The vocational crisis in medicine and nursing

Unlike many occupations medicine and nursing are primarily and historically vocational professions. A wish to comfort, relieve pain and hopefully to cure other human beings who are ill should be the essential motivation to pursue these professions. Social status, remuneration and political bureaucratic compliance are of secondary importance. Both professions have traditionally been held in high regard by the public, but changes associated with advances in understanding disease processes and technological innovations have altered the nature of both medicine and nursing.

Before 1947 many medical specialists ran highly lucrative private practices but worked as honorary practitioners in the voluntary charitable hospitals, receiving no pay. Following the introduction of the NHS in 1947 it was the politicians' pipedream that the national health service would be so good that private practice would become irrelevant. Unfortunately the opposite has occurred and private practice is thriving.

There have been enormous advances in all branches of medicine and surgery. New diagnostic machines particularly for imaging have been introduced and increasingly highly complex technical treatments have been developed, requiring skilful expertise but in ever-increasingly narrow fields. There has been a huge increase in the number of consultants, but often with inadequate facilities for them to work so that waiting times have increased and operations are cancelled. Many consultants have used their extra free time for private practice; the longer the waiting list the better the prospects for private practice.

Certain specialist units have outstanding medical and nursing care, but there is a serious weakness in emergency out-of-hours medicine and surgery because many of the 'super-specialists' have such a restricted experience in training that they are incapable of functioning efficiently outside their own narrow fields.

The increasingly shortened hours of work permitted means that patients often will be seen by one doctor and then, while they are being investigated, will be transferred to another doctor. Traditionally the doctor was responsible for his or her patient as long as was necessary. There is now little continuity of care and patients with treatable conditions like acute appendicitis and ruptured ectopic pregnancies can slip out of the hospital system and become extremely ill and can die. Recently, after seeing several doctors a young woman died in hospital from a perforated ulcer that can be cured by simple surgery.

The Cinderella of medicine is geriatrics which, with the ageing population, is increasing. It is an unpopular speciality for doctors and even more so for nurses because of the heavy lifting and repeated cleaning that is necessary. Elderly patients, some incontinent and with dementia, enter the geriatric wards of many hospitals in a 'lottery for euthanasia', because of the serious danger of hospital-acquired infection, malnutrition and dehydration.

Medical education and training

To train as a specialist takes time, with hands-on experience in an apprenticeship relationship with an experienced teacher. In this relationship, a good role model is essential. Only with this approach can clinical skills be developed effectively. This applies especially to learning the importance of listening and talking to patients, which is quite different from giving or watching a PowerPoint computer presentation.

The whole question of medical education requires rethinking, now that many aspects of medicine are so technically specialized and restricted. Why should years be spent learning unrelated specialties such as psychiatry and dermatology for a specialist in knee surgery who is unlikely to venture much beyond the ankle and hip professionally? On the other hand generalists are essential for good care covering the whole of medicine. Traditional medical education is more suited for general practice, anaesthesia and a hospital-based generalist. A new technological training may be best for the super-specialist, who is rather like an airline pilot requiring some basic knowledge of flying but being restricted to the type of plane he or she is permitted to fly and also required to clock up a number of hours per year, but not more than a prescribed maximum.

Nursing

The nursing profession has always been underpaid. As a consequence of bad treatment of nurses the unions have become very strong and discipline has deteriorated, so that it is almost impossible to dismiss an unsafe nurse whose poor practice endangers patients. The managerial staff is frightened to cause offence even when gross violations of hygiene occur, particularly in geriatric wards. Many doctors are fearful of being admitted as patients in their own hospital.

A reduction in hospital-acquired infection is possible if there is a will and appropriate arrangements. On a recent trip to Japan I was told that hospital-acquired infections were unusual but extremely serious and to be avoided at all costs. An example of the approach in the busy teaching hospital was the requirement to wash one's hands in antiseptic soap. The procedure was monitored electronically and when complete the sliding door of the ward was opened to admit the possessor of clean hands.

The flagship units in the UK of intensive care and specialist surgical units have high morale with excellent hygiene, in marked contrast to the dismal environment of most geriatric wards. The shortage of nurses as a result of poor pay and perceived poor status has forced us to rely on the services of nurses from abroad, often from countries which can ill afford to lose their nurses, such as the Philippines.

Patients

I suggest that a patient in hospital should be managed with the care and seriousness of a passenger in an aeroplane. No one would dispute the authority of a pilot and the hierarchical discipline of crew to ensure the safety of the passengers in the plane, yet in hospital a similar discipline that was traditional and essential for good patient care has been lost. The pivotal figure of the ward sister should control the ward like the captain of an aircraft, responsible for all ward activity, liaising with doctors, supervising the meals, cleaning the ward and above all ensuring the welfare of the patients and nurses with full support from the senior administration.

The state of affairs is nearly as bad as Florence Nightingale found in her day and she was a strong enough personality to enthuse nursing with a completely new and caring vocational approach. To restore the traditional vocational nature of nursing would be difficult but not impossible. Certainly the funding for nurses needs to be improved, but also a complete change of attitudes is necessary. In many hospitals there are too many consultants for the facilities available and this is extremely wasteful. The other obvious gross excess is the vast number of managerial posts and a system which enables managers to promote each other and proliferate in an almost malignant manner, adding another financial burden to the hospital and also causing ridiculous bureaucratic duplication and unnecessary minor regulations not related to patient care.

Patients' attitude to the NHS has also changed. The public expects the most expensive modern treatment and equipment to be available to everyone. This is not possible even in the richest countries and it is difficult for the public to realize that there is already a system of rationing, although that word is not used.

Patients in hospital need kindness and mutual trust as well as skilful care. If the vocational aspects of medicine and nursing were restored, so too would the patients' trust in the professions to do the very best they can within the financial limits of the facilities. BJHM

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KEY POINTS

- Medicine and nursing remain vocational professions but advances in medicine and changes in the structure of nursing have undermined this traditional ethos.
- Geriatrics as a speciality is increasing with the ageing population but it is unpopular with both doctors and nurses and in many hospitals the wards have become dangerous; a lottery for euthanasia from infection and malnourishment.
- The extreme technical skill required for 'super specialists' does not fit in with traditional medical school education and should be a new technical specialist education. Nevertheless traditional training is needed in general practice, anaesthesia and as hospital generalists.
- The pivotal figure of the ward sister with power and support should be restored to provide a disciplined nursing service which is as necessary as the discipline of a flight crew in an aeroplane.
- The public expects the most expensive treatment and equipment to be available to everyone. This is not possible in any country. A form of rationing is a fact but if patients are treated with kindness and skill, mutual trust between patient and the medical nursing profession could be restored and the public would realize that they were getting the best that could be available.

Correspondence

Do you agree that medicine must maintain its vocational feel?
Do you mourn the passing of the traditional nursing system or do you think that hospital practice needs to move forward?
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