

Research Article

Health-care system and nursing in Sri Lanka: An ethnography study

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Abstract

This article stems from a larger ethnographic study that primarily explored nurses' cancer pain management in Sri Lanka. The findings presented in this article report on two aspects revealed in that study: the Sri Lankan health-care system and nursing. The findings indicate that the Sri Lankan health-care system is under considerable strain. Poor hospital management allows doctors to admit too many patients, resulting in chaotic and overcrowded work environments with unsustainable resources. This then impacts on the role of the nurse. This study highlights the adverse conditions under which nurses in Sri Lanka try to administer care, within a powerless and unchanging professional situation. Although this study extends the level of understanding of the situation for nurses in a government hospital, it also offers directions for policy-makers and international nursing organizations to improve nursing education and governance in Sri Lanka.

Key words

developing country, ethnography, health care, nurse, nursing, Sri Lanka.

INTRODUCTION

The health system of Sri Lanka offers a diversity of services based on indigenous and Western medicine. The health services are delivered through an extensive network of primary-to-tertiary level community centers, hospitals, and dispensaries (Department of Census and Statistics, 2008; Jayasekara & Schultz, 2007). It is acknowledged that the health services offered have helped the country to achieve a relatively high health status despite a relatively low level of annual expenditure (Tan *et al.*, 2008). Within the Sri Lankan health system, nursing has a valued presence caring for patients, preventing illness, and assisting in advancing the health status of the country (Jayasekara & Schultz, 2007).

For many South-East Asian countries, including Nepal, Bangladesh, Thailand, and India, advances have been made in the status of nursing with the establishment of nursing and midwifery councils. The South-East Asian Nursing Council's activities are reported as addressing workforce issues and providing a level of protection for patients from nursing care (World Health Organization, 2002). An effective nursing council has not been established in Sri Lanka despite attempts to do so in 1988 when the *Nursing Council Act*, Number 19, was adopted. This Act only applies to government-sector employees and, currently, nurses and midwives in Sri Lanka are registered under the Medical Council (Jayasekara, 2009).

A Sri Lankan health-care delivery review identified that a considerable shortage of qualified nurses exists in almost all medical institutions in all settings (Abeykoon, 2003). The inadequate recruitment of students into state nursing schools and limited facilities to educate nurses has been promulgated as a factor in the shortage of qualified nurses within the country. Not only is the quantity of nurses an issue, but the quality of care provided by nurses has been alluded to in the literature as problematic (Jayasekara, 2009). For a nurse in Sri Lanka, poor working conditions, an inadequate salary, and limited career prospects have been shown to influence the quality of patient care provided (Jayasekara, 2009).

The education of nurses in Sri Lanka, according to Jayasekara (2009), has experienced minimal efforts to improve standards of nursing care and education. The nurses complete a 3 year General Nursing Diploma under the direction of the Department of Health Services (Department of Health Services, 2003). Currently, there are 11 schools of nursing, with >1000 nurses graduating annually. In 2002, it was estimated that the shortage of nurses in the government sector amounted to 25 000 nurses (Jayasekara, 2009). It is not known if the public perception of job prestige, the nursing working conditions, and the poor salary are factors in the inadequate recruitment of students into nursing schools and the staff shortages in hospitals.

Specialized nurse education after basic training is limited in Sri Lanka (Williams *et al.*, 2001). Access to professional development sessions once nurses are qualified and employed also is rarely available (Hiscock & Kadawatage, 1999). The consequence is that nursing specialization areas have not been developed despite the rapid aging of the population and a shift in the disease burden towards non-

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communicable diseases, including ischemic heart disease, neoplasms, mental health, and accidents (Abeykoon, 2003).

The increase in the rate of patients requiring care for neoplasms can be considered to warrant specialized cancer management education for health practitioners, as cancer pain management has been identified as being poorly managed in both developing and developed countries (Goudas *et al.*, 2005). It is known that many patients with cancer experience pain and a reduced quality of life because of limited pharmacology knowledge and poor patient education (Size *et al.*, 2007). Quality primary health care is acknowledged as playing a major role in achieving the good health indicators that Sri Lanka has managed previously; however, the changing disease burden requires changes to health-care delivery and nurse education.

This article consists of two aspects of an ethnography study that explored the cancer pain management practices of nurses in Sri Lanka: the Sri Lankan health-care system and nursing, which emerged as a major study finding. It is anticipated that additional articles exploring Sri Lankan nurses' cancer pain practices in more depth will be published later.

METHOD

An ethnographic research design was chosen as it enables investigation into the context of nursing in Sri Lanka, as well as identifying the cultural components of practice and understanding the meaning of practice (Bloor, 2001). Ethical approval to conduct the study was granted from the Human Research Ethics Committee, Australian Catholic University and the Ethical Review Committee of Sri Lankan Medical Association. The values and principles of ethical conduct that apply to human research, as set out in the *National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2007), were maintained throughout this study. No ethical issues were encountered that compromised this statement's values and principles.

Sample and setting

Many gatekeepers had to be approached before this study was undertaken: hospital medical and nursing management personnel, supervisors, and charge nurses. Once approval was granted to conduct the study, a written invitation to participate in the study was extended to nurses working in the cancer medical ward in a large general hospital in the capital city of Sri Lanka, Colombo. Eight registered nurses, aged from 33–42 years and who had worked in the selected hospital as a cancer nurse for 3–16 years, volunteered to participate in the study. Two key participants, including a clinic nurse and nurse educator with knowledge and experience in the health-care system, were purposefully recruited into the study as they were able to assist with further explaining gaps in the data.

Data collection

The first author spent >3 months in the field as a non-participant observer to gather the data. Meanwhile, field

notes of what was observed were being written. Semistructured, in-depth interviews were conducted with the 10 research participants. A theme list, generated from a literature review, provided the structure for the interviews that mainly focused on cancer pain management. The themes included what the participants knew about cancer pain, nursing practices to care for patients with cancer pain, and the methods used to assess patients with pain. The interviews were audio-taped and lasted for ~ 1 h. Though the participants used English as a second language, the interviews were conducted in the Sinhala language (Sinhalese), which is the native language of Sri Lanka, as an in-depth understanding about nursing and health-care management was required. The interviews were translated and transcribed by the first author. A diary was written after the interviews and after each observation session in the ward. Thus, reflections on the process and outcomes of the interviews and participant observation events were recorded regularly.

Data analysis

NVivo software for qualitative data analysis (QSR International, Melbourne, Vic., Australia) was used to manage the research data. The analysis commenced during the data-gathering process, with themes emerging from the field notes and gaps in the data being identified. The authors generated ideas through the data, which were then coded. Finally, reflection on the process occurred and new categories were developed and concepts were linked (Richards, 2005).

FINDINGS

The findings of the study that relate to this article include two major core categories: the nurse and the health-care situation in Sri Lanka. The subcategories that were identified influenced the care that patients received by nurses at the hospital and the care provided by nurses within the current health-care system. The findings of the study are presented as narrative description and interpretations of phenomena. The quotations are often grammatically awkward due to translation; however, the meanings are reflective of the situation of nurses and the health-care environment in which they were immersed.

Health-care situation in Sri Lanka

The health-care situation in Sri Lanka identified in this study is one of large numbers of patients requiring care, a lack of resources to provide the care, management influences that create a busy ward environment, and poor infrastructure (Fig. 1). The result is that nurses are caught in the midst of a system that requires them to work hard with no professional recognition of their services.

The hospital and the ward were overcrowded and noisy, with large numbers of patients, bystanders, and health-care workers, including doctors, nurses, and attendant staff workers, in the corridors, ward areas, and outdoor areas. The popularity of the hospital with so many people in its environs



Figure 1. Model of health-care situation.

and the need for the services that the hospital provides was evident. According to the field notes:

Many people are in the ward and most of them are engaged in some work. Nurses, doctors, minor staff persons, bystanders, and the patients can be seen. It looks very busy, as well as being very noisy.

On one day, 94 patients were admitted to the ward despite there being only 58 beds. The number of nurses rostered on duty remained unchanged. Only six nurses were allocated on the day shift to care for the 94 patients. The nurses were expected to care for the patients that were on chairs and even nursed them on the floor. It is a chaotic and demanding environment for nurses to work in. Large patient numbers do not increase the number of nurses and the roster remains the same. Nurses are expected to do overtime to make up minimum nurse workforce numbers. There is no allowance for additional patient numbers. A participant described the situation:

... only 13 nurses, and including our Sister, all are 14 ... for three shifts: it is so difficult. But, we can't do anything. If we want to increase nurses, we have to do more overtime duty. It is also difficult to do too much ... Normally, there are seven nurses in the morning shift, 7.00 a.m. to 1.00 p.m., at least five for evening shift, 1.00 p.m. to 7.00 p.m., and only two for the night shift. But, some days we can't arrange like this ... today, we have only six nurses for morning shift. So, it is very difficult to work like this.

... most of the patients are on [the] floor or on chairs. Only 58 patients are on beds ... Sometimes, our total is over a hundred. However, there are generally 80 or 90 patients in our ward, but few nurses are on duty.

Hospital management allows the uncontrolled patient admission system, resulting in the overcrowded, noisy, ward environment. Most of the patients admitted to the hospital are through referrals from other government hospitals, through the hospital clinics, and through the consultants' private channeling system or their private hospitals. Due to the limited available resources, patients cannot get appointments for scans and radiotherapy treatment. As most of the patients come from all over the country, they stay in the ward till their radiotherapy and scan appointment times. Despite

the overcrowding, the doctors continue to admit patients to the hospital and patients continue to return despite alternative hospitals being available. The reputation of the treatment and facilities available at the hospital influences patient numbers and doctors' referrals. According to the field notes:

There is no control on admissions to the ward. If patients register at one time to this ward under the consultant, they always come and are admitted for planned treatments, emergency, or other related treatments. I saw some patients come to the ward from private consultant referral.

Another management issue of concern to nurses is that of drug ordering and record-keeping. Most of the time, drugs are not issued according to the requested amount. Nurses who manage the supply and administration of drugs at the ward level require doctors' written orders before the pharmacy will supply the drugs. The drugs might be given directly to the patients or could be used to maintain ward stock. However, the pharmacists are often reluctant to issue the requested amounts of drugs. Many drug books have to be maintained, with the counting and ordering of drugs done by nurses manually. It is a time-consuming process:

Actually, there are some difficulties in handling drugs and ordering drugs according to these systems. We have to count all the drugs, order, and balance the books: a lot of work.

The hospital management is strongly influenced by doctors. The shortage of nursing staff and overcrowding in the wards remain unchanged as the hospital admission system supports doctors' needs. The nurses identified problems with the management system, especially ward overcrowding and drug administration processes. However, no change has occurred as the nurse's voice is not heard in the operational management of the hospital.

The nurse in Sri Lanka

The nurse in Sri Lanka carries out many roles including providing care to patients, administering medications ordered by the doctor, coordinating paramedical services, as well as supervising junior nursing and assistant staff members.

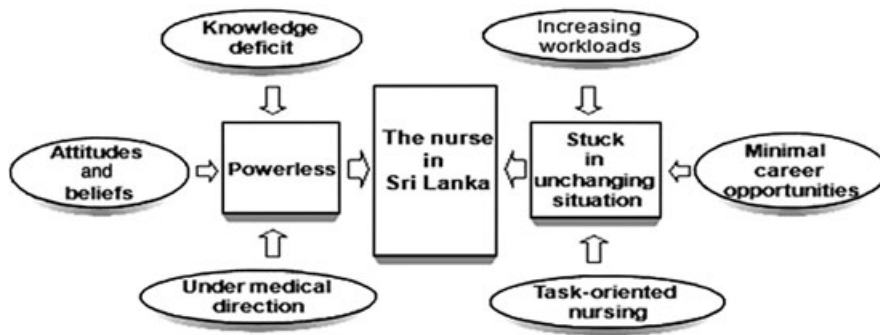


Figure 2. Model of the nurse in Sri Lanka.

A description of the nurse in Sri Lanka presented by one participant is that they are “bulls tied to the cart”. A bull signifies the harsh role of the nurse while the cart is the ward and nursing duties. A bull is a beast of burden that carries out work under the direction of a master. Bulls work constantly ploughing fields and pulling carts throughout Sri Lanka. It is an important part of the lifestyle for village people. For nurses to be portrayed as bulls identifies them with a heavy workload directed by other forces such as hospital administration and medical staff (Fig. 2). The nurse is not able to work independently and is completely task-oriented. The following anecdote describes the tasks that nurses must undertake daily and the perception of the status of nurses in Sri Lanka:

Generally, 85–90 patients are in the ward. But five-to-six nurses are on a shift. So, we have to do all routine works. As an example, if we come to morning shift, we have to make beds, take blood for specimen, and see to some patients' hygiene. Then, we have to check all the charts of patients and mark bowel open or not; what are the special problems such as if chemotherapy patients have vomiting? After that, two nurses bring drugs trolleys for medication. Apart from that, though this ward is oncology medical ward, we have to also attend to some dressings . . . Therefore, we are like “bulls who [are] tied to the cart”. They cannot go their own ways, as we have to fulfill only the routine work in the ward.

Nurses are powerless, not only because of their burden of work but also because of their knowledge deficits and attitudinal beliefs. The participants in the study had completed 3 years of general nursing training in a government nursing training school but had no opportunity to undertake specialized education in oncology, which was the speciality area in which they worked:

Honestly speaking, I haven't any oncology training. We have only our general nursing training. It hasn't also enough oncology nursing. Actually, it is a separate thing. We practice here through our experiences. If we want to know something, we ask our seniors or refer [to] the book. Otherwise, we haven't any proper guidance to this work.

Due to the lack of specialized education, the nurses learned to practice oncology nursing by observing senior

nurses. The nurses then copied the senior nurses' practices. This situation results in nursing practices remaining unchanged. Most of the time, the nurses work under medical direction and do not seek further education. Consequently, the nurses do not have a professional attitude to nursing and consider their work as just employment. The mind-set of the nurses is that they come to the job every day and do extra shifts to obtain more money. The lack of a formal appraisal system after gaining a permanent appointment at a government hospital does not encourage career aspirations and the development of nursing as a valued career. One participant described the attitudinal situation of the nurses:

Some nurses just think this is a job . . . and focus only for money. On the other hand, there is not any assessment or evaluation system for nurses. If they get an appointment, they can continuously work for years and years.

Due to a lack of an effective strategy to control the admission of patients, the workload is always arduous for nurses. Their daily routine tasks consist of procedures such as the administration of medications, injections, and chemotherapy, as well as other patient-related tasks including blood transfusions. Nurses also have to act as coordinators of patient-care requirements including radiotherapy, scans, and biopsies. The impact of a high workload is that the nurses are not available to give psychological support to the patients. Routine nursing tasks are all that the nurses have time to undertake. The working situation is described in these anecdotes that highlight why the nurses have limited time to interact with their patients:

See our ward; there are many patients. Nurses cannot tolerate their workload. Nurses have more workload than they can tolerate.

It is a great effort to find a floor patient to give drugs. Most of the time, ward total is over 70. So, it is very difficult to work. When we start to give drugs, we have to spend at least one hour or one and half hours. Then, we have to give chemotherapy, blood, injections, and antibiotics, and also referrals. We have to send patients for radiotherapy, scans, and biopsies. So, we haven't time to talk with patients.

All senior management positions in the Ministry of Health are held by doctors, including the Secretary. Within

the Ministry of Health, there are three Director of Nursing positions: Director of Medical Services for hospital nursing services, Director of Education for nursing education, and Director of Public Health. They function under the hierarchy of Deputy Director General, which is a position held by doctors. The Hospital Director is also a doctor.

The ward has two permanent consultant doctors and those consultants manage the patients and the ward. The ward consultants influence the workload and the nursing situation. One of the nurse participants believed that medical professionals do not respect other health-related professionals:

... Consultants work their own ways. They try to manage the hospital their own ways and interfere with everything. Our health service is a doctor-dominant one. They don't like to respect other professions. They think they are the dominant people, specialized for different fields.

For the nurses in the study, oppression by doctors over patients' care requirements was problematic. Sri Lankan nurses feel unsupported in their professional role because they are always influenced by medical professionals. Task-oriented nursing occurs because of workload demands, with many tasks to complete in a defined period of time. The nurses must work quickly and efficiently to complete all the tasks. As the nurses have been educated to copy senior nurses' practice, the situation remains unchanged. The maintenance of traditional task-oriented nursing practice continues in such an environment.

DISCUSSION

This was a small study in one hospital in Sri Lanka. The study uncovered information on the situation of nursing and the health-care system at this hospital in Sri Lanka. The limited space of the hospital and the many patients and people in its environment created a chaotic health-care situation for the nurses to work in (Beck, 2000; Williams *et al.*, 2001). Abeykoon (2003) also described the state-sector health services in Sri Lanka as busy and overcrowded.

As the Sri Lankan health-care system, including hospital management, is strongly influenced by doctors (Fernando, 1999), the issues of the shortage of staff (Jayasekara & Schultz, 2007) and overcrowding in the wards remain unchanged. The powerlessness of nurses is evident in their lack of decision-making ability. All decisions are made by medical staff even though the decisions can influence the role of the nurse. Oppression by doctors and a lack of autonomy that is influenced by nurses' knowledge deficits and poor professional nursing attitudes are factors impacting on nurses in Sri Lanka. As has been identified in this study, these factors result in poor-quality nursing care for patients and nurses being identified as "bulls tied to carts". Quality care indicators have been identified as factors in the way forward for health care in Sri Lanka because of the changing technological developments in health care (Abeykoon, 2003).

The nurses in Sri Lanka are stuck in an unchanging situation by medical dominance and minimal acknowledgment of the value of nursing, which results in a high workload,

task-oriented nursing practice, and minimal opportunities for career development. The nurses identified problems with the hospital management system, especially ward overcrowding, a lack of team work, and drug administration processes. However, no significant changes have occurred as the nurse's voice is not heard in the administration of the hospital or at the Ministry of Health.

Nurses are a significant workforce in Sri Lanka, yet this study identified that they have no control over their work situation or opportunity to make changes to their employment conditions. This is a different situation to other South-East Asian countries, where advances have been made to nursing governance with the advent of nursing councils (World Health Organization, 2002).

Nursing education in Sri Lanka remains focused on general nursing, rather than specialization, despite a change in the disease burden of the country. As has been asserted previously, a change in nursing education is required to prepare nurses with assertiveness skills and technical competence to work in the rapidly changing health-care environment (Jayasekara & McCutcheon, 2006). It is through education and a change in the professional governance of nursing in Sri Lanka that advances can be made in the quality of patient care and nurses' satisfaction with their career choice.

CONCLUSION

The health-care system in Sri Lanka is overburdened with patients and a lack of resources. Nursing care for patients is the best that it can be in an adverse situation. As has been recommended by Jayasekara (2009), the nursing profession requires change as it is now under scrutiny because of the advances in medicine and technology. For nursing to advance professionally, separation from medicine is required. An independent nursing council that governs education and practice will assist in the advancement of nursing. Additionally, the quantity and quality of nurse educators need to be addressed so that specialization areas of nursing, such as oncology, can be developed to provide quality care for patients and the advancement of nursing professionally. This study extends the understanding of the situation of Sri Lankan nurses employed in a large government hospital and offers direction for policy-makers and international nursing organizations to improve nursing education and governance in Sri Lanka.

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