



Inter-professional working: power and politics in the operating department

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Power and politics in operating theatres

Endoscopy services reviewed

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Power and politics in the operating department

Improvement in interdisciplinary working in the perioperative environment is essential and old habits and ways of thinking have to be abandoned, says SINEAD HAHESSY, lecturer, National University of Ireland.

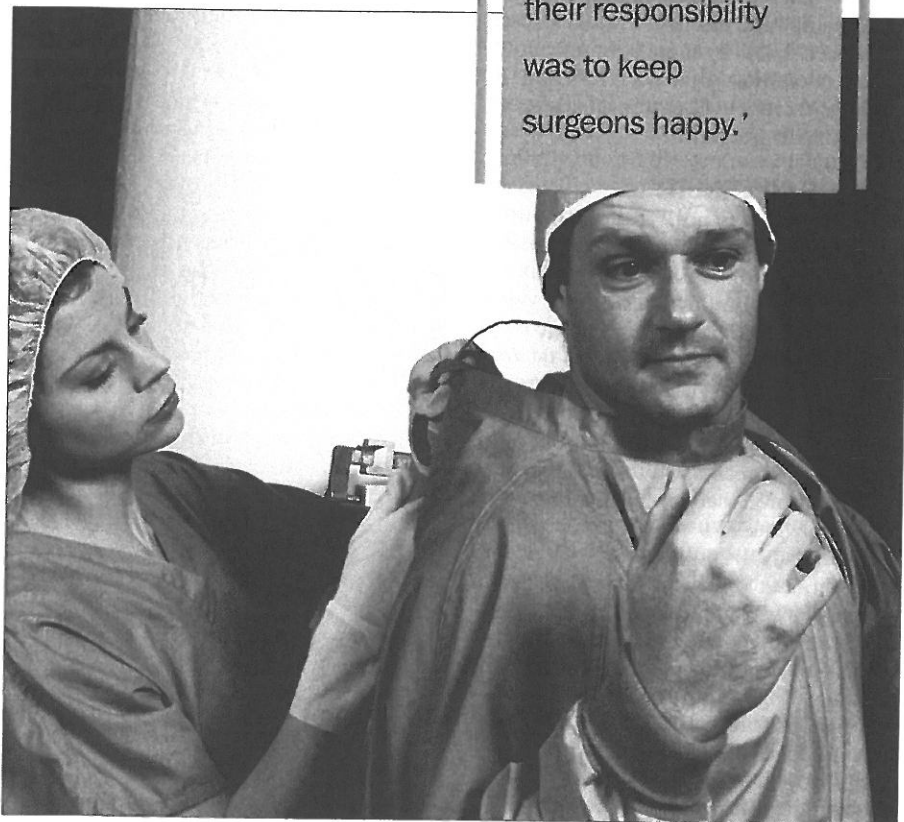
Modern discourse regarding the concept of disciplinary knowledge employs many interchangeable modifications, such as "multi", "anti", "cross", "trans", and "inter", linked to the word "disciplinary".

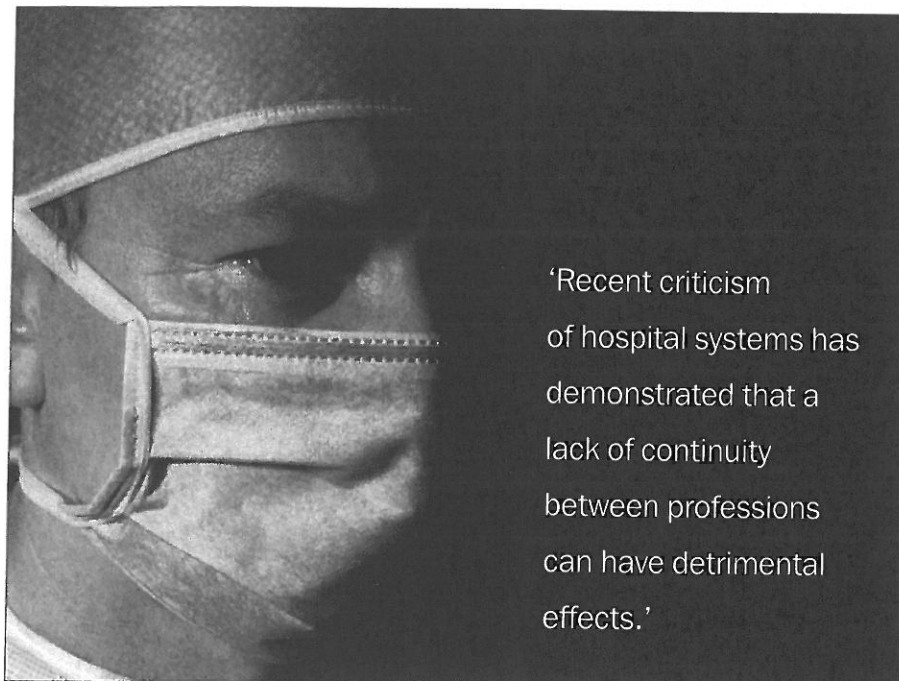
It is noted that these prefixes signal subtle yet important differences. The terms "multi" and "inter" are referred to most frequently in healthcare and explicating the differences between them at the outset may clarify their importance in terms of how these interface with power and politics. Multi-disciplinary is identified as involving a number of different disciplines, where there is an emphasis on the contribution of each discipline as exclusive. Interdisciplinary denotes mutuality, in professional ideals and goals.

Ostensibly, interdisciplinary working is underpinned by an ethos of collaborative practice, between members of similar disciplines. The general premise is that this means of working requires commitment to engage in shared dialogue which aims to contribute to better patient care outcomes. The model envisions an understanding of roles within a given team, and that players contribute equally and effectively. However, while the rhetoric of interdisciplinary working may seem ideal and at times over-inflated the reality of interdisciplinary working may not be all that it seems. Taking two perspectives pertinent to the operating theatre environment this article will analyse the concept of interdisciplinary working while analysing the interplay of politics and the concept of power. Suggestions for reflecting on practice and some solutions are offered while remaining cognisant of recent changes in healthcare practice.

The emergence of interdisciplinary ideology is located in liberal politics. The movement surfaced in the aftermath of social unrest most apparent in 1960s America and represented awareness that academic disciplines could be linked to social control. Viewed as a veritable panacea to overcome what was viewed as the fascist public education system, it perpetuated the ideal that there are systemic connections between racism, capitalist production and the social

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reproduction of knowledge.

Interdisciplinary working dispenses a sort of amazing grace to scholars and critics once bound by institutional parameters (Castronovo, 2000).

Applying these assertions to healthcare practice, it may on the outset seem difficult to locate similarities. The difficulty in tracing a historical emergence of interdisciplinary practice in healthcare rings true as it is a new direction in overcoming political tensions that typify healthcare professions. Rationale for its inclusion in healthcare has been addressed in terms of its ideological stance to improve relationships and promote mutual respect. It has been hailed by some to improve patient outcomes – that is if it functions. However there is little empirical evidence to prove such assertions.

LACK OF CONTINUITY

Debates in modern healthcare have centred on the diplomatic movement characterised by inclusiveness, most apparent in the notion of teamwork, collaboration and collectivity. Recent criticism of hospital systems has demonstrated that a lack of continuity between professions can have detrimental effects. It has been noted that it is not until relationships break down that the absence of the skills necessary to collaborate become obvious.

Historically the professional development of medicine evolved alongside nursing. However, Darwinian Theory fits well here to demonstrate the strength of evolution of one profession compared with the stagnation of another. The professional growth of nursing was halted for many reasons. Some theorists have attributed its lack of growth to issues such as its association with a vocational ethos and the

nature of the work which in its earliest form was closely aligned to domestic activity (Savage, 1987). Conversely, medicine asserted professional dominance through accumulation of knowledge that promoted curing, exercised social closure to non-members and reigned unquestionably autonomous. A powerful trait in the marrying of these two professions is the reality of gender. This reality warrants little discussion in its simplest form but its power has major significance for political dissonance that militates against interdisciplinary working.

Cogent professions (physiotherapy, occupational therapy etc) do not enter the equation in the early development of healthcare systems as we know them today and their proliferation is most noted in America in the 1970s onward reaching Europe in a slower manner. The emergence of the modern hierarchy of the hospital was characterised by educational attainment and nursing has only recently caught up, evidenced in the demise of the apprenticeship mode of training. Qualification and award underpinned by academic involvement provides a level playing field for all professions engaged in healthcare in today's world.

Interdisciplinary working could not develop in a system characterised by hybrid educational systems. From the perspective of longevity it could be argued that medicine has engaged in interdisciplinary discourse as a means of proving that it can refashion to move with the times. Long criticised for being conservative and resistant to change, interdisciplinary working offers a much-needed reinvention for medicine and a chance to interact in a more meaningful manner.

Interdisciplinary working operates from the premise that a plurality of approaches

and perspectives endeavours to establish a middle ground of knowledge that proves to be innocuous in the face of criticism. Interdisciplinary working is therefore a political move on everyone's part. However, the reality of articulating new directions in the working life of a given healthcare system may be propagated only by those in powerful positions. Those most powerful in the macro structure may promote the tokenistic value of interdisciplinary working without being cognisant of the difficulties of such political agendas on the microcosm of day-to-day interactions.

As Castronovo (2000) notes "interdisciplinary sidesteps the inherent disagreement and antagonism of democratic striving".

This statement has resonance for healthcare structures and two areas common to all operating theatre environments will be analysed to demonstrate this.

RULES, NORMS AND COMMUNICATION

Current beliefs about patient safety policy are characterised by a reliance on a rules based system which limits the space for individual accountability. The sharing of responsibility and belief is enshrined in policy documents that emphasise a standardisation of procedures and promote an assumption of common agreement in the prevention of harm, (McDonald *et al* 2005).

Guided by Government protocol risk management policy usually expounds a rhetoric of commonality and presumes that everyone in the team will adhere. As discussed earlier the idea of collective value underpins multi/interdisciplinary working. However, evidence suggests that doctors and nurses hold incongruent values regarding the adherence to rules and guidelines.

In a British study conducted by McDonald *et al* (2005) it was found that nurses are more likely than doctors to report non-adherence to protocol and emphasise the universal over the local, evidenced in seeing protocol through to the end without awareness of the role of uncertainty and individual variation. Junior nurses were found not to criticise breach of protocol as this would upset the given norms. The researchers make an interesting observation here, noting that the smooth operation of theatres is influenced by the behaviours and subscribed norms expected by medical staff and correctly state that nurse managers have little control over this professional group. Doctors in the study explicate the reasoning behind non-compliance which they closely align to their own professional identity as is evident in this statement: "Each individual situation is slightly

different. You can't say if this happens, then do this. Also, they could be more dangerous; people may not think for themselves, they don't make good decisions, and prior to the protocol being introduced they may well have thought about things in more detail." (Consultant Anaesthetist, McDonald *et al* 2005, p.292).

This statement is powerful as it illustrates the position of the surgeon and his world view. Autonomy over clinical decision making may be a luxury to some well established professions and the lack of individual input as prescribed by protocol, as adhered to by the nurse, is the antithesis to professional freedom.

Political power is subtly generated and the medical staff ostensibly conduct matters in their own right exclusive and separate to that of the nurses, but they can rationalise these individual decisions. An impasse is presented here. Those who hold power in designing policy that ideologically presumes that everyone will be complicit may need to review the thinking processes of members of differing professions.

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Interdisciplinary approaches to safety policy in the operating theatre are not underpinned by the collective purpose that they purport to serve. One of the reasons behind such dissonance may be the lack of communication that is rife between doctors and nurses. This was shown to be the case in the following extract from the aforementioned study: "Not everybody is honest, that is the biggest problem... It is the surgeons that don't communicate more than anybody, generally speaking surgeons don't communicate, they are the worst for communication." (Nurse Manager, McDonald *et al*, 2005 p.292).

A further analysis may suggest that nurses and doctors are not aware of the rationale of each other in decision making processes. The rationale given by the anaesthetist previously seems perfectly logical. However, the nurse perceives medics' lack of adherence to the rules and guidelines as a breach of trust evidenced in her comments on lack of communication.

Shared conversation is needed for the correct functioning of interdisciplinary working. It is important to note the role of accountability here also. Nurses may often feel like they are the moral police and become the monitors of ethical practice for other professions which is perhaps underpinned by a vocational hangover from the days when the nurse was perceived as "the eyes and ears of the doctor". Nurses have a duty to ensure accountability not least to professional regulatory bodies but also to patients and to colleagues. In a discussion of ethical decision making and moral theory,

"Aristotle's and Plato's emphasis on the moral agent as not being a complete 'law unto themselves' but needing to co-operate in organisational, political and social life", becomes relevant (Thompson *et al* 2006 p.344).

Frustrations can evolve from a conflict of values where the personalist and universal come out most clearly where the rights of individual patients have to be balanced against the interest of third parties, (*ibid* p.190). A collective vision and purpose is the determining factor in interdisciplinary working and where disparity exists rifts in perceptions of others can develop as outlined in the following statement: "If doctors' views are inconsistent with those of nurses on the subject of guidelines, to what extent does this indicate an absence of the sort of shared norms which are seen to be essential to both trusting relationships and the development of a safety culture?" (McDonald *et al* 2005, p.290).

What is required is a shared recognition of values that is supported by an awareness of each professional grouping's philosophical underpinnings. Perhaps then doctors and nurses may begin to understand each other in a more equitable manner. Solutions to this will be suggested.

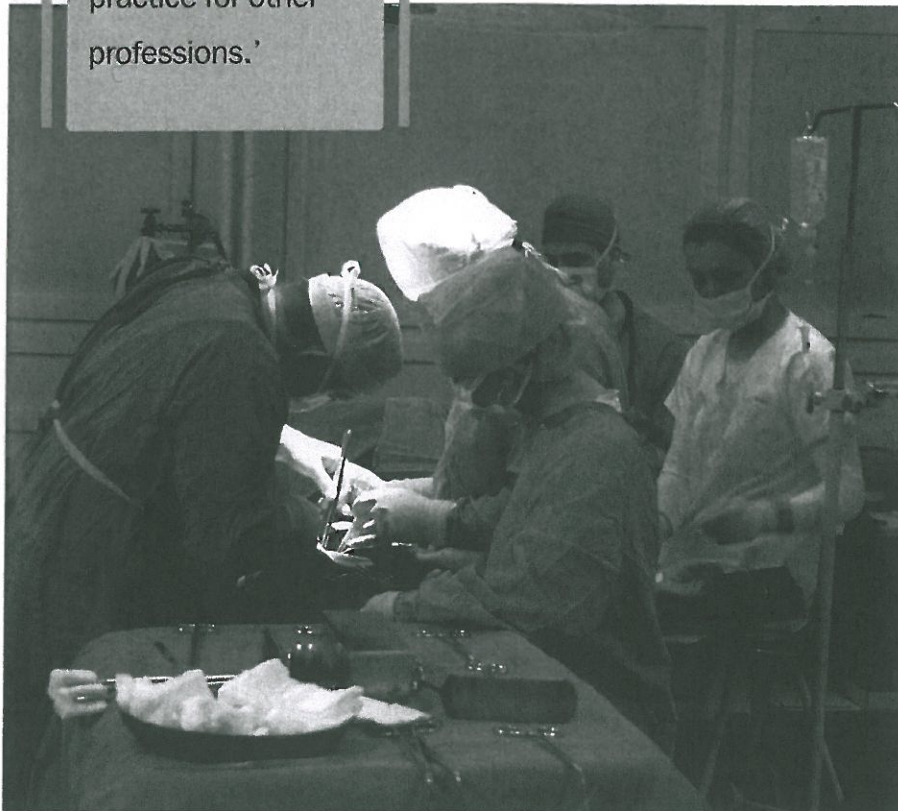
EMOTIONAL LABOUR AND GENDER

The second perspective for discussion in relation to interdisciplinary working area discusses a much under-researched area.

The term "emotional labour" was coined by Hochschild (1983) in her analysis of airline stewardesses and the emotional expectations demanded of them in the course of their work. The issue of emotional labour is addressed here based on the premise that "the deference accorded to the medical profession and the acceptance of doctors' power and status centrally inform the way in which nurses relate to doctors." (McKay 1993 cited in Timmons and Tanner, 2005 p.86).

Keeping in mind that interdisciplinary working is based on collective values which imply respect, a study of emotional labour in an operating department in Britain may have far reaching similarities for other such departments. In the analysis of data the researchers found that theatre nurses played out a "hostess" role that implied that part of their responsibility was to keep surgeons happy. This behaviour was played out in recognising the nuances of individual doctors as demonstrated in the following excerpt: "[The Surgeons] are good most of the time, although some of them have tantrums. You give them what they want and you look after them." (Nurse, Timmons & Tanner, 2005, p.88).

This is a clear example of emotional labour, with parallels to a hostess role as highlighted by the researchers. A second mode of emotional labour is described also



– that of not upsetting surgeons. It is related to the issue discussed previously where nurses are reluctant to intervene when practice is poor. The following statement illustrates the point: "He likes using [ether]. We have to get pharmacy to supply it especially for him. Yes, I know we shouldn't be using it." (Nurse, Timmons & Tanner 2005 p.88).

The issues of cooperation by pharmacy in this instance emphasises the lack of interdisciplinary accountability and illustrates the power that politically dominant professions hold in healthcare.

The fact that the nurses "have to get" pharmacy to supply ether almost infers an unethical persuasion on the part of the nurse. This reaches beyond a prescribed scope of practice and blurs the boundaries of acceptable demands. Gender plays a vital role here. The majority of nurses are female and some theorists have analysed emotional labour and the sexual division of labour (Savage 1987, Porter, 1995) and as Hochschild (1983) comments "the gender division of labour results in a gender division of emotion." Viewed in this way nurses are required to act in a certain way and display obedience to the doctor. The "old" system of nurse training reinforced Victorian ideals of obedience and subservience and was in place in the British Isles for approximately 100 years.

Underpinned by a clear demarcation of "gender" defined roles the doctor nurse relationship could evolve in terms of a social hierarchy. The survival of this hierarchy was dependent on the relationship between doctor and nurse. This cultural ascription is still well ingrained in many hospitals and it may seem that if nurses continue to subscribe to culturally defined roles the pursuit of professionalism in nursing may be a Pyrrhic victory. Power as disseminated in this manner adversely affects interdisciplinary working as it is true to say old habits are still alive and die hard. Nurses must be willing to defer the need to maintain the *status quo* by propagating a culture that in the end de-professionalises nursing. The smooth operation of any department requires flexibility but it is the nature of that flexibility that needs a review.

SUGGESTIONS FOR CHANGE

To change the practical working methods of professionals, Taanila *et al* (2006) suggest that education that is inclusive of inter-professional collaboration is put in place, throughout the process of a given training/education programme.

As discussed above the territorial nature of defence offered by the professions hampers the effective functioning of interdisciplinary working. The starting place is to develop a culture that promotes an awareness of issues. Open dialogue is

required to start change and it should be intended to allow members to become aware of what motivates their ingrained behaviour. Taanila *et al* (2006) cite the work of Caldock (1994) who suggests that collaboration in a communicative manner between representatives of given professions should establish an awareness of roles and ways of thinking. This will contribute to a fluent exchange of information, reciprocity of views and collaborative planning of activity.

The problems discussed above suggest that currently professions, while seemingly working as teams, are acting and thinking in isolation. Educational programmes in healthcare need to implement shared learning as a means of overcoming the weaknesses in collaborative engagement. A pilot education programme addressing this was put in place in the UK and it involved seven healthcare professions (Parsell *et al*, 1998). Interactive small group learning was utilised and by addressing themes the students could identify issues around inter/multi-professional working. An evaluation of the programme signalled its positive contribution to understanding other professions. Students would welcome early and regular opportunities to use this mode of learning. A similar study by Lary *et al* (1997) demonstrates that by utilising innovative educational approaches, such as problem based learning, there is an improvement in group working and learning in relation to each other's profession. Interdisciplinary working requires a new way of knowing and learning for all involved. Healthcare environments cannot grow given the current nature of working. There is a need to abandon old habits and ways of thinking, and a commitment from all staff to engage in a meaningful way forward is urgently required. +

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