debate. The aesthete, the manager, and the therapist are therefore in different but complementary ways concerned only with technique, skill, profit, and effectiveness. They are uncontested figures who engage only in the kind of discourse in which rational agreement is possible—the realms of fact, means, and measurable effectiveness.

“For all of us, whether doctors or nurses, genuine compassion must be the foundation for care.”

And here we see the link with current nursing attitudes towards patient care, which sacrifice the traditional metaphysical principles of truth (and hence the moral and scientific principles derived from it) for aesthetics, therapeutics, and managerialism. The aesthetic nursing attitude seeks to provide “holistic and spiritual” care directed at contemplation of beauty and the arts; the therapeutic nursing attitude seeks to transform “maladjusted” patients through psychological and emotional techniques of counselling and complementary therapy; and the managerial nursing attitude seeks to manipulate human beings into compliant patterns of behaviour to achieve purportedly measurable standards of quality.

Yet we are forced to ask whether this discourse, which replaces ultimate moral principles with techniques of productive and psychological effectiveness, offers a possible or desirable method for producing nurses who can give patients “tender loving care” and can offer medical and other colleagues partnership, team loyalty, and mutuality? Can the morality of this contractual nursing, derived from the cult of autonomy, engender in a nurse a warmth and freedom of the heart that is independent of either material rewards or competition for status? Traditional nursing depended on an ethic of service derived from the moral principles of *caritas* or *agape*. This ethic was the basis of the nursing tradition revived by Nightingale, handed down to generations of nurses by Evelyn Pearce,⁷ and affirmed by the eminent surgeon Lord Webb-Johnson.⁸

Genuine compassion: the foundation for patient care

The same ethic, as Lord Walton argued in his 1990 Harveian oration to the Royal College of Physicians, formed the basis for the humane practice of medicine by humanising the Hippocratic tradition and so extended medical care to all and even to those with incurable disease.⁹ Indeed this same moral tradition was responsible for the foundation of the modern hospice movement and thus palliative care of terminally ill and dying patients.¹⁰ So it is not surprising that the chief medical officer, Kenneth Calman, should acknowledge that quality in health care is related to human values.¹¹ But these values need not only coherent articulation, as Calman suggests, but also incarnation. The story of care in post-communist Russia surely demonstrates how easily the values of genuine compassion can be lost and our hearts harden. And for all of us, whether doctors or nurses, genuine compassion must be the foundation for care.

No better illustration of this can be found than in Sir Archie Cochrane’s autobiography. He relates an incident during the second world war when a dying Soviet prisoner was dumped in his ward. The patient was moribund and screaming. Sir Archie examined him, believed the cause of the pain was a severe pleural rub, and, having no morphine gave him aspirin. But the prisoner still screamed, and Sir Archie took him

in his arms. The screaming stopped at once. “It was not the pleurisy that caused the screaming but loneliness.”¹²

I suggest that if we are not to lose the humanity of caring for vulnerable members of society (and the medical basis for this caring), all of us involved in health care need to examine the roots of our tradition of dedicated service. Perhaps then we will be able to build quality and cooperation in health care in the future and keep alive the founding values of the NHS.

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Towards an ethos of interdisciplinary practice

Mike Nolan

Anyone browsing through the nursing journals over the past few months will have noticed that the profession seems to be undergoing sustained and quite unprecedented change. While change characterises the health care environment in general, several factors seem to have impinged on nursing and exacerbated an already fraught situation.

On the one hand there are dire warnings of the potential impact of “multiskilling,” whereby unqualified and minimally trained personnel are undertaking activities previously deemed to be the province of nurses. Indeed in the United States such workers seem to be already moving into quasi-medical territory and are suturing wounds, injecting intravenous drugs, and inserting catheters.¹ Paradoxically, in Britain there are concurrent accounts of the potential benefits, particularly for junior doctors, of nurse practitioners completing a similar range of tasks.²

Although some experts feel that the development of the nurse practitioner will also benefit nursing, there are those who argue that such an initiative is of questionable value and does little but reinforce the traditional “handmaiden” relationship, with the nurse now cast in the role of “technical functionary.” In considering alternatives, others assert that nursing’s future lies outside acute care, in such domains as health promotion, which is seen to offer “truly infinite scope” for professional growth and development.⁴

Against this backcloth Castledine suggested that nursing is currently in the throes of an identity crisis, initiated and sustained by the scale and pace of technological, economic, and scientific change in the NHS.⁵ To consider the likely impact of such factors on the delivery of health and social care and the role of the nurse in the next century the chief nursing officers for England, Northern Ireland, Scotland, and Wales convened a group of nursing leaders and other professional colleagues in May 1993. The report of their deliberations outlined several potential scenarios based on the premise that there is, and will continue to be, a shift in the balance of health care away from institutional provision and towards community care,

coupled with an increasing emphasis on chronic illness.⁶ The net effect of this, it was argued, was that the ecological balance between all those involved in health and social care would be disturbed and that traditional roles and responsibilities would need to change.

Parkin has argued that the current state of flux has resulted in several occupational groups seeking to "lay claim to territories of ambiguous ownership in health care," with a consequent heightening of traditional power struggles, a tension exacerbated by the emergence of consumerism so that challenging professional opinion is now seen as normative rather than deviant.

Much has been written over recent years about multidisciplinary teamwork, and terms such as collaboration and participation have proliferated, with a growing emphasis now on the involvement of patients and carers. For example, a recent report by the Royal College of Physicians addressing issues of equity in service provision for older people stated, in respect of decisions about admission to residential care, that informed choices by patients should always predominate.⁸ Unfortunately, such fine sentiments are rarely realised, often because differing professional groups do not share a common understanding of the relevant issues.⁹ If this situation is to improve then the diversity and complexity of the health care environment must be acknowledged more fully, reinforcing the fact that no profession has hegemony across all contexts. Such an acknowledgment has a particular impact on the interface between medicine and nursing.

Relation between medicine and nursing

Castledine suggested that the relation between medicine and nursing can be summarised by three viewpoints¹⁰:

- Nursing is an autonomous discipline, independent of medicine
- Nursing is inextricably linked to and largely dependent on medicine
- Both medicine and nursing are part of a continuum in which cure and care have a reciprocal relationship, with the relative emphasis shifting depending on context.

While these models may be oversimplifications, they are useful heuristic devices. Some professionals doubtless subscribe to the first or second approach, but I contend that the third approach represents the only viable model for the future.

Few would argue with the fact that the medical model is the most appropriate, and indeed the one of choice, when cure is possible.¹¹ The application of such an approach, however, is counterproductive in chronic illness. Yet despite the growing importance given to the health needs of individuals with such conditions¹² interventions are still largely characterised by the use of treatments derived from acute care.¹³ True progress will not be made until there is a fundamental reconceptualisation of the meaning of some terms—such as rehabilitation and the role that various groups play in the process. There are encouraging signs that this debate has begun, at least in respect of older people,⁸ and that it is widening to include health promotion and recognition that outcomes of care extend beyond the objective and must concern satisfaction with life and health. It therefore seems ironic that such factors receive only tacit recognition in the perceived aims of important services for older people, such as care in day hospitals.¹⁴

Professional reductionism is the tendency to restrict the legitimate focus of attention to an area consistent with a given professional paradigm.¹⁵ All professional groups engage in such activity, to the detriment of genuine collaboration and service innovation. Indeed

this is probably one of the primary reasons that multidisciplinary working has often remained simply rhetoric.

From multidisciplinary to interdisciplinary care

Recently it has been possible to discern a subtle shift in emphasis away from multidisciplinary care towards interdisciplinary care. The concept of multidisciplinary care is based on the premise that health care is delivered by a team, each member of which has a different professional training and brings different skills to bear.¹⁶ The main task is therefore to coordinate the team effort. Interdisciplinary care, although not denying the importance of specific skills, seeks to blur the professional boundaries and requires trust, tolerance, and a willingness to share responsibility.⁹ Although such sentiments may sound trite in the current climate—which is more conducive to maintaining than dismantling barriers to collaborative working—trust, tolerance, and a willingness to share responsibility are what is needed.

"It is time for constructive debate and some clear thinking to facilitate interprofessional dialogue."

During periods of rapid change there are always those who seek solace in the past. Within the present context, however, maintaining the status quo is simply not a viable or even sensible option. Rose tinted reflections on a better, albeit probably largely, mythical past do little to point a constructive way forward. In fact the nature of professional relationships in health care has changed. The lessons of the past are there to be learned but cannot be built on by reifying what has gone before. Rather it is time for constructive debate and some clear thinking to facilitate interprofessional dialogue. Such dialogue requires agreed definitions as to purpose and intent, free of much of the current rhetoric. While "pseudo-managerial gibberish"¹⁷ may indeed abound, its existence is indicative of a potent set of forces that will feed on, rather than be countered by, verbiage and unsubstantiated opinion.

In a recent critique of the seemingly endless reports detailing a vision for nursing in the year 2000 and beyond, Smith stated that what is needed is the development of a nursing profession that consists of "well educated, articulate, and assertive practitioners . . . who use their hands, hearts, and heads."¹⁸ This is only likely to be achieved when there is a wider appreciation that the balance between these latter three ingredients must be flexible and shift in response to the health care environment in which we operate. Therefore while hands and hearts will always play an important part in nursing, the development of critical thinking is also essential.

As nursing produces its well educated, articulate, and assertive practitioners there is evidence that they are becoming increasingly disaffected with the commonly held view of the profession, particularly the perceptions of some medical colleagues.¹⁹ It is to be hoped that the disparate views in this issue of the *BMJ* will pave the way towards the level of continuing, well informed, and constructive debate that is necessary for enhanced interdisciplinary care.

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Nursing: no regrets

Heidi Lemp

If innovation in the nursing profession is the future then the future is already here, but it is not yet evenly distributed. The nursing profession claims direct patient care as its own special area of expertise.¹ To provide patient care effectively and to innovate, nurses need to have control over their professional practice. The concept of a profession includes accountability and autonomy for personal actions: accountability means that the nurse is answerable for his or her own behaviour, while autonomy means that she or he has the freedom and the authority to act independently.² Historically, both have been in short supply, with nurses often being left with feelings of inadequacy and powerlessness, as their attempts to establish areas of autonomous practice have been frustrated. Indeed their situation is weaker because nursing has little theoretical foundation of its own; rather it has often borrowed theories from medicine and from behavioural and physical sciences. Turning this to advantage, however, newer approaches to academic nursing training, under the umbrella of Project 2000, are now developing from the results of theory-building research, grounded in clinical work. Within this structure that is clinically rich, poor in theory, and laden with hierarchy, how can a nurse be creative? Three factors have helped me to remain positive about nursing after over 20 years in the profession. These factors—innovation, the move from secondary to primary care, and ongoing further education—even helped me to return to nursing after I left for six months when I felt completely exhausted.

Innovative nursing posts

The first factor that has helped me to remain positive about nursing was my decision to innovate by taking posts that had been newly created. In 1986, for example, I began a job share post as ward sister, the first in Britain, after a battle lasting almost a year against a doubtful hospital management. The alternative on returning to work after the birth of my first

child—demotion—would have been both unacceptable to me and wasteful. With the support of many nursing and medical colleagues, I showed that such an unusual arrangement could work, and job sharing at all levels in nursing has now become much more common.³

My second “new start” post was to help set up a nurse specialist community and liaison service for people with HIV infection or AIDS living at home in south London in the late 1980s.⁴ By then I had had enough of the restrictive hospital environment and hierarchy, and, although I enjoyed caring for acutely ill patients, I had enough expertise and confidence to work in the community more independently. From my experience in intensive and terminal care I brought ideas that shaped this newly created team. The demands on such a community hospital liaison service were enormous, including, for example, giving intravenous infusions and performing venepuncture at home, and providing 24 hour on call care for clients who were deteriorating or in their terminal phase.

These clients often asked for much greater flexibility from staff than they had been offered in hospital. Indeed, as many people with HIV infection or AIDS are very knowledgeable about their diseases, they encouraged me in a much more open, continuing, and robust clinical relationship than I had known in hospital. Along with a commitment to constant monitoring and evaluation of the newly established service, we were able to set up a team in which the clients, the hospital, the primary health care staff, and the community nurse specialists worked as interdependent and strong partners. In both these new posts I found that innovative practice, if carefully argued, supported by strong background evidence, and forcefully presented, could be successfully introduced into nursing.

From secondary to primary care

The second influence on my nursing practice has been a move from secondary to primary care, which I made for two reasons. Firstly, having a base in primary care as a member of a community nurse specialist team gave me, for the first time in my nursing career, a sense of how I fitted into the whole life of individual clients rather than of how they fitted into a narrow hospital routine. Secondly, some of my work now included

“As long as nurses are educated to be competent to carry out new nursing practices . . . the future will be exciting.”

teaching clients and their families and friends the practicalities of continuing and terminal care, such as self administered inhalations and intravenous therapy. In interesting and parallel ways, therefore, as I gained more confidence in applying what were usually hospital based procedures at home, so our clients and their carers did likewise. Indeed the whole home care approach has helped to demystify many professional practices.

Since I have taken on this extended nursing role my relationship with medical colleagues has completely changed. The reasons are that many general practitioners and other primary health care staff knew little about HIV and AIDS and that we took responsibility for 24 hours nursing care; in practice this meant assessing patients on a regular basis, admitting them to hospital, taking blood, administering all palliative and terminal care with community nurses, helping with discharge to home, and acting as a link between the hospital