

Interdisciplinary Working Relationships of Health Care Staff in Late 20th Century Britain: A Cultural Study of Practices from the Past and Implications for the Present

Angela Turner-Wilson, Bournemouth University, UK
Richard Fisher, Bournemouth University, UK
Holly Crossen-White, Bournemouth University, UK
Ann Hemingway, Bournemouth University, UK

Abstract

Interdisciplinary working is a common phenomenon in healthcare in many countries throughout the world, yet the United Kingdom cultural history of this employment model appears to be under-researched. A pilot study was therefore undertaken that sought to obtain insights into this form of working in clinical environments during the latter part of the 20th century in Britain. The participants were all retired British National Health Service (NHS) professionals. An oral history approach was used, and in addition participants were also encouraged to handle old historical medical objects dated to the time period under review. Three of the themes that emerged from the narrative data analysis, “hierarchy” “altered hierarchy” and “the family”, are discussed, and the authors review how these concepts acted as enablers, and sometimes barriers, within interdisciplinary working. The authors also question whether, in recent times, there has been a change to the sense of “belongingness” that some of these ideas seemed to nurture. It is asked if, in the modern setting, some healthcare staff feel insecure as they no longer believe they are as supported, or as accepted by their interdisciplinary colleagues. The paper concludes by considering if the ideology of a “healthcare family” could speak to those currently engaged in clinical work today.

Keywords: culture, health care, history

Introduction

In 1967 the British government commented on the organisation of medical activities within the National Health Service. A report noted that it was “obvious that the chairman of the executive committee (an experienced medical clinician) would need to work as closely with the chief nursing officer ...” as possible (Ministry of Health, 1967, p. 59). The comment highlights that interdisciplinary working was becoming an established part of practice by the latter part of the twentieth century in the United Kingdom (UK). This is a pattern of working that is not dissimilar to other parts of the world, such as the United States, where the idea of collaborative working and its benefits appears in twentieth century health care rhetoric (for example see Baldwin, 1996). Modern historical healthcare literature addresses interdisciplinary working during this period, but there is less emphasis on the underpinning cultural day-to-day practices. The researchers in this study sought to redress this by developing a study that would provide a platform to speak from for those who lived through these times. An oral historical approach was adopted that allowed participants to share their insights and emotional journeys of interdisciplinary working from the late 1960s onwards. The authors will highlight some of the findings that emerged from this process, and in particular look deeper into some of the cultural themes that came out of this work.

Background

Interdisciplinary working is a common approach in many healthcare systems today (for instance, Eaves, 2002) and it is therefore unsurprising that there has been some interest in this field through historical studies. If we turn to the British evidence, for example, Hall’s (2005) work considers professional cultures within the history of interdisciplinary groups. Reeves, MacMillan & van Soeren, (2010) postulate a similarity between modern interdisciplinary working practices and ancient medieval craft guilds. Some authors have explored the working practices between two distinct professions, such as nurses and medical doctors. Price, Doucet & Hall (2013) discuss the historical social positioning of these two disciplines, whilst MacMillan (2012) review the role of Florence Nightingale and her influence regarding interdisciplinary working, particularly in regard to medics. Along a similar theme Crowther’s (2002) paper looks at the working relationship of British doctors and nurses during the 19th and 20th centuries. There are also those authors who have contributed to historical understandings of interdisciplinary working, but from the perspective of a single profession. Sweet & Dougall’s (2008) work on community nursing, Billingham, Morrell & Billingham’s (1996) insights into health visiting (part of public health nursing in Britain), Parker & Dowding’s (2011) discussions regarding nursing auxiliaries, as well as Arden’s (2005) text on the role of the nursing sister are a few examples. Personal narratives also exist. Practitioners who worked during the 20th century in the UK healthcare system such as Cox (2005), Graham & Orr (2013) and Bayer & Oppenheimer (2002) all talk about their experiences. However, when interdisciplinary working is mentioned, it is usually woven into the overall story. This review appears to suggest that there are not many attempts to capture personal stories which are directly associated with interdisciplinary working in the British clinical environments from the 1960s onwards.

Research Question

Using narratives gathered from retired health care practitioners, the researchers in this study chose to undertake a pilot study to investigate professional roles and working boundaries in UK health care during the late twentieth century.

Aim and Objectives

The aims and objectives of this study were to:

- Gain insights from a group of retired health care workers relating to their professional roles and interdisciplinary working practices during the latter part of the 20th century.
- Use old medical objects to enhance communication between the participants and the investigators, and to act as triggers for personal memories.
- Collect data using structured, open-ended interview questions.
- Identify themes and patterns that emerged from the interview material.
- Propose interpretations that further inform the historical cultural study of interdisciplinary health care working practices in the late 20th century, and consider whether these findings can offer insights into current healthcare delivery.

Methodology and Methods

Two approaches were adopted for this cultural study. The first was grounded in oral histories. Reinharz (1992) suggests this method can liberate the narrators, allowing them the means to express ideas that may not be preserved in traditional writings. As such, it can be regarded as a method that creates a new social history (Boschma, Scaia, Bonifacio, & Roberts, 2008). It is well suited to this research as it allows for, as Peniston-Bird (2009) highlights, the capture of details relating to daily life and experience.

The second method was closely aligned with the field of visual studies and was based on the assumption that the use of images within a research methodology can, “act as a medium of communication between the researcher and participant” (Clark-Ibáñez, 2004, p. 1512). Harper (2002) has argued that the inclusion of visual items alongside the traditional research interview has the potential to create different forms of information. In his work he has a particular interest in photo-elicitation, but it can be proposed that the idea of object-elicitation sits equally well within this approach. In object-elicitation the participants are invited to use their sense of vision, but they may also touch and even smell the items which, in Harper’s (2002, p. 13) words can, “connect core definitions of the self to society, culture and history”. Dobres (1995) adds that objects can act as a reference point for individuals to grade themselves and others in terms of competence and adherence to group standards.

In addition, as a result of museums and art galleries looking for new ways to engage the public with their collections, there is an emerging body of research that looks at how interacting with heritage objects can benefit individuals, see for example Ander’s et al (2013) work. Indeed, much of this work reflects research into the value of object handling to particular patient groups such as those who require longer periods of time in hospital settings. What the findings indicate is that objects are “containers of memory” (Mack, 2003) and handling these objects can “trigger memories in ways that other information-bearing material do not” (Camic & Chatterjee 2013, p. 67). Moreover, there is increasing evidence that handling objects can increase an individual’s sense of identity (Ander et al., 2013). If this is indeed the case, then holding items related to a professional context may potentially not only elicit memories of the past, but also stimulate recollection and reflection upon roles within interdisciplinary teams. Hence this study adopted the use of historical medical objects such as the type previously used by interviewees within their everyday practice.

Clearly the approaches rely on the memory of the participants, and it is also clear that there exists some tension between memory and the creation of individual and collective histories (Confino, 1997). Memory is known to be unreliable and subjective, yet it provides us with the means to travel back into our own past. It offers a closeness to events that is often absent in official documents. Davis & Starn (1989, p. 5) sum this up by stating, “the private sphere and the practices of everyday life define and conserve alternatives to the official memory of public historiography”. Thus different memories offer different perspectives on the past.

Ethical, Legal and Professional Matters

Institutional ethical approval for this study was obtained from the researchers’ university and from the hospital research department. Individuals who expressed an interest in volunteering for the study were informed that the ethical reviews had taken place, and were provided with a participant information sheet which highlighted, amongst other things, that participants could withdraw from the study at any time without giving any reasons. All participants signed a consent form prior to taking part in the study and this included an agreement for verbatim quotations to be used within publications. A health and safety risk assessment was also completed.

Sampling

Purposive sampling was adopted as this study addressed a specific group within the population (Polit & Beck, 2004). Five participants, who were all retired members of hospital staff and had worked in health care during the 20th century, agreed to participate. The sample was small, but as this work was a pilot study, and the investigation assumed a constructivist position, it was deemed appropriate (Teijlingen van & Hundley, 2001; O’Leary, 2004).

Interviews and Objects

The interviews were conducted in non-clinical rooms at the hospital which was a convenient location for the participants who lived locally, and it provided easy access to the old medical object archive. Data was collected by using structured and open-ended interview questions with the latter allowing the interviewer to change the order of questions as the discussion progressed (Bowling, 2002). Participants were invited to look at or handle a number of small old medical objects which were, for health and safety purposes chosen from the hospital archive by the researchers. The same items were used for every participant. The participants were asked to select one item that they could particularly associate with during their working lives. The old medical objects (all estimated to be about 30 to 60 years old) included:

- Inhaler Device (marked Dr Nelson’s Inhaler) (ceramic, cork stopper)
- Syringe (spinal) (glass)
- Surgical needles (metal) and needle holder(metal) and carrying case(wood)
- Soap (boxed)
- Kidney bowl (metal)
- Instrument sterilisers (steam and chemical) (metal)
- Bandage (wrapped in cellophane)
- Surgical operating instrument (metal)

The data analysis began by summarising the categorical data. Then, in order to adopt a more nuanced analysis and to explore greater complexities within the data, printed transcriptions of the interviews were scrutinized using a thematic approach. The transcripts were read several times and annotated to show how recurring themes emerged from the data. Themes were compared between transcripts, adopting the approach of constant comparison as identified by Silverman (2000). This, it is argued, helps to enable the researcher to convey a sense of meaning about the observed world.

Findings

The five participants (all retired) had been employed by the NHS from the 1960s onwards. They came from a range of specialisms. One of the two doctors had worked in surgery, whilst the other in anaesthetics. Two of the nurses had medical backgrounds. The final participant had held a number of clinical posts in health care. In relation to the selection of the old medical objects most participants chose different things, although an instrument steriliser was selected by two different participants. When the participants were asked who mainly used the object they had selected, they all reported that it was only used by their profession.

The analysis of the interviews revealed a number of themes which included:

- Hierarchy
- Altered Hierarchy
- Family

Hierarchy

The idea of hierarchy was presented in a discussion when Participant 1, a nurse, focused on a Dr Nelson's inhaler. This equipment consists of an earthenware vessel which was used for inhalation purposes post anaesthesia, and on ear, nose and throat wards (see figure 1). The participant noted that she did not ask why when requested by senior staff to administer treatment using this equipment. She stated that junior or student nurses did not question the justification for treatment, but accepted that it was necessary. Some doctors, she noted, may only have spoken to a student nurse once they were in the third year of training. She went on to paint a picture of strictly controlled environments, both on a physical and psychological level. Examples of this were the ways in which a student nurse might be permitted (or required) to speak with, what one of the participants termed, the "all powerful matron" during a ward round, although this did not happen at any other times. Psychological control was demonstrated by the use of ritual humiliation of junior staff such as being shouted at by more senior colleagues. Importantly, reference was made to the control exerted over students' off duty time which she referred to as "not having holidays". This retired nurse explained that, "everybody knew their place", stating there was strict acknowledgement of seniority among the nursing staff and students. Junior students were often taught by their senior student counterparts. However, this nurse revealed that students and junior nurses were not entirely powerless in this process and some rebelled against the system.

Participant 4, also a retired nurse, recalled a "pecking order" in which the junior doctors would tease junior nursing students. For this nurse, an old steriliser (see figure 2) evoked memories of student nurses, of whom there were many, cleaning the wards and treatment rooms, rolling bandages, recounting how surgical instruments were boiled in similar appliances. This participant remarked that "you knew your place, and you were happy with that".



Figure 1: Dr Nelson's Inhaler (Authors' own photograph)

Participant 3, who began her working life as a dental nurse, was then employed as a cardiographer before changing to become a health care assistant had a different recollection of hierarchy in the British NHS. She recalled a matron living in a flat at the hospital. The hospital acted as a home as well as a work environment. In one discussion the participant noted that there were demarcations in the dining arrangements for staff. Specifically, the tables reserved for heads of departments had tablecloths, but those for other members of staff did not. It was noted that people ate in separate groups. Participant 1 remarked that medics ate separately, and food was served in order of seniority. When she was not on duty Matron's meals were served in her flat. Even at Christmas time (December 25), a cooked turkey, traditional fare for the patients and staff at this time of the year, would be carved by a senior doctor. In the example given here a pathologist performed this ritual.

Altered Hierarchy

The other two participants in this study, both retired doctors, offered a slightly different perspective on interdisciplinary working practices at this time. Generally the medics appeared to have more positive views concerning the hierarchy that was in place, compared to their subalterns. Participant 2 was a surgeon, whilst participant 5 was an anaesthetist. The surgeon, who during the interview selected old needles and needle holders from the archive, recalled that hierarchy changed over time. The particular equipment, he stated, would have been used, "by my boss, when I was a houseman (junior doctor)". He related hierarchy to the tasks performed by individual types of professionals, remarking that whereas in the early stages of his career it was usually junior doctors who assisted the surgeon, it was latterly nurses who assumed this role. The anaesthetist, who chose the syringe noted that the de facto locus of control often did not lie with the expected professional and sometimes he had needed permission from the theatre sister to carry out certain activities.

Interestingly, during the interviews the surgical instrument steriliser was chosen twice (see figure 2). This might simply reflect the specialisms of the participants, or that this was an item was common to both surgical and medical settings. However, instrument sterilisers were an important part of working life during this period (see for example Newsom & Ridgway, 2014), and that appears to have been the case for two different health care groups of staff in this study, a qualified nurse and a health care support worker. Although not his first choice, a medic also looked at a tall upright sterilising container for surgical instruments and noted the importance of it. Given its role in the hierarchy of the health care settings the medic may not have felt entirely comfortable directly relating to an item that might, for this profession, merely represent a cleaning instrument. Nevertheless, it shows that objects such as this one did connect all three healthcare groups.

Family

A theme which emerged from the data may be explained in part by feelings of nostalgia. Nevertheless, participants either mentioned “family” or alluded to a form of camaraderie within the workplace environment. Participant 1, holding the Dr Nelson’s inhaler (see figure 1) noted her happy memories of being a nursing student, stating that, “this object reminded her of bedpan cleaning, and emphasized the camaraderie that grew from these activities”. Later she remarked that, “fellow students often lent support to each other”. She also recalled Sunday tea on the ward with cup-cakes. The other nurse, participant 4, likened the ward environment to a family where the ward sister was seen as, in her words, “a mother”. She felt people trusted each other, morale was good and although people worked hard there was, as this participant noted, “plenty of job satisfaction”. She continued that people worked in well-established teams for periods of two to three months at a time.



Figure 2: Surgical instrument steriliser and surgical instrument (Authors’ own photograph)

Further, she remarked that initially in her career hospitals were much smaller in size, commenting that such an environment was, “all much more like a family.”

Participant 3 noted this family atmosphere, recalling that there was “a lot of compassion and concern at that time.” She offered the example that, “a consultant put his arms around me” when she had become upset. She further amplified the “family” theme by explaining that, “pre-1960s sisters did not marry, therefore (there were) a number of older sisters on the wards. They would spoil other people’s children and buy them presents.” At Easter time (a holiday period around the months of March or April), “everyone received an Easter egg.” The participant also noted how consultants and their families would visit patients and staff on the wards. A slightly different perspective on this theme was given by the anaesthetist (Participant 5), who remarked how teams would often socialize across disciplines, undertaking a bridge climb in Sydney for example.

Conclusion

In these extracts from the interview data, it is possible to see themes which demonstrate how the perspectives of people delivering health care have altered since the middle of the 20th century. Whilst recognising that no claims can be made regarding representation or generalisability, it is evident that for the participants in this study, working life is remembered as having a greater sense of belonging than appears to be the case in the early 21st century. This is despite working in a more rigid hierarchical setting.

This poses questions for health care providers and for society at large. First, it can be asked whether the picture painted by these recently retired health care workers shows a “true” representation of the changes in “belongingness” as described by Somers (1999, p. 16) as “the need to be, and perception of being involved with others at differing interpersonal levels ... which contributes to one’s sense of connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared about, valued and respected by others), while providing reciprocal acceptance, caring and valuing to others” and identified by Levett-Jones & Lathlean (2008) as being an important factor in student nurses’ experience of clinical practice. Second, did the apparent formal social and professional order of health care in earlier times enable the efficient working of clinical areas? Third, if this is the case, it can be postulated that a diminished formality has led to a lessening of feelings of security (and being cared for) within the health care “family”. If this is so, is it possible that an estrangement within the healthcare family has contributed to some of the poorer aspects of care delivery seen in the UK in recent years? For example, a catalogue of events highlighting a number of problems within a British health care establishment was described in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (The Mid Staffordshire NHS Foundation Trust, 2013). This triggered a range of responses from professions such as the UK General Medical Council who wrote that there should be closer collaboration between themselves and the UK Nursing and Midwifery Council (General Medical Council, 2014). This can be seen as an echo of the plea from the 1960s report.

It might then be proposed that the idea of a health care family (with elements of a secure and comfortable structure) is once again fostered. It is recognised that social connections can lead to improvement in health and wellbeing, which in turn is related to positive social behaviour (Seppala, Rossomando & Doty, 2013). The social construct of the family (in its many forms) represents one of these connections. Families, Moullin (2012) argues, can create an interdependency on each other which produces “inoculations against social problems, or exclusion” (Moullin, 2012, p. 515). Issues which are, it is suggested, present in team work. Given the

interest in Britain through, for instance, the NHS England National Quality Board (NHS England, 2017), the reintroduction of the healthcare family might reignite that sense of togetherness, creating stronger bonds and reducing barriers between the various professions. For example, a less experienced healthcare member of staff may be more at ease discussing an aspect of patient care with those from other professional disciplines if they felt these people were a closer part of their professional, social and cultural identity. Of course such thinking would not be in isolation, but sit alongside existing ideas, such as those proposed by Baxter & Brumfitt (2008) in their discussion concerning overcoming professional differences. Perhaps, then, the ideology of a health care family could offer a powerful addition to this field of work.

This study contributes to understandings of professional roles and working boundaries during the latter part of the 20th century. The two different interviewing techniques applied helped build up a detailed picture of working life during this time, and the use of old medical objects added an extra dimension to the method and findings. By listening to the voices from those who had first-hand experience of interdisciplinary working in the past, the study revealed a number of insights, including the idea of the health care family, albeit in a strongly structured framework. The significance of this work lies not only in its contribution to cultural historical narratives, but also in its ability to broaden our thinking about how we address current challenges within the care sector. Indeed, further work on the idea of the health care family past and present is recommended.

Limitations

The research was limited by its small number of participants, and its qualitative methodology means the findings are not generalizable. Nevertheless, these results may be useful to inform understandings and further studies into the culture of working environments both past and present.

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Corresponding author: Angela Turner-Wilson

Contact email: aturnerwilson@bournemouth.ac.uk