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TERRITORIAL RIVALRIES IN HUMANITARIAN WORK AND NURSING: CRITICAL EXAMINATION OF PROFESSIONAL IDENTITIES AND DELIVERY OF CARE

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Abstract

This article explores the challenges of professional identities and delivery of care in humanitarian work and nursing practices. Using a twofold methodology comprising a literature review and analysis of two case studies – humanitarian responses to the 2004 tsunami in Sri Lanka and responses to the COVID-19 pandemic in a hospital setting in the USA – the authors highlight how traditional education may fall short in preparing individuals to be compassionate and effective caregivers. This article suggests that drawing on ideas from ancient philosophies beyond the Euro-North American perspective could help to improve learning. By incorporating values like teamwork, joyfulness, openness, and humility, we might create better strategies for training and avoid conflicts within caring professions such as nursing and humanitarianism.

Keywords: care, rivalries, territories, ancient philosophies, nursing, humanitarian, collaboration, transparency, humility

Introduction

Modern societies primarily function on professional identities rooted in knowledge and qualifications, dominated by primary and higher education. In primary education, the focus on exams and performance indicators can lead to children competing with one

another and can limit their opportunities to cultivate compassion, care, and humility. As these children move to higher education, they can have a self-focused mindset, which the curriculum may inadvertently reinforce instead of encouraging reflection on their own attitudes and values. Mainstream education in some contexts can be repetitive when there is an emphasis on memorization and standardized testing, the focus can be on a transfer of information rather than critical examination (Smith, 2000; Illich, 1971) and exerts significant influence over many caring professions, including humanitarian work and nursing (Eisler, 1987). When the identities of individuals are developed through knowledge and qualifications, these individuals become more attached to their professions. In the current marketplace, there is a struggle to maintain these identities and their meaning. The authors hypothesise that Euro-North American influences on educational institutions contribute to the territorialities and rivalries prevalent in nursing and humanitarian settings. This struggle arises as individuals focus more on their own egos than on the collective workplace and society at large. Moreover, their concern for societal perception of power and success can be directly related to their level of self-confidence. Without a true sense of self, the short-term solution to feelings of inadequacy is to reinvent one's identity so that it fits into either the workplace, into society, or both.

Looking past the importance of the individual ego, this article suggests that invented identities can harm individuals, their professions, and societies, and contends that existing education systems, based on knowledge and qualifications, fail to enable individuals to realise their true potential. In this article, the definition of ego can be understood as the individual's attachment to self-importance, which perceive the formation of self as an entity that exists without interconnectedness to other human beings and nature (Radhakrishnan, 1950; Rainey, 2010). With caring professions such as nurses and humanitarian workers in mind, this article investigates how their effectiveness diminishes, particularly in times of uncertainty. By comparing responses to the 2004 tsunami in Sri Lanka and to the COVID-19 pandemic in the US, the authors outline how mainstream education, professional identities, and egos hinder the effective delivery of care in contemporary caring environments. The aim of this article

is to explore ways to cultivate caring professionals who have compassion for themselves and others, partnering to deliver effective care even in times of uncertainty.

Background

This article emerged from discussions between the authors, sparked by experiences of the second author, a novice nurse who worked in hospital settings in the US during the COVID-19 pandemic. As a newcomer to the nursing workforce, she noted the territorial behaviours and rivalries among nursing staff assigned to unfamiliar units in the hospital. These issues echoed similar challenges in the humanitarian sector. The first author, an experienced humanitarian worker and academic, has encountered these divisions and contentions among caring professionals including nurses and humanitarian workers first-hand.

Nursing Context

In theory, caring professionals are expected to exhibit compassion, consideration, and collaboration to provide the best care for individuals and communities they serve. According to Goff (2018), actions such as alienation, intimidation, sabotage, and intellectual disrespect among nurses in hospitals are factors that contribute to intra-professional conflicts and territoriality. According to Vessey et al. (2009) and Stanley et al. (2007) both lateral and vertical violence among nurses can be understood as verbal and nonverbal abusive behaviours that cause psychological pain. Lateral violence occurs between peers at the same power level on the nursing hierarchy, while vertical violence arises between individuals at different power levels on the nursing hierarchy and may be directed downward. Notably, the term horizontal violence is used interchangeably with lateral violence, as it is understood as behaviours of hostility among nurses, such as avoidance or undermining, specifically in the context where there are different power dynamics negatively affecting teamwork (Bloom, 2019). Purpora et al. (2012) stated that horizontal violence and bullying are common and persistent within the global nursing workforce. According to Dellasega (2009),

horizontal violence includes verbal and non-verbal behaviours which this second author observed first-hand as mentioned above.

Humanitarianism Context

In the humanitarian sector, the challenges of territorialities and rivalries are evident in efforts to coordinate the various parties. As far back as 1994, during the response to the Rwandan genocide, the lack of coordination in the humanitarian system has led to the evolution of rivalries within the humanitarian system. Borton (1996) explored this problem and stated that this humanitarian system was

> …far from having a strong capacity at the centre to provide leadership and overall coordination to a system involving not just eight UN agencies, but donor organisation teams, military and civil defence contingents, government agencies and over two hundred NGOs involved in the response during 1994; the centre was weak, poorly resourced and lacking in organisational clarity (Borton, p. 5).

Though time has passed since 1994, the fast paced and top-down system described by Borton has not changed. Humanitarian agencies are competing with one another for funding and other resources, and consequently, may employ humanitarian workers with unethical principles and behaviour (Jayawickrama, 2018). There is a systemic condition for humanitarian workers and organisations to be territorial and become rivals, which will be depicted in the case study of responses to the 2004 tsunami in Sri Lanka.

Eisler and Potter (2014) suggested that humanitarian systems and nursing practices both operate within the dominator model. This model describes a culture in which force and fear maintain rigid understandings of superiority and power within a hierarchical structure (Eisler, 2005). A dominator culture has an authoritarian structure in which high levels of violence and abuse have become normalised (Eisler, 2015). Interestingly, both humanitarian systems and nursing practices function within rigid authoritarian structures with high levels of violence and abuse (Kim et al., 2021).

Methodology

The methodology employed in this article is twofold: a literature review followed by a reflection of each authors' experiences in their respective professional settings. The literature review aims to explore mainstream and ancient literature relevant to the topic at hand. Thus, a narrative literature review was chosen as the most suitable mechanism to summarise the intersection of literature in education, pedagogy, care, and caring. Grounded in a narrative review framework, this article's exploratory approach is directed towards a qualitative interpretation of prior knowledge (Sylvester et al., 2013). The exploratory process aims to summarise existing literature on education, pedagogy, care, and caring without overgeneralising from the reviewed materials (Gregory, 2002). The review synthesises literature to highlight current issues within education, pedagogy, care, and caring (Baumeister & Leary, 1997).

Incorporating learning and reflections from professional experiences, the authors utilised the technique of accidental ethnography. This approach allows authors to examine their past experiences to contribute to scholarly discourse (Levitan et al., 2020). The case studies presented in this article are based on the authors' work experiences in their respective fields. These examples occurred within the social, political, cultural, economic, and environmental contexts of the US (2020) and Sri Lanka (2004–2005). Reflections on these experiences are analysed through the lens of current discourse on education, pedagogy, care, and caring. Specific details of individuals or organisations were excluded from the case study outlines.

Understanding the Problem

It is nearly impossible to define education, due to the diverse traditions and approaches utilized worldwide across various civilizations. Gregory (2002) asserted that education is focused on training minds to make sense of the physical, social, and cultural worlds. Papadopoulos (1998) suggested that the elements of education achieve several purposes, from the standpoint of both products and processes. The current hierarchy

of education, known as modern education, can be understood within these two definitions. However, scholars like Illich (1973), Bush and Saltarelli (2001), Smith (2000), and Eisler (2005) argued that both its repetitive nature and its challenges in transferring knowledge to students are due to a lack of critical thinking, imagination, and creativity within modern education. As a result, any intellectual debate, scientific inquiry, personal development, or responsibility towards society are motivated by financial benefit. Illich (1973) predicted that modern education systems would evoke frustration, hatred, self-indulgence, and greed in humans and consequently, take the joy out of life.

According to Patalay and Fitzsimons (2020), about 7% of UK children have attempted suicide by the age of 17, and according to Megraoui (2021), one UK student dies by suicide every four days. According to Kang et al., (2021), among undergraduate university students in the United States, the widespread occurrence of mental health disorders is high: eating disorders (19% to 48%), compulsive disorders (2% to 12.27%), depression (22%), posttraumatic stress disorder (8%), and sleep disorders (9.4% to 36%). While the cause of these tragedies cannot be clearly determined, there is a concern that schools and universities are not successfully promoting physical, mental, emotional, and spiritual health among their students. Illich (1973) contended that the transformation of learning into institutionalised education took away one's power to define the world with a personal meaning. Based on the arguments of Bush and Saltarelli (2001), Smith (2000), and Freire (1970), modern education systems are permitted to shape and reshape learners until they fit the demands of the market and eventually become motivated by their own profits. This article argues that neither nurses nor humanitarian workers are immune to this reshaping through modern education and training practices.

Lindekens and Jayawickrama (2019) noted that in caring professions such as nursing and humanitarian, measurable outcomes in place to prove efficiency in these fields have become more important than the delivery of care. They further argued that an ideal nurse or humanitarian worker must be compassionate and humble, with an ability to

collaborate with individuals and communities in vulnerable situations. In contemporary nursing and humanitarian approaches, Euro-North American knowledge foundations currently dominate the rest of the world based on scientific reasoning (Bracken et al., 1995). Mlambo (2006) pointed out that this domination goes beyond the nursing and humanitarian fields and has infiltrated modern educational institutions.

According to Tikly (2004), modern forms of education are founded in Western cultures and prepare generations through the cultivation of basic skills, personalities, and attitudes that serve the marketplace. Scholars such as Nandy (1997) and Ngugi wa Thiong'o (1981) had identified this process as colonisation of the mind. Similarly, Summerfield (2013) argued that mainstream education is dominated by Euro-North American thought, which fails to move beyond arrogance to confront the core question at hand: "whose knowledge counts, and who has the power to define the problem?" (p. 2). Summerfield (2013) highlighted another critical issue: not only are the current education system's methods unable to facilitate creative and imaginative human beings, but they also do not prepare individuals to effectively deal with life.

Eisler's (2015) cultural transformation theory advocates for collaborative and equitable partnerships, challenging mainstream approaches, and examines dichotomies such as traditional and modern; eastern and western; urban and rural; and other attitudes, values, and beliefs that are often absent in nursing and humanitarian sectors dominated by Euro-North American ideologies. Kleinman (2012) criticised contemporary science and education, claiming that the promotion of caring and other ethical concepts has succumbed to market pressures, undermining ethical values of nurses, humanitarian workers, individuals, and communities that are in crisis.

According to the Hindu philosophical text *Bhagavad Gita* (Radhakrishnan, 1950), humans are distinct from the rest of the animal kingdom because they make decisions based on what is right versus wrong. However, humans tend to become devoted to their personalities and distressed by conflicting dynamics in the world. The Chinese philosopher and politician Confucius added a practical perspective to this concept

suggesting that to live with less sorrow, we must embrace humanity and humans should overcome greediness and self-interest. Humanity is defined as the opposite of gathering materials and possessions, selfishness, exploits, and profits (Rainey, 2010). The Buddha, in *Dhammapada*, Verse 203, explained that self-indulgence or greediness is the worst among all illnesses, and attachment creates the greatest sorrow, which can be overcome with self-discipline (Radhakrishnan, 1950).

The Indian saint Kabir Das explained that one's own happiness and joy is within themselves and there is no need to search the external world (Jhawar, 2004). In Buddhist teachings, humility and reflections are together so that one can easily recognize their own greed, hatred, and ignorance. Dhammapada, Verse 201 claimed that winning produces hatred and the defeated suffer from sorrow; therefore, giving up victory and defeat create a happy life (Radhakrishnan, 1950). The opposite of humility is to be distracted by status, qualifications, and presentation.

Through education and practice, there is an opportunity to empower individuals to become critical thinkers and challenge what is written in a book or taught by teachers. According to Henning (2002), the Buddha challenged blind faith and said:

> Do not go upon what has been acquired by repeated hearing; nor upon tradition; nor upon rumour; nor upon what is in a scripture; nor upon surmise; nor upon an axiom; nor upon specious reasoning; nor upon a bias towards a notion that has been pondered over; nor upon another's seeming ability; nor upon the consideration, "The monk is our teacher." Kalamas, when you yourselves know: "These things are good; these things are not blameable; these things are praised by the wise; undertaken and observed. And when you know for yourselves that certain things are wholesome and good, then accept them and follow them." (Henning, p. 59-60).

Critical thinking is required to question what one does not understand, nor should one believe without clear understanding. By believing what is presented to us through

various information channels, including educational institutions, we can easily end up arrogant, giving rise to hatred, self-indulgence, and greed. These prevent the humility that is needed in engaging with our families, societies, and the natural world.

Isha Upanishad, a principal Upanishad in the Vedantic tradition of Hindu philosophy, pointed to the problem of knowledge that is acquired without critical examination. The quote, "*Andham tamah pravishanti ye avidyam upasate tato bhuya iv ate tamo ya u vidyayam rataah*," is translated to, "They who worship ignorance enter into darkness, they who worship knowledge enter into greater darkness," (M, 2016, p. 21). While knowledge is useful in certain aspects of life, when assumed knowledge becomes a belief as ultimate truth, it can lead to darkness. According to this Upanishad verse, contemporary society has an abundance of information taking the form of knowledge and people carry this knowledge with the belief that it makes them important. This learned self-importance does not facilitate prosperity in societies nor harmonious relationships between humans and nature.

The worship of knowledge risks stagnation and intolerance to alternative perspectives, perpetuating colonial notions of superiority (Nandy, 1997; Ngugi wa Thiong'o, 1981). Moreover, this prevents the mind from evolving further and leads to a sense of restlessness, followed by aggression and destruction. According to ancient philosophical understandings, the highest level of wisdom is knowing oneself and the most powerful success is conquering oneself.

This literature review provides a contextual lens to understand the root causes influencing the case studies to follow, enabling a thorough analysis of each scenario.

Experiencing the Problem

These case studies provide evidence of a lack of coordination among caregivers and their resulting problematic behaviours. They are drawn from real-life experiences in each author's respective field. Supported by literature, these experiences highlight

systemic failures throughout both sectors and on a global level rather than criticising individuals or institutions. They serve as learning experiences for these two authors and prompt an investigation into preventing rivalries and territorial behaviours in caring professions during times of stress and uncertainty.

Case Study 1: Response to COVID-19 Pandemic in a US Level 1 Trauma Hospital (2020)

During the initial response to the COVID-19 pandemic, every unit within the second author's hospital had shifted to keep COVID-19 patients separate from other patients. Some nurses were recruited to work on COVID-19 units, and others were to follow the patients in their specialty to other unfamiliar units. When multiple specialties are suddenly combined in a single unit, nurses are challenged to take care of patients with diagnoses that they might have no experience with. According to Groff-Paris and Terhaar (2010), when practice environment needs are not met, nurses are less likely to progress towards higher-level functions. Obstacles quickly arose and, instead of overcoming them through teamwork and collaboration, territorial behaviours and rivalries evolved. Nurses caring for patients in unfamiliar specialties did not ask nurses with the expertise to teach and help them care for these patients.

Wilmot and Hocker (2011) defined conflict as a struggle between parties with concerns over scarce resources and perceived incompatible goals. The lack of trust in leadership and in nurses from other units during times of uncertainty can be explained by Johansen's (2012) report identifying how health-care conflicts are rooted in emotions and complicated relationships. Relying on and supporting one another would lighten the load all around, yet it appeared that these were simply not options between these co-workers. Participants in a study conducted by Goff (2018) felt that nursing careers in hospitals fail to meet psychological and professional needs; they blamed the culture of their hospital organisation for perpetuating horizontal violence and bullying.

Another practice used on some COVID-19 units in US hospitals was the team nursing model. There were larger numbers of critically ill patients assigned to one critical care

nurse, with the support of one or two other nurses who did not have critical care experience versus the previous ratio of one to two critically ill patients assigned to one critical care nurse. The critical care nurse was the primary nurse who managed ventilator settings and titrated medications such as sedatives and paralytics. The secondary nurses administered other medications, assisted the primary nurse with positioning and cleaning the patient, and collected blood for lab work. Rivalries and conflicts arose between primary and secondary nurses due to a focus on individual egos rather than on the well-being of the patient, when the primary nurse did not make use of, or even rejected, help from the secondary nurses. Mahon and McPherson (2014) stated that individual power affects whether social behaviours benefit the individual or others. A power imbalance can arise when professionals have overlapping competencies and responsibilities, combined with preconceived notions about their own roles, and most importantly, stereotypes about other disciplines or specialties (Goff, 2018). This was an opportunity for all nurses involved to learn how to collaborate and delegate efficiently. Unfortunately, in a stressful environment, some nurses were hindered by their lack of trust in their co-workers and by their own egos. Roberts (2015) asserted that nurses who experience feelings about limited control and power may exhibit signs of oppression such as horizontal violence and bullying.

Case Study 2: Response to Tsunami in Sri Lanka (2004)

The first author found evidence of similar issues throughout his experiences as a humanitarian worker, especially during the response to the tsunami in Sri Lanka in 2004. Early on, communities in other parts of the country and the Sri Lankan government provided displaced citizens with food, water, shelter, health care, and other needs. Within six weeks, international humanitarian agencies arrived, causing tension and divisions between international agencies and local organisations and communities, specifically due to their differing styles of interventions (Cosgrave, 2007). The influx of funding and resources led to humanitarian agencies competing for space, while lack of information sharing created ineffective humanitarian responses (Walter, 2005). Foreign humanitarian workers and organisations overcrowded the humanitarian response. In a public office in Eastern Sri Lanka, the first author witnessed first-hand a physical fight

between two international organisational leaders for the same land, so that they could build houses for the displaced population.

According to the World Disasters Report (2005), rivalries between humanitarian workers and agencies contesting to spend extraordinary budgets caused duplication in distributing items to affected populations by different agencies. In some fishing villages in Sri Lanka, the non-fishing families received boats. There appeared to be no interest in sharing information or creating effective communication within the international humanitarian community. Jayawickrama (2013) wrote of how the affected populations in Sri Lanka perceived the international humanitarian efforts and how frustrated they were with the foreigners:

> No one within our community requested these international organisations to come and help us. We have been surviving the conflict since the 1980s and disasters since the 1950s. Before 1990, we were helping each other and the few organisations in our area were listening to us. Now, it is different — all these foreigners and their assistant Sri Lankans who come in Land Cruisers with questionnaires only want our information. Then they disappear and a new group comes. I think that if they can't do any good, they shouldn't come. (Jayawickrama, p. 13).

Humanitarian workers are to provide relief and assist the affected populations, yet different parties attempted to become relevant in society and competed to be perceived as most effective.

Examining the Problem

In this analysis, ancient wisdom from Hindu, Buddhist, Taoist, and other philosophies is explored in the context of contemporary issues in education, pedagogy, care, and caring. The analysis outlines key issues identified in the case studies, combined with

the knowledge compiled in the literature review while focusing on caring and the delivery of care, education and pedagogy, and hierarchies and qualifications.

Caring and the Delivery of Care

The consensus of the authors was that, in caregiving – whether it be humanitarian or nursing – the aim is to facilitate wellbeing of the affected individuals and communities. In this process, the value of the patient or affected community should come before the importance or ego of the caregiver. However, experiences in the humanitarian and hospital settings during times of uncertainty have shown that caregivers can become territorial and sometimes bitter rivals.

The delivery of care is founded in understanding and remembering the human condition of facing uncertainty. The human element in caring is often overshadowed by the system in place to deliver care in an industrialised manner. The authors in a previous article (2019) argued that the acknowledgement of uncertainty and danger as a part of caring for someone in crisis allows caregivers to empower those they care for and put the ownership back into their hands. But what happens when the caregiver and the person they are attempting to care for are both in crisis? How does a caregiver function in this capacity? Does this argument change? Further, if a collaborative relationship does not exist, will the caregiver be able to cope with being in crisis at all? In this line of questioning, the authors find an inherent lack of collaboration and an inappropriate power dynamic between caregivers and the individuals or communities they care for. This is a fundamental problem in the delivery of care that must be examined before caregivers can truly move forward in preventing territorialities and rivalries from occurring in a care setting.

In times of uncertainty or danger, individuals may choose to rely on an expert for help. Kleinman (2008) stated that crises are a part of the human experience and ought to be embraced to understand how to make sense of the crisis at hand. This contradicts current practices in which experts diagnose individuals with vulnerabilities and labels to find short-term solutions. The COVID-19 pandemic provides a rare opportunity to

learn from those struggles and create sustainable solutions in caring and the delivery of care. The focus on short-term solutions is driven by a product-oriented system where caring has become a commodity (Collyer & White, 2011). In ancient cultures, the act of helping or caring brought a sense of satisfaction that did not need to be associated with payment or professional impact. Healthcare and humanitarian workers today are, overall, not motivated by this individual satisfaction because of the industrialised and "one size fits all" approach (Pillay, 2019; Roberts, 2015; Kleinman, 2012).

A meaningful caring relationship is established in trust and quality time, which is difficult to achieve within a hyper-specialised and medicalised system. Product-oriented systems value the outcome rather than the experience, which can lead to competition between caregivers. In turn, these issues can cause frustration for both caregivers and the affected persons, even before both are in crisis, such as during the COVID-19 pandemic or the 2004 tsunami. A caring dynamic involving collaboration, compassion, and empowerment between two equal parties is needed especially if there is a crisis, or else, the understanding of crisis and being in crisis renders all parties powerless. This is extremely dangerous and can become detrimental if there is a global crisis. What happens if everyone is powerless? How are individuals supposed to help one another?

Caring is rooted in allowing individuals to re-define their wellbeing in their own terms during unavoidable and unfortunate circumstances (Eisler, 2015). If caregivers can motivate the affected individuals to become active participants in their recovery, these caregivers should be able to motivate themselves to do the same in times of crisis. Authors of this article argue that "the culture of health is established by developing a life that increases human capability to maintain wellbeing" (2019, p. 13). Long-term solutions are facilitated by identifying the underlying cause of an issue and preventing it from recurring. This is a unique opportunity for the caring fields to highlight the issues mentioned in this section, identify the underlying causes, and resolve them before further damage is done.

Education and Pedagogy

The case studies combined with the literature review have provided evidence that, when faced with uncertainty and danger, the natural human response is to hold onto things that one believes they truly know. In modern education systems, confidence is directly associated with level of knowledge (Perkins, 2018). This is a false connection because knowledge is not always a certainty given that the understanding of the world evolves over time. If ego and self-importance are established at such a young age in the process of developing knowledge, the value of humility and collaboration can be minimal. The process of acquiring knowledge may seem precise and logical but devising knowledge may be just a misconception (Bolisani & Bratianu, 2017). The truth is far away and can be distorted by attempts to justify misunderstandings of an individual who is delivering or acquiring knowledge.

Dombrowski et al. (2013) explained that there are three types of knowledge, which are interconnected: experiential knowledge, skills, and knowledge claims. Experiential knowledge is what humans gain from their connection with the environment through their senses and then is processed by the brain. Skills are based on experiential knowledge; however, skills are structured and action-oriented knowledge that is gained by performing a certain action repeatedly. Knowledge claims are what humans assume to know and are transferred through educational institutions such as schools and universities. This transference becomes shared knowledge as individuals learn from one another by passing on and discussing ideas. However, when people base their individual identity on shared knowledge, this can become detrimental as their values align with what they believe others in society want to perceive.

Professional identity can be defined as one's professional self-concept based on their attributes, values, motives, and experiences (Ibarra, 1999). Professional positions are defined as prestigious and provide the position-holder with independence and privilege (Benveniste, 1987). Successful careers are associated with positive professional identity, which is important in modern careers while shifting boundaries in occupational, organisational, national, and global work arrangements (Arthur et al.,

1999). Indeed, both professional identity and modern careers are subject to relational and social influences within and even beyond the individual's present occupation or organisation (Peiperl et al., 2002). Many individuals may be motivated to be perceived by others as having the most knowledge or having done the most work, as their identity and self-confidence may depend on such perceptions.

Education has become institutionalised, and, through that process, knowledge is linked to power and to establishing an individual's ego. In these educational institutions, qualifications and hierarchies are methods of measuring each student's and professional's level of power. At each stage of training or education, there is an imbalance of power, creating a dynamic of expert and novice. The expert can be a teacher or a caring professional such as a nurse or humanitarian worker. The novice is viewed as vulnerable and inferior. In each form of this power dynamic, relying on an expert to solve the novice's problems is involved and creates an imbalance of power.

Hierarchies and Qualifications

According to the European Centre for the Development of Vocational Training (2009), qualifications are a powerful mechanism for improving the match between demand for and provision of education and learning. Further, the European Centre for the Development of Vocational Training (2009) described qualification standards as a result of interactions between the worlds of work (social partners, professional associations, employment services) and education (training providers, teachers, awarding bodies, education ministries). Fundamentally, this shows the value of both knowledge and qualifications to obtain a profession in the marketplace. Qualifications are aimed to achieve, but caring is a lifestyle. The current understanding within the marketplace is that if one has more qualifications, they are more suitable to deliver care. However, there is a risk that the person with more qualifications may believe they are better than someone with less qualifications, giving rise to territorialities and rivalries between caring professionals. Goff (2018) contends that caring settings do not necessarily facilitate actual care in a crisis because professional communities and hierarchies give rise to politics. The current model requires managers and allocated duties per person.

In larger communities, this creates a division of labour as well as disjuncture between the management and caring professionals. The division of labour not only divides management from those who deliver care firsthand but, within a global marketplace, this division easily leaves gaps in understanding between each party (Cassel & Reuben, 2011).

Those who chose to deliver care today have come to view caring as a profession and themselves as professionals who require training to be accepted as qualified individuals. Training and educational programs are established in modern institutions founded on shared knowledge. Collective understanding of identifying one right way to deliver care requires an expert to share this information with those who may not know. The expert and novice power dynamic impacts the ego of everyone. The way that we measure one's level of knowledge and power is through qualifications and hierarchies identified by these educational systems. Transformation of education and its inherent power dynamics is required to improve the delivery of care and prevent another poor response to uncertainty in future crises.

A Proposed Idea

There is a pressing need for an honest and long-term commitment to change the current system and establish collaborative caring processes. Rather than advocating for a linear training course, the authors propose an underlying set of principles applied throughout training programs focusing on understanding the purpose of education in these fields. While theory is important, nursing, and humanitarian work are primarily practice-driven professions. What works for one patient may not work for another; similarly, what works in the US may not be useful in Sri Lanka. Faculty and students at nursing and humanitarian training institutions need to accept that the education portion of the program cannot replace the hands-on practical training that occurs on the job. By understanding that both parts of learning for the delivery of care are equally important and go together, the academic aspect can be transformed to provide a strong foundation for the training and acquiring of skills portion of learning.

Nursing courses at the university level cover material on each part of the body and their disease processes. However, the true understanding of how to manage diseases as a nurse does not occur until one is at work because every hospital has a different set of rules, and each unit takes care of patients with a specific disease process. Similarly, most humanitarian courses at the university level cover the frameworks and systems as well as theories of disasters and conflicts. However, until one starts working in a real-time crisis, it is difficult to understand the social, political, cultural, economic, and environmental dynamics of care. Therefore, the training at work should be the place where the care worker develops their techniques. At this point, if the individual has a foundation rooted in the common purpose of caring for others in a joyful, inclusive, and collaborative method, the techniques that they learn would not overshadow the human being that is providing the care. An essential component of a curriculum focused on caring should be helping individuals recognize the benefits of becoming inclusive and joyful human beings. This can only be facilitated through examining one's own attitudes, values, and worldviews (Jayawickrama, 2007). The benefits are for the greater good of those one is caring for, uniting on a common purpose, not just for individual benefit. This benefit becomes clear when caregivers are empowered by this common purpose and feel fulfilled from within so that they can look beyond their individual ego. Commitment to a common purpose is a long-term process. Professionals need to develop over time to learn about the different competencies in their team and to see the differences as an advantage rather than a problem (Øvretveit, 1993).

Leaders and educators in the caring fields ought to become humane individuals who make compromises on behalf of interprofessional collaboration. This characterizes transformational leadership which lacks the territorial quality of transactional leadership (Bass & Steidlmeier, 1999). Promoting ownership in practice and in oneself decreases interest in external factors such as the perceptions of others or society at large as well as in competing for resources. These values should be transferred to education institutions and hierarchies in health-care systems by re-inventing the role of educators and managers. Starting with leaders who become humane individuals and transform themselves, so they become part of the team, mitigating the power

imbalance. There can be multiple leaders in one team, and team members can be flexible to collaborate. If this transformational leadership can become a new system within the field of education, many so-called experts whose egos are based on their knowledge claims and power will learn to change and adapt into humble individuals.

Another important value that can transcend the education provided to caregivers is transparency. Establishing transparency between specialties will promote trust and respect among collaborators. However, the trust and respect must originate in oneself first (Eisler & Fry, 2019). Transparency can extend beyond each specialty towards the common purpose through frequent communication and continuing to address barriers to collaboration (Eisler, 2005). Through respectful transparency and communication, resilience can be built to help navigate cultural and professional challenges that arise during times of uncertainty. It is important to distinguish this approach from frequent reorganisation, such as the numerous changes to hospital policies during the early phases of the COVID-19 pandemic. Similarly, the global humanitarian system constantly changes due to changing global political and economic interests. This commonly leads to disengagement at the individual level and distracts from the overall collaborative goal. If everyone holds the value of being a collaborative person working to care for and promote the wellbeing of others, the risk of disengagement is decreased. The common purpose and clear aims do not change, and individuals are able to rely on one another for support without the need for territorialism or competition. They can set aside their individual ego and concerns for others' perceptions of their professional skills or knowledge because they have self-confidence and an understanding of their greater purpose to care for others.

Finally, the context of COVID-19 as a recent global disaster must be considered as the precursor to this evaluation of modern education systems. The case studies presented are mechanisms to highlight cracks in the current delivery of care, secondary to the industrialisation of education over time. Moreover, this pandemic has presented a rare opportunity to step back and assess how current systems of health care, humanitarian response, education, and political structures can be transformed. This component of

the proposal reflects the authors' desire to change the understanding of what it means to be in crisis. Currently, being in crisis is synonymous with being powerless, needing help, or being vulnerable. This is problematic on a multitude of levels starting with the power dynamic associated with being in crisis, which teaches the caregiver to have a strong individual ego and to believe they are more powerful than those in crisis as the expert. Secondly, when the whole world is in crisis, technically, no one can be an expert. If everyone is helpless, the only option is for people to work together to rebuild. To put it simply, the COVID-19 pandemic has levelled the playing field between 'helpers' and 'help seekers'.

The values identified in this proposal include transformational leadership, collaboration, joyfulness, transparency, and inclusivity. This article is not intended to reinvent the wheel or be unrealistic about the current expectations of those within the field of education. The goal is to incentivize all parties within the education system to invest in core values and practices and incorporate them into the current curriculum. This is a conversation to highlight shared values that are lacking from the industrialised educational system. If education is improved and expectations are clearly identified, positive effects will spread beyond the classroom and into practice so that new nurses and humanitarian workers do not feel intimidated or experience bullying. The techniques they learn on the job will not change their fundamental goal, which is to care for another human with a joyful and collaborative approach. Finally, changing the definition of the word crisis will fundamentally help us all learn from the past and take this opportunity to prevent mistakes from being repeated in any future crisis. In this, there is a lot to be learned from ancient philosophical traditions beyond the Euro-North American context.

Conclusion

Through a thorough literature review, this article explored the foundations of education and pedagogy, revealing the dominance of Euro-North American values and their influence on these modern systems to conform to the global marketplace by

establishing power dynamics, hierarchies, and qualifications. The consequences of these establishments were elucidated through two case studies, each illuminating the emergence of territorial behaviours and rivalries within the caregiving professions.

The analysis pinpoints critical issues within the current education of caregivers which contribute to a divisive environment that impedes collaboration and detracts from the primary objective of delivering care.

This article proposes a paradigm shift in education, advocating for the incorporation of values such as collaboration, joyfulness, transparency, and humility. By instilling these core principles into the educational curriculum, caregivers can be well-equipped to foster inclusive and harmonious caregiving environments.

In conclusion, by reimagining education to prioritise values that promote unity and compassion, the nursing and humanitarian professions can transcend territorial behaviours and rivalries, thereby fulfilling their fundamental purpose of caring for others with empathy and collaboration.

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