ABSTRACT
Several factors contribute to the antagonism between doctors and nurses in the third world countries. These factors include the system of nursing education, which makes nurses subservient to doctors, the position of women in the society, difference in remuneration, emergence of male nurses and the legally supported monopoly over practice granted to the doctors. At the same time, the roles of the two professionals are not or were not clearly defined. The study aims at examining the relationship between doctors and nurses in two large hospitals in Sokoto metropolis. A sample size of 150 individuals was randomly selected from a study population of 610. The sample size consisted of 90 nurses, 50 doctors, and 10 pharmacists for the purpose of comparison. A tested questionnaire was used to collect data from the sample population and data were analysed using percentages and reasons for the responses. Data analysis revealed that 55.3% of the respondents agreed that doctors should lead the health facilities. Some 77.3% of the respondents were of the view that doctors display a dominant attitude over other professionals of the health care system. This was attributed to the duration and nature of their training and legal backing granted to the doctors by the state. Although 51% of the respondents were of the view that the doctors should earn higher than all the professionals, 52% of the nurses were of the view that their role in patient care should earn them wages higher than the doctors. Despite the apathy, 50% of doctors were married to nurses and have stable marriages showing that the conflict was more of professionalism. Identified factors contributing to the conflict include the superiority complex of doctors, the nurses’ quest for professional status and lack of properly defined roles. Suggestions for improving the conflict include careful definition of roles during training, improving the entry qualification for nurses, replacing the schools of nursing with colleges and faculties of nursing within a university system and offering them university degrees, regular workshops and seminars for doctors and nurses where team work is emphasized.

KEYWORDS: Doctors, Nurses, Professional relationship, Power, Antagonism.

INTRODUCTION
Nursing and medicine are inseparably intertwined in hospital care. Patients’ outcomes are contingent upon the physicians’ skills in diagnosis and treatment, as well as upon nurses’ continuous observations and their skills in communicating the right information to the right professional partner (Krogstad et al, 2004). There has been a lot of antagonism between doctors and nurses especially in third world countries (Friedson, 1975). The antagonism is partly due to the fact that the system of nursing education in third world countries makes nurses subservient to doctors. Basic nursing education or training is mainly confined to schools of nursing while in the United States of America, nursing education is obtained from colleges of medicine or health sciences.
The dominant-subservient relationship between doctors and nurses is also rooted in status differentials, the position of women in the society, differences in education and remuneration and the tendency of nursing to be an adjunct to medicine. The Sanskrit Vedas, the earliest Indian literature describes the nurse as “that person (alone is fit to nurse and to attend to the bedside of a patient) who is demeanour, does not speak ill of anybody, is strong and attentive to the requirement of the sick and strictly and indefatigably follows the instructions of the physician” (Calder, 1966). The Victorian ethos of male superiority in the early twentieth century reinforced the nurses’ differential attitudes to the doctors far into the twentieth century. The nurses were mainly females while doctors were mainly males. The nurses then saw doctors as superior because of their gender. Today, the nursing profession has quite a number of male number of males nurses who will stop at nothing to ensure that they are given their due respect and rights.

In the early twentieth century nurses accepted the monopoly of practice by doctors without questioning. This might have been because they were ill-equipped as professional and could not contest their subservient position. In the late sixties and seventies when nurses started getting college degrees, they became increasingly aware of their potentials and therefore the need for recognition as an independent professional body. This quest for autonomy and recognition by nurses has engendered conflicts between the nurses and doctors in the course of performing professional roles. This study aims at establishing the causes of the conflict, examining its nature, and proffering solutions and suggestions that will improve their relationships, to the interest of their patients.

THE PROBLEM
The influx of male nurses discharged after the world war and the male superiority culture of Nigeria, gave the nursing profession a male outlook at inception, but with the establishment of the University College Hospital, Ibadan in 1952, male nurses were excluded from admission into the profession. The minimum entry qualification required was raised from primary six or government class four to full secondary school education.

The revised 1965 curriculum stipulated a training period of three and half years. This was again revised in 1978, reducing the training period to three years, and making the training of nurses’ community oriented. It also expanded the role of nurses to include some functions traditionally performed by doctors, and replaced the more service oriented block system of clinical experience with the planed “clinical experience system”(NCN,2000)

At the end of the training, the registered nurse was started off on salary grade level 07, and after one year, moved to grade level 08, which is the entry point of fresh university graduates. But for a nurse to acquire a university degree, and thus be a university graduate, he or she is required to satisfy the general university requirement for admission, or obtain an additional diploma certificate (JAMB, 2001), which the nurses probably did not possess before qualifying as a nurse.

On the other hand admission to the medical school to read medicine or pharmacy at the 100 level requires a minimum of five credits in physics, chemistry, biology, mathematics and English language. While advanced level passes in chemistry, biology and physics/mathematics are required for direct entry admission (JAMB, 2012).

The duration of training for medicine is six or five years, while pharmacy takes four or three years. At the end of training, the doctors or pharmacists enter the labour force on grade level 08, similar to that of the nurse, one year post graduation. Doctors and nurses are fundamental professionals in the provision of health care. Yet these two professional do not seem to be getting on without conflict. Besides, the advent of the comprehensive and community based nursing care does not seem to have improved the relationship between the two professionals. Therefore the objectives of the study are to:
1. Examine the type of relationship between doctors and nurses.
2. Establish reasons for the existence of such relationship.
3. Identify ways of improving or modifying such relationship for the benefit of the patients.
4. Proffer solutions that would improve the relationships.
CONCEPTUAL FRAMEWORK

Power, according to Max Weber, is the chance of a man or a number of men to realise their own interest in a communal action, even against the resistance of others who are participating in the action. Power is thus an aspect of social relationship. It is not held in isolation by an individual or group but in relation to others. It is simply the degree to which an individual or group can get its own way in a social relationship.

In conflict theory, power is not seen as a resource of society, but rather as something which is exercised to protect the interest of the dominant class. Depending on the social circumstances, it is an instrument of domination, manipulation, of society and exploiting it. The exercise of power creates two unequal groups. The inequality so created engenders antagonism when the reward-cost outcome of the two groups is seen as mutually exclusive, such that each group can improve its outcome only at the expense of the other. The stage for conflict is therefore set. In Marxism, the basis of conflicts is to be found in the social relationship of production. A conflict between differentially located classes in social relations of production spills over to become conflict in all spheres and the social system becomes one of two warring camps.

According to Friedson (1975), “‘the foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in the modern society’”. Most of the medical profession’s strength is based on legally supported monopoly over practice. This authority is granted by the state, as in Nigeria health care system in which the leadership role is conferred on the doctors by legislation. The conferment of such an authority is bound to breed some form of conflict among the various professional groups, especially where roles are not clearly defined.

In the face of conflict between two groups or professions, the dynamics of inter-group relationship comes into play. Each group establishes boundaries for distinguishing between members and non members of the group. Members of the group tend to regard themselves as somehow special, while those of other groups are regarded as less worthy and may even be viewed with hostility. Cooperation with members of the other group, especially if that group is seen as a source of competition or annoyance, can be stifled. Thus conflict becomes a common way of maintaining strong boundaries between groups. This is the situation in the conflict between the nurses and doctors in Nigeria.

Despite the pressure for greater status and influence at the policy making level, the subservience and second class status of nurses has remained. Very few have posed a serious challenge to the status quo. Rather they prefer to engage in ‘games’ described by Stein in Dingwall and McIntosh (1978). These interactional gambits allow nurses to exercise some control and a measure of decision making, while at the same time acceding to the medical doctors’ authority. Thus nobody feels threatened and peace is maintained. Dingwall and McIntosh (1978) posit that the interactional relationship between doctors and nurses is quite intensive, exuding mutual respect and co-operation as long as the rules of these games are not violated.

Traditionally the physician is totally responsible for taking decisions regarding the management of his patient. These decisions are guarded by medical history, medical examination, laboratory results etc. Also important in his decision are recommendation he receives from the nurse. The interaction between the doctor and the nurse through which the recommendation is made is guided by the object of the game. According to Dingwall and McIntosh, the object of the game is as follows:

The nurse is to be bold, have initiative and be responsible for making significant recommendations, while at the same time, she must appear passive. This must be done in such a manner as to make her recommendations appear to be initiated by the physician. (1978:58).

The cardinal rule of the game is that open disagreement between the players must be avoided at all costs. The doctors, in asking for recommendation or the nurses in making recommendations, should not appear to be doing so. This doctor-nurse game fits the none zero sum game, in game theory. Rewards and punishment are shared by each player. The most obvious reward is an efficient doctor-nurse team, which results from a well played game. The physician is able to utilize the nurse as a valuable consultant and gain respect and admiration from the public and the nursing services while the nurse on the other hand gains self esteem, professional satisfaction from her job, and the reputation of being a good nurse. On the other hand a game failure results in the doctor having to be called out several times at night for reasons from resetting of drips to the patient refusing to sleep.
The major disadvantage of the game is its inhibiting effect on the open dialogue which is stifling and anti-intellectual. The game is basically a transactional neurosis and both professions would enhance themselves by taking steps to change the attitude which bred the game (Dingwall and McIntosh 1978). This change becomes more necessary in the face of emergent professionalism and technological advancement in medical circles which makes demands much greater than bedside nursing from the nurses. Technical competence, however superior becomes a dangerous weapon without scientific professional nursing foundation and direction (Roger, M. 1988).

The process of bringing about professional nursing is as important as professional nursing care itself. The process must be gradual, beginning from the drawing up of the curriculum, the admission criteria, the actual course content and the quality of the certificate the nurse receives at the end of the training. If the nurse is not fully equipped to play the professional role demanded of her, then that scientific professional nursing foundation and direction will be lacking and the doctor-nurse conflict situation will be left to rage on as it is today in Nigeria.

METHODOLOGY
The study group comprised the doctors, nurses, and pharmacists at the Usman Danfodiyo Teaching Hospital and the Specialist Hospital Sokoto. Both hospitals are located within the Sokoto metropolis. For the purpose of this study, a doctor is defined as any person who has obtained the MB, BS degree, while a nurse is defined as any person who has passed through a basic nursing education or midwifery training and is registered with the nursing and midwifery council of Nigeria. The pharmacist is defined as a person possessing the B, Pharm degree. At the Usman Danfodiyo University Teaching Hospital Sokoto, there were 70 doctors; 350 nurses and 7 pharmacists. While at the Specialist Hospital, there were 30 doctors, 150 nurses and 3 pharmacists. The opinions of these health professionals were sought in an attempt to establish the nature of the relationship between the doctors and nurses and to discover some of the root causes or contributory factors to this relationship with a view to suggesting how the relationship could be improved. The pharmacists are introduced for the purpose of comparison.

COLLECTION OF DATA
A sample size of 150 was selected from the two hospitals using stratified random sampling. The sample consisted of 90 nurses, 50 doctors and 10 pharmacists. Each member of the group was served a pre-tested self administered questionnaire. The questions on the questionnaire consisted of (i) the open ended questions which allowed the respondent the opportunity of freely expressing their opinions, (ii) the closed or fixed choice questions which required a choice between a number of given answers. In this type, the dichotomous, the multiple choice and the rating scale varieties were utilised. Questions were designed to obtain some demographic data, e.g. Age, sex etc. and the subsequent part of the question was directed at obtaining opinions on issues related to inter-professional relationship among doctors, nurses and pharmacists. Simple statistical analysis was used to analyse the data.

DATA ANALYSIS AND DISCUSSION
The analysis of the responses in the closed ended questions were done using frequency tables while that of the open ended questions were considered alongside the reasons given for the responses. Out of the 150 questionnaire given out, 114 (76%) were returned and analysed.

Table 1: RESPONSES ON WHO SHOULD LEAD IN HEALTH CARE TEAM

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>28 (100%)</td>
<td>00</td>
<td>00</td>
<td>00</td>
<td>28 (100%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>26 (30%)</td>
<td>39 (55.7%)</td>
<td>00</td>
<td>5 (14.3%)</td>
<td>70 (100%)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>03 (60%)</td>
<td>00</td>
<td>2 (40%)</td>
<td>00</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>57 (55.3%)</td>
<td>39 (37.9%)</td>
<td>02 (1.94%)</td>
<td>05 (4.9%)</td>
<td>103</td>
</tr>
</tbody>
</table>

55.3% of all the respondents indicated that the doctors should lead the health team. However, 55.7% of the nurses, majority of them from the specialist hospital were of the view that the nurse should lead the health team. The differing view of nurses from the specialist hospital against that of their colleagues from the teaching hospital, stems from the fact that the specialist hospital retains some relics of the colonial hospitals, where the nurse is seen purely as a helper to the doctor. Whereas in the teaching
hospital seminars are organised to highlight the roles of the various professionals, the professional role of the nurses is recognized. Consequently, most of the nurses from the teaching hospital, armed with the awareness of the roles of the various professionals in the health team were of the view that the doctor should lead the health team. This finding greatly underscores the place of proper orientation through seminars in reducing conflicts and conflict situation in a field where several professionals are involved.

The leadership role of the doctors was attributed to the nature of the doctors’ training in terms of the duration and amount of knowledge acquired during the training and the legislation which confers leadership on the doctors. These ingredients; the nature of the doctors’ training and the legislation backing, create an atmosphere of inequality among the various professionals in the health care system and set the stage for conflict to erupt at the slightest provocation.

Secondly, the legislation power given to doctors indicates the relationship of their profession to the ultimate source of power and authority and presents the foundation on which the analysis of the profession should be based. This power, which the doctors hold becomes an instrument of domination, manipulation and coercion, and enables them maintain their dominance of the health team and consequently engenders conflict and rivalry.

TABLE 2: RESPONSES AS TO WHO HAS A DOMINANT POSITION IN HEALTH MATTERS?

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Who Dominates in Health Matters?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doctors?</td>
<td>Nurses?</td>
</tr>
<tr>
<td>Doctors</td>
<td>36(100%)</td>
<td>00</td>
</tr>
<tr>
<td>Nurses</td>
<td>50(73.5%)</td>
<td>18(26.5%)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>04(66.7%)</td>
<td>02(33.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>85(77.3%)</td>
<td>25(22.7%)</td>
</tr>
</tbody>
</table>

About 77.3% of the respondents agree that the doctors display a dominant attitude in the discharge of their professional duties. This too, was attributed to their training and the legal backing their profession receives from the system.

Each of the groups of professionals in the study, namely doctors, pharmacists and nurses arrogated as much of the hospital duties as possible to their profession, while at the same time attempting to exclude any other rival professional group from sharing in the hospital duties. However, the three professional groups clearly accepted that it is the primary duty of the doctors to admit patients, prescribe drugs for them and request for laboratory investigations. The doctors see these duties as their exclusive preserve, while the nurses think that they should share in all of these duties. The nurses too, think that the pharmacist should not take part in these duties for the reasons that the pharmacists do not come in direct contact with the patients, and are not trained to make diagnosis. The pharmacist as a group, agree that the nurses should share in the aspect of patient admission, and requisition for laboratory investigation, but that they (the nurses) should not share in the area of prescription of drugs because the nurses do not have sufficient knowledge of pharmacology to confer such responsibility on them.

The conflict between the doctors and the nurses could be traced to lack of properly defined roles between the two professionals. The advent of the comprehensive nursing care and the community based nursing, arrogate to the nurse, some of the duties that ordinarily would be performed by the doctor. These non nursing functions prescribed by the nursing curriculum, confers on the nurse the duties of a second doctor at the surgical table and an instructor to the pre-registration doctors and nurses, in certain minor surgical and medical procedures. The similarities in the training of doctors and nurses, the content and depth notwithstanding, and in their overlapping roles in the hospital, breed the feeling of equality between the doctors and the nurses and prepare the stage for professional conflict. The resultant effect is that much energy is expended prosecuting the conflict, to the detriment of the development and advancement of the respective professions.

The respondents in the study agree that the professional relationship between the doctors and nurses is poor, when compared to the professional relationship between the doctors and pharmacists, and between the nurses and pharmacists. The relationship was found to have a reach measure of professional conflicts. The reasons advanced for the conflicts include:

1. The superiority complex of the doctors.
2. Ignorance on the part of nurses as to the limits of their professional duties.
3. Inferiority feeling among the nurses.
4. Power/leadership tussles between the doctors and nurses.
5. The nurses quest for professional status.
6. Lack of properly defined roles.
7. The young age of the graduating doctors which makes them look like minors when compared to the elderly age of the nurses.
8. The fact that some of the nurses saw the doctors through as medical students, makes it difficult for them (the nurses) to be subject to the professional dominance of the doctors.

Friedson’s view on professional dominance is that the medical profession’s strength is based on legally supported monopoly over practice. In an attempt to hold on to this authority and still make the nurse feel that they play an important part in patient care, the doctor and the nurse enter into the doctor-nurse game described by Stein. This game, according to Dingwall and McIntosh (1978), has the disadvantage of stifling open dialogue and being anti intellectual.

**TABLE 3: RESPONSES AS TO WHO SHOULD EARN HIGHER AMONG THE PROFESSIONALS?**

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Who Should Earn Higher Among The Professionals?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>Doctors: 30(100%)</td>
<td>Nurses: 00</td>
</tr>
<tr>
<td>Nurses</td>
<td>Doctors: 24(31%)</td>
<td>Nurses: 53(69%)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>Doctors: 3(60%)</td>
<td>Nurses: 00</td>
</tr>
<tr>
<td>Totals</td>
<td>Doctors: 57(51%)</td>
<td>Nurses: 53(47.3%)</td>
</tr>
</tbody>
</table>

In this study, 51% of the respondents were of the view that the doctors’ take-home pay should be higher than those of the pharmacists and the nurses. The pharmacists were of the view that the doctors’ wages should be minimally higher than theirs, while the remuneration of the pharmacists should be higher than those of the nurses. The pharmacists see themselves and the doctors, as holding university degrees which the nurses do not have. In addition, the pharmacists are the custodians of the vital ingredients with which the doctors effect treatment of their patients. The nurses (69%), do not accept that the doctors should have higher remuneration than themselves. In their view they (nurses) make more prolonged contacts with the patients and as such, of greater value to the patients than the doctors. Therefore they, the nurses should be entitled to greater remuneration than the doctors and the pharmacists.

Consequently, each category of professionals, constitutes a group, demanding one form of allowance or the other to improve its outcome, to the detriment of the other. The dynamics of inter group relationship come into play, each group pursuing goals which will be directly beneficial to its members. Thus while doctors, demand for call duty allowances, the nurses ask for shift duty allowance.

**TABLE 4: MARITAL RELATIONSHIPS WITHIN THE PROFESSIONALS**

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Spouses of Professionals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>Doctors: 00</td>
<td>Nurses: 18(50%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>Doctors: 18(26.9%)</td>
<td>Nurses: 02(03%)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>Doctors: 01(16.7%)</td>
<td>Nurses: 01(16.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>Doctors: 19(17.3%)</td>
<td>Nurses: 21(19.3%)</td>
</tr>
</tbody>
</table>

In this study, 50% of the doctors were married to nurses, while 17% of the pharmacists were married to nurses. They all responded that their marital relationship was quite stable. The implication was that despite the raging professional conflict between the doctors and nurses, their marital relationship remained unaffected. This fact suggests that the conflict between the doctors and nurses appear to be essentially at the professional level.

**SUGGESTIONS**

The short term suggestion towards the improvement of the professional relationship between the doctors and nurses include careful definition of their roles at the training stages. Similarly, regular workshop, seminars, and orientation on inter professional relationship should be organised regularly for the doctors and nurses in particular, and for all the professionals involved in healthcare. This will keep in check some of the causative factors of conflict relationship between...
the professionals. Such definition of roles will ensure recognition of the various professional and harness their knowledge towards better patient management. At the bedside of a paraplegic, the doctor emphasizes the patho-physiology of the condition; the nurse speaks on the nursing care and the probable complication of default, while the pharmacist highlights the drug treatment and the attendant side effect. This provides a team approach to care of patients.

As a long term measure, there is the need for the development of the decision making ability of the nurse beyond its present scope. This can be done by expanding the nursing curriculum, and upgrading the schools of nursing to the status of a degree awarding colleges. Before now, the entry qualification to the school of nursing cannot be compared to that of medical school. This situation created a feeling of superiority in the medical students, over the nursing students. Furthermore, a registered nurse is required to obtain an additional qualification before he or she is granted direct admission to pursue a university degree in nursing, nutrition or sociology. This places the nursing profession at a lower pedestal when compared to the other medical professionals with university degrees.

There is some degree of mutual respect between the doctors and pharmacists; this is attributable to the fact that the admission requirements are similar for the two professions. Students admitted for the two professions receive the same lectures and sit for the same examinations up to a certain point during the course of their training. During this period, some of the students of pharmacy may excel over some of the medical students in some examinations. This attracts some form of mutual respect for each other as students and later, as professionals. This is not the case between nurses and doctors.

CONCLUSION
Given the sharp differences between the medical and nursing professions, conflicts are bound to arise if the two professionals are bought to work closely, without clearly defined roles. The suggestions presented may not completely address the issue of conflict between the doctors and nurses. As long as the duration of training is longer for one than for the other and the legal backing of doctors still in place, conflicts between the two professionals are bound to persist. This is to say that conflict cannot be completely removed in a human society. According to Peil, (1978), “societies are a tissue of conflicts and loyalties.” However the implementation of some of the suggestion presented here will go a long way in improving the professional relationship between doctors and nurses for the benefit of their patients and the society at large.

BIBLIOGRAPHY
Joint admission and Matriculation Brochure (JAMB) 2011/2012.