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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 fascistic public education system, it perpetuated the ideal that there are systemic connections between racism, capitalist production and the social.

‘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.’
Recent criticism of hospital systems has demonstrated that a lack of continuity between professions can have detrimental effects.

RULES, NORMS AND COMMUNICATION

Current beliefs about patient safety policy are characterised by a reliance on 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.

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 doctors' 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 been 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 group'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 discusses a much under-researched area.

The term "emotional labour" was coined by Hochschild (1983) in her analysis of airline stewardsesses 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 [other]. 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 either almost interferes with the role 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 Hoschold (1983) commented “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 reinfored Victorian ideals of obedience and submission and was in place in the British Isles for approximately 100 years.

Underpinned by a clear dichotomy 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, Taamila et al (2006) suggest that education that is inclusive of interprofessional 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 approach. Taamila 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 [Parcell 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.

REFERENCES


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