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Safety in Collaboration: Upholding Standards of Care

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The cornerstones of the nursing and medical professions are their codes of ethics, which supply standards of professional conduct and guiding principles. Common to each profession's code of ethics is the underlying philosophy of promoting good and preventing harm to patients, and an understanding of what constitutes right and good in professional relationships. Both focus on the safety and welfare of patients, interests that form the fundamental link between nurse professionals and physicians.

The principal code of ethics for medicine and nursing are the American Medical Association's *Code of Medical Ethics* and the American Nurses Association's *Code of Ethics for Nurses*, respectively [1, 2]. The codes of ethics for nursing and medicine postulate a framework for interprofessional collaboration, described as "interactions of two or more disciplines involving professionals who work together, with intention, mutual respect, and commitments for the sake of a more adequate response to a human problem" [3]. Moreover, the codes of ethics for nursing and medicine suggest that a key component to interprofessional collaboration is effective communication among professionals. "Each health care profession has information the other needs to possess in order to practice successfully. In the interest of safe patient care, neither profession can stand alone, making good collaboration skills essential" [4].

This article will examine the nurse-physician relationship within the context of patient safety and case law. The concepts of communication, collaboration, teamwork, and conflict management will be explored. The legal cases illustrate the intricate nurse-physician relationship and its impact on the provision of care and treatment to patients.

The Nurse-Physician Link

Are there essential characteristics of the relationship between nurses and physicians who care for the same patient? Do nurses and physicians have a responsibility to interact, communicate, and collaborate when caring for the same patient?

In *Petryshyn v. Slotky*, the Appellate Court of Illinois, Fourth District examined, along the "providing-medical-care continuum," the intrinsic nature of nurse-physician interactions as they provide care for the same patient [5]. This case concerned the level of interaction necessary for nurses and physicians on the same surgical team. In *Petryshyn*, a patient alleged that a portion of an intrauterine pressure catheter (IUPC) had been left in the uterine cavity following a cesarean

section. At trial, Petryshyn's expert, a board-certified physician in obstetrics and gynecology, testified that the operating room nurses deviated from the standard of care by failing to remove the IUPC, to inspect all equipment following the C-section, and to communicate to the obstetrician that there was a problem. The court interpreted the expert's testimony as a description of "integrally related obligations within the standard of care" in which professionals rely upon team members to perform specific duties and to communicate with each other to satisfy the standard of care. Subsequently, the obstetrician argued that he was not liable because the nurses violated the standard of care outlined by Petryshyn's expert. After the jury returned a verdict in favor of the obstetrician, the patient appealed, arguing that the court erred in accepting her expert's testimony on the standard of care for nurses [5].

The appellate court found that while the nurse and physician, as surgical team members, have distinct and specialized responsibilities, their work is contemporaneous when caring for the same patient. Further, the court opined that the expert testimony related to the "intrinsically intertwined interaction" between those responsibilities, and thus, Petryshyn's expert was qualified to testify as to the standard of care for nurses on the surgical team. The appellate court denied Petryshyn a new trial [5]. The court's finding emphasizes the value of effective communication and teamwork between nurse professionals and physicians, particularly when caring for patients in high risk settings like the operating room.

Petryshyn is distinguishable from other cases in its emphasis on the integrally related obligations within the standard of care. Cases at the other end of the "providing-medical-care continuum" emphasize the distinct nature of the nursing and medical professions or "schools" in the provision of care rather than the interaction between them [5]. In *Garley v. Columbia LaGrange Memorial Hospital*, a patient died from pulmonary embolism 3 days after multiple abdominal surgeries. Wrongful death allegations were brought against the hospital based on the nursing staff's failure to ambulate the patient in an appropriate and timely manner and to notify the physician of the patient's complaints of pain [6]. Three physicians testified that the nursing staff deviated from the standard of care. Subsequently, a verdict was rendered against the hospital and physician; the hospital appealed. The appellate court held that qualified and competent expert physicians may testify as to the standard of care of a particular school or profession only if they are licensed by that school. In *Garley*, since the plaintiff's expert physicians were not licensed in the field of nursing, they were not competent to establish the standard of care for the nursing staff. The appellate court cautioned against imposing a higher standard of care upon nurses "than society and the law should expect," since inequities could result from doing so [6].

Wingo v. Rockford Memorial Hospital presents a case in the middle of the "providing-medical-care continuum." In *Wingo*, a pregnant patient claimed her water had broken and that amniotic fluid was leaking [7]. The obstetrician's examination did not reveal any leakage; however, the nurse later observed that the patient was losing fluid. The patient was discharged but readmitted within hours for an

emergency delivery. The baby suffered severe brain damage [7]. The court opined that cases in the middle of the “providing-medical-care continuum,” like *Wingo*, involve allegations of negligence for a nurse’s failure to communicate critical information to a physician, rather than failure to carry out a specific nursing procedure [6]. Such failures can adversely impact a physician’s or another team member’s ability to treat the patient effectively, which could lead to harm, medical error, or serious adverse events.

Safe Advocacy

In these decisions, the courts determined that, by failing to take action in the patient’s best interest, these nurses did not uphold the standard of care. That standard can also be violated if nurses advocate for the patient in an unsafe—i.e., uncollaborative—manner. In *Finnerty v. Board of Registered Nursing*, a professional registered nurse’s refusal to comply with a resident physician’s order led to her termination and disciplinary action by the state board of nursing. The resident physician ordered emergency intubation for a patient on a medical floor, but the nurse countermanded the order by unplugging the bed and transporting the patient to the ICU which was located on another floor. The court concluded this action to be unprofessional conduct—incompetence and gross negligence—supported by substantial evidence and upheld the Board’s ruling [8].

The court held that Finnerty’s “extreme departure” from the standard of care would not have been exercised by a competent nurse. The disregard of the resident physician’s order was a display of passive-aggressive behavior—which could also be defined as disruptive behavior [8]. The Joint Commission’s *Sentinel Event Alert 40* addresses intimidating and disruptive behaviors as a catalyst for medical errors and preventable adverse events that anyone on the health care team can commit [9].

The nurse contended that she was acting as the patient’s advocate by taking the patient to the ICU setting for intubation rather than permitting intubation in an environment outside the ICU. The court found, however, that the nurse’s failure to apply ordinary precaution in this situation served as a medium for jeopardizing the patient’s health and well-being [8].

In *Finnerty*, the court deferred to the California Code of Regulations, which stipulates the standards of competent performance. The code requires nurses to act “as the client’s advocate as circumstances require, by initiating actions to improve health care or to change decisions or activities which are against the interests or wishes of the client”[8]. In this case, the patient’s respiratory status and overall medical condition were compromised by actions that had the potential to exacerbate an adverse outcome. The court affirmed the board’s judgment that Finnerty merely substituted her own clinical judgment for that of the resident physician, thus constituting a “failure to provide care or to exercise precaution in a...situation which the nurse knew, or should have known, could have jeopardized the client’s health or life” [8]. In short, the ideal of collaboration was not under cognizant consideration.

The court reasoned that there are circumstances where a nurse's refusal to follow a physician's order is justified and acknowledged a nurse's duty to act as the patient's advocate "by initiating action...to change decisions...which are against the interests of the patient." Of note, there are situations where a nurse's vigilance in questioning a physician order can prevent patient harm—for example, those involving medication errors. Therefore, advocacy in the interest of safety is always warranted. In this case, however, since the nurse did not express at the onset of the incident her concerns regarding the resident physician's ability to competently intubate the patient, her later refusal to follow the order was not justified [8].

The ideal of collaboration necessitates a shared goal of jointly rendering care to maintain the patient's safety and well-being, thereby preventing harm, unlike the actions noted in *Petryshyn* and *Finnerty*. Collaboration requires mutual trust, recognition, and respect among the health care team, shared decision making about patient care, and open dialogue among all parties who have an interest in and a concern for health outcomes [10]. L.R. Bronstein developed a model for interdisciplinary collaboration which includes five aspects of successful teamwork—(1) interdependence, (2) newly created professional activities (collaborative acts and structures), (3) flexibility in traditional roles, (4) collective ownership of goals, and (5) reflection on process [10]. Interdependence is often viewed as difficult for health care teams to achieve, inasmuch as sophisticated negotiation skills are necessary for a balance of autonomy and group effort [10]. Reflective process practice, however, enables members of the team to learn what works and to stay engaged in the midst of conflicting interests. Effective conflict management is vital to teamwork and safe patient outcomes.

Patient safety is the business case for improved communication and interprofessional collaboration between nurse professionals and physicians. Poor communication, unresolved conflicts involving the provision of care and treatment, and passive-aggressive behaviors impede safety and advocacy. These impediments can diminish trust and undermine a culture of organizational safety for all stakeholders. A collaborative work environment is essential for the health care team's optimal performance.

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