society, we shall get recognition, and we should like such recognition from the people, not from physicians and not from health officials.

*Dr Liisberg*—Would you say that maybe nurses suffer from the legacy of Florence Nightingale? Is that part of the problem? It seemed to be taken for granted many years ago that nurses had that sort of vocational orientation and that doing nursing was a reward in itself.

*Dr Sorvetula*—Yes, partly. We certainly can’t avoid the fact that Florence Nightingale has had an impact on Finnish nursing. But you were referring to Scandinavia, and we have to bear in mind that there are differences between these northern countries. We can’t put them into one group on an issue like this. So there is that element to consider. But when you say “vocational orientation” do you mean that that is not acceptable?

*Dr Liisberg*—I think it’s wonderful and acceptable. But there is sometimes a feeling that nursing associations and nurses as a group are very interested in developing as a profession and may be less interested in nursing. I am trying to egg you on, of course, but you do sometimes get the impression that the important thing is getting into university, getting degrees, and so on, and that nursing is being left to the aide nurses and the family, or to the woman who washes the floor. These are the things

If we are talking about the status of nursing as a profession, my answer is that nursing does not have the status of a profession in my country.
you hear—that the real nursing is being done by others, while the nurses are administering it all, that’s what I was trying to say. Perhaps we could come back to it a little later. For the moment let us move on to another part of the world. How is it in Japan, Dr Minami?

*Dr Minami*—Well, in my country there has been a rapid increase in the number of elderly people, and we are in the process of trying to find a different strategy for providing health care. At the same time we have a severe shortage of nurses, so we cannot really meet the needs of the population. To add to the problem, there has been a very large growth in the economy and a tremendous improvement in the quality of life of the people, so that the demand for caring is really increasing. The net result is that the country as a whole is facing a different strategy for health care and welfare, and altogether it is a very interesting period in terms of nursing development, because society is very keen on nursing. We have started a special day called “Nursing Day” which is on 12 May, Florence Nightingale’s birthday. All in all, it is a very critical period, and our nurses are working hard. Nurses are very devoted to their profession and the care of patients, but we have not yet come up with the new strategies that are necessary to meet these needs. But we can do it. In the meantime, we have had to face the challenge of a competing profession, which has also been making a bid to meet the needs of society.

*Dr Lüsberg*—A competing profession?

*Dr Minami*—Yes. The social welfare system has developed a new occupation called the care worker. And what the care workers do is to work either at a nursing home for the elderly or in the homes of the elderly, taking care of basic things such as dressing and eating and so on—these kinds of things.

Nurses do the same, of course, but our numbers are much smaller, so we employ the helpers in this field. And since the number of care workers has increased tremendously, they want to have a special licence for their profession. Naturally, we have to try to coordinate with them. Nurses, of course, have the advantage of knowing more about health problems, and will no doubt retain their professional status, but it is critical for them to communicate with the care workers and try to work together and develop a new system.

*Dr Lüsberg*—Now let’s turn to Africa. Dr Kupe, what is the situation in Botswana?

*Dr Kupe*—I am glad you said Botswana and not Africa. I couldn’t possibly speak for the continent—it is too large. As you are very well aware, Botswana is a very young country. We became independent in September 1969 and up to that point there were really no organized health services, so we had to start from scratch. I returned home from Canada at about that time, and there were only about 200 very poorly trained nurses in the whole country. The problems were enormous, all of them related to either poverty or ignorance, so we tried to develop a type of health care system that would concentrate on the prevention of diseases and the promotion of health. Primary health care had yet to be born, but
in 1972 our government published a policy paper on what was effectively primary health care.

Dr Liisberg—So you did primary health care before the term was invented.

Dr Kupe—Yes. We just decided we were not going to build huge hospitals. We would develop clinics, health centres, and what we called health posts, the aim being to ensure that everyone had access to some health care services. But we had one advantage—our small numbers. We are a huge country with a very small population. At that time there were only about 666,000 people. In fact we only recently reached a million, marking this with a big celebration. But because of the poor development in the country, education was at a very low level, and we needed schools before we could produce nurses. Education was the priority. The Ministry of Health was training all the health workers, and the most effective health workers who could be produced quickly were nurses. So we focused on that, and as I was the first chief nurse I was determined not to start nursing education on the wrong foot. We negotiated with WHO and got money and help from DANIDA to put up our first school for nurses. That was called the National Health Institute. It was primarily for nurses but later other health workers were admitted, though not doctors. At that time it was the only multidisciplinary health workers’ institution in the country. The school was opened in 1970, and in 1978 we had our first class admitted to the university, to a three-year programme for post-basic nurses. I was very pleased with the progress made. I have now left the ministry as chief nurse to become Head of the Department of Nursing Education at the university. Everybody thought I had taken a job of lower status, but I told them: “My focus is not status but service to the nursing profession. If I can achieve that I will be very happy”.

Dr Liisberg—So we come back to Dr Sorvetutta’s point, which is that I may have used the wrong word when I said “profession”. We always talk about the medical profession, and I have often heard people talk of the nursing profession in the same way. But Dr Sorvetutta says that nurses are not a profession in her country but doctors are. What is the difference, and why is it important?

Dr Kupe—Can I comment on that? I don’t think that any of us here dispute the fact that we are a profession, but there is no doubt that a lot of people merely pay lip-service to that notion. When I took up nursing I was told it was a profession. I trained in a hospital. But it was the type of profession in which you were told from the very beginning—it is a profession, it is a vocation, it is a calling, and you are not supposed to complain about salary. You are not supposed to complain about overwork. You just do or die, ask very few questions. Serve the doctor. The doctors say that nursing is a profession but in reality when it comes to the working situation you are just a glorified handmaid to the doctor.

Dr Al-Gasseer—I think maybe this is one of the challenges we are trying to face. Maybe also we are seeking recognition. If we call ourselves professionals then we are comparing ourselves with other professionals such as engineers, doctors, and pharmacists. I believe indeed that we are a profession, because we have certain characteristics that are lacking in other categories of health personnel such as technicians. One characteristic is the body of knowledge that we possess and which we are trying to develop further. Another is our research orientation. And then there is our autonomy. Mind you, that might be a big question, depending whose side you are on. The physicians claim they are professionals because they can make decisions and nurses
can't. Nurses have to be the followers of the decision-makers. I do not myself believe that we are followers of the decision-makers. I think our practice is dependent and interdependent and independent. There are overlaps, but there are many situations in which a nurse makes a lot of decisions for the health of the people in the community, especially if they are working among the people. Even in the hospital a nurse is there for eight hours a day observing a patient, deciding what that patient needs, and recognizing the changes that are happening.

Dr Minami—I think there is also the readiness of society to recognize the profession. When society sees one group of people doing a special job that other people cannot do, society tends to speak of that job as a profession. Physicians and technicians have special knowledge and techniques which, in general, people do not have. It was once thought that nursing was not really something of high knowledge, that it was women's work, and that anybody could do it. But now if people look at nursing care they realize they cannot do it and that it is only people with special skills and training who can perform this kind of work. So they are starting to see it as a profession. Another thing we have to consider is the recognition of science as having very high prestige, while anything related to human life has been thought of as an everyday-life kind of thing and not scientific. However, our view of science has also been changing. Family matters and the study of daily habits have come to be considered as science too, and nursing is seen as a part of this science. So I think it is a very good time for nursing to be considered as a profession. We have always called it a profession from the beginning.

Dr Lüsberg—Let me raise another point. At one time the medical profession and the nursing profession were as if in competition.

When I was a medical student, only medical students and doctors could give an intravenous; nurses could not. There were a lot of similar restrictions and I think that this attitude created problems because in fact nurses were doing these things. But what I hear now is that it is the nursing profession that is protecting itself—against the aide nurses. Is that true? Is there a problem there about task distribution?

Dr Kupe—I think the doctors started planning for power very early on, while nurses were busy looking after patients. One of the strategies the doctors used was protection of their boundaries—you know, creating a boundary within which only a doctor can function and from which all other health workers are excluded. So it ended up with every other health worker focusing on the doctor, helping him to succeed—the nurses taking care of the patient, the technician carrying out tests on his behalf and telling him what to do, the radiographer reporting to him, and so on. This amounted to a very good control of power by the medical profession. And the doctors have maintained this. Even outside in the community they are seen as the central point of all health workers. The patient is the doctor's patient admitted into the hospital, and everybody has to do little bits and pieces for this patient, so promoting the doctor's work. When we talk about the relationships within the health professions and the recognition of nursing, I think that what we are really talking about is this historical power structure of the doctors. In the USA where I spent much of my time, the Medical Association is the most powerful organization with the strongest lobby in government. There is no way to change the structure until the doctors decide what is going to be done.

Dr Sorvetula—I would like to continue from Dr Kupe’s analysis which shows very clearly
one historical fact—that nursing has developed in the shadow of medicine. We could have taken the lead but we didn’t. So we have been developing in the shadow of medicine, but we have discovered that we are not doing the same tasks or following the same procedures as medicine. We made the mistake of thinking that if we modelled ourselves more closely on the doctors we would achieve recognition, but we have discovered that that was not our mission at all. Some of my colleagues have said that physicians never created a group of people to serve them—like medical assistants—but they have used nurses as their assistants. So we are following doctor’s orders in some areas, but that is not nursing per se.

Dr Lüsberg—But, if it’s not too mischievous a question, aren’t the nurses doing the same now to the aide nurses? Are you not professionalizing yourselves in the same way, by starting to draw boundaries?

Dr Kupé—I think this Florence Nightingale “service” attitude has really blinded us in terms of political power—I am speaking for only myself and my country. Indeed, we do have what we call the “enrolled nurse”, who is the assistant-type of nurse earning less than the registered nurse and does not require as much academic acumen. Enrolled nurses are trained on a two-year programme, but the nurses allow them to do practically everything the registered nurse does. So now we have a problem. They are saying “Why

should I get less money than you? I do the same work as you. You take three years to become a nurse, you need a Cambridge Certificate to go into nursing. I need only two years after secondary school and I do everything”. So you see the problem that arises by not saying firmly: “Look, you are my assistant”—as the doctors did to the nurses—“You are allowed to do this and this, but beyond it you don’t go”.

Dr Al-Gasseer—What we have to ask is, how many categories of nurses do we want? We have been discussing this in Bahrain for the last six months. It has created lots of confusion. We had three categories—the nursing auxiliaries, the practical nurses, and those with the associate degree. The auxiliary nurses received only one month’s orientation, and patients were saying “such and such a nurse came and gave me this, she did not treat me properly”. We have started to reduce this category in the last two years. Then the associate degree nurses were complaining that they were doing the same work as the practical nurses. For the past six months we have been studying the matter carefully to give our recommendations on nursing to the government, and we have decided to say that we want the basic entry at associate degree level. The reasons were that when we began to state the functions and roles of the various categories we saw that the education of the practical nurses was very limited. They could not give total care to the patients. They could not carry out certain tasks and certain responsibilities. They could not see the overall situation and could not give patients health education. The associate degree nurses, on the other hand, are more versatile. They are prepared to serve in the community or in the hospital setting. So there are good reasons to have the basic entry at associate degree level—to reduce public confusion, to specify the image and the role of nursing, to be able to
work with the health professionals in the team much better, and to provide quality care to the people. They would recognize us then.

Dr Minami—I think that a profession grows in the course of time. Nurses used to be the servants of the doctor, but because we have worked hard and found different ways of serving the population nursing has become a proper profession. In the nursing profession we have different levels of workers, and some of them still do not have the required knowledge. In future they may develop into different professions apart from nursing, but at the moment they are still grouped in different levels under nursing. This sort of thing is not uncommon in other professions such as the law. So why is nursing challenged on this ground? At present, qualified nurses will have leadership and will supervise the other levels.

I think that this is a very interesting period for medicine. As we said earlier, the doctor was always at the centre of medicine, but in Japan we are now seeing something different. Other professions are emerging to compete with the doctors—not only nurses but, for instance, social workers. We have a new licence for social workers under the welfare system, and another for psychologists under the Ministry of Education, both of them outside medicine. Their preparation is different from that of nurses or doctors, so why do they have to come under the physician? They belong to a different domain of service. Other professions are competing, both with medicine and with nursing.

Dr Al-Gasseer—I should just like to clarify my concern that we shouldn’t call everybody a nurse. I am not opposed to having another health care category to compete with nursing, but if you call them nurses you will create confusion for the public.

Dr Sorvetula—If we look back at the way nursing developed we see that the constituent parts like education, research, and practice were not all developed in a coordinated way. We used to believe that we could achieve our goals through management, but this again showed a lack of balance in our thinking. This question of nursing aides is to my mind partly related to all that. When you, Dr Liisberg, ask us whether we are doing the same to others as doctors did to us, I think you are right. There are similarities. I know some countries have solved that problem, though mine is not among them. But it is very clear that several categories of nurse have been created without a complete understanding of nursing. It was seen as a series of tasks, and the overall understanding of the mission was not there.

Dr Liisberg—Let’s talk about the mission. We have been talking about doctors and nurses; we haven’t mentioned the patients. What are your comments on this? What are we going to do to get primary health care going? To get Health for All? To get people in the centre rather than the doctor or the nurse? Where are we going in the next 10 years?

Dr Al-Gasseer—I do strongly believe that physicians need not necessarily be in the centre. I see it as cooperative work. Health education can help to make people more self-reliant, and nurses can be used to reach the community.

Dr Liisberg—Does it mean that we have to change? I think doctors and nurses have to change. But in what way?—that’s my question.

Dr Minami—In my experience—and now I am speaking about my own country—it’s not easy to get rid of the old system, which
People in society are taking the initiative anyway, and we have to listen to them. We have to find out what sort of solution they are aiming at. Let them make the decisions. We are the resource people.

is an illness-centred institution-oriented system. It's really difficult. The only way of making the change is for nurses to take the lead at country level and to bring about changes gradually through discussion and

education and research. It has to happen as a grass-roots movement among clinicians — clinicians, not managers or academics.

Dr Liisberg — But what do we need to do? What kind of different approach do we need to adopt? What is it we really need to change in ourselves in order to put the people at the centre?

Dr Minami — We have to change our attitudes. I think people in society are taking the initiative anyway, and we have to listen to them. We have to find out what sort of solution they are aiming at. Let them make the decision. We are the resource people.

Dr Liisberg — So we have to be more sensitive to what people are saying and not impose ourselves on them. Because of course we have had that attitude — both doctors and nurses. We tell the patients what to do and we expect them to do it. I think that has got to change, but it's going to be difficult because sometimes we feel they do the wrong thing.

Dr Minami — The nursing profession has always claimed that nurses are different from physicians because they are much closer to the people. We claim to listen to the patients more than doctors do. In fact that's not true, really. Compared to the doctors we do better. But we still think that what we do for patients is good for them and that they are supposed to listen. That's the attitude we usually have, because we have always thought that teaching is important and that we have to give proper service — from our standpoint at any rate — but perhaps that is not true any more.

Dr Kupe — The question is a very difficult one. Because it involves almost a somersault in terms of how we see ourselves — doctors and nurses — and how we see the patients. We must move from a "them and us" framework to one in which we are all together as a team tackling the problem of health care. But it is very difficult ...

Dr Liisberg — Because we are afraid of losing control?

Dr Kupe — Yes. Because, after all, our control is based on knowledge that the patients do not have. So it really is a major somersault that is being asked of us.

Dr Liisberg — What do we do to arrive there?

Dr Kupe — It's up to the individual. You can't expect to change a group as a group. We must change individually and having changed individually we have to talk among ourselves. Partnership implies equality, so how can patients be partners when they lack the information that we have? The situation is lopsided.

Dr Al-Gasseer — Certainly, if we want to change in order to reach the population, we must study ourselves carefully. The clinicians too will have to study themselves
and their own role in serving the people. But we cannot leave the academics out of this process as Miss Minami implied, otherwise they will still think in terms of the traditional nursing care profession and the new ways will not be taught to the new recruits. Research will help us, in partnership with the people, to inform the clinicians and academics of what we are doing. Perhaps it will be the people who will tell us what sort of research. Nurses in other countries may well have to use the approach that we are already using in Bahrain, in which we go to a women's community association or to a men's club and ask how we can help them. It has worked very effectively.

Dr Minami—Yes, I agree with you. What I was stressing was that the centre of change is in the clinical area, that means the health unit and the hospital. We do not have to re-educate everybody. We have to trust our colleagues to make the changes too.

Dr Løisberg—So what we are talking about is a change in attitude rather than a change in knowledge. We must yield a bit of our power and really believe what we are saying, when we say that people are at the centre. And we need more social understanding in our training curricula—behavioural sciences, culture, and so on.

Maybe the conclusion is that we should be less concerned about making boundaries between the different kinds of health worker and more concerned with opening up between ourselves and particularly between ourselves and the people. It sounds very nice. It's also very difficult, but I think we agree that that's the way we have to go if we really want to succeed in getting things done differently.