

Virtual Mentor
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Virtual Mentor

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FROM THE EDITOR

Job Description: Nurse, 2010

This month's issue of *Virtual Mentor* explores teamwork in health care by examining various aspects of the nurse-physician relationship. With health care becoming ever more complex, and national health system reform on the horizon, efficient and effective teamwork is more important than ever. A common thread in all contributions to this issue is the recognition that teamwork is a pillar of safe, quality patient care and that collaboration with other members of the team is part of a profession's responsibility to patients, and, therefore, an essential element of medical professionalism.

This month's issue might not be so urgently needed if teamwork in medicine were easy to achieve. But a variety of historic, gender- and status-related assumptions and expectations create barriers to physicians' and nurses' working together collaboratively. The three clinical cases presented illustrate some of these sources of tension and how they manifest in the clinical environment.

The first clinical case describes a common result of nurses' being "stuck in the middle" of patient advocacy and medical hierarchy. Ann Hamric, PhD, RN, offers a thorough commentary that examines the shared and distinct perspectives of physicians and nurses that can both contribute to moral distress and relieve workers from it. She also introduces the theme of hierarchies and power gradients that underlies the traditional, and often contemporary, nurse-physician relationship. The clinical pearl picks up on the coronary illness of the patient in this case and discusses the diagnostic and therapeutic benefits of heart catheterizations—with a Shakespearean twist.

The second case presents a medical-business-ethics dilemma: the conflict between a nurse practitioner and a physician hired to supervise her work. The case commentary by Erin L. Bakanas, MD, focuses on the physician-supervisor's primary obligations to the patient and explains why professionalism demands that physicians and nurses make an effort to create the collaborative relationships that are so crucial to effective patient care.

Expanding on the topic of advanced practice nurses' relationships with physicians, and connecting some aspects of teamwork to health care reform, the policy forum contribution from Randy Wexler, MD, MPH, argues that, although nurse practitioners are part of the answer to our primary care shortage, the deficit will be reduced only by the creation of patient-centered medical homes overseen by physician-led medical teams.

To flesh out a nurse's perspective on the many practice and status questions associated with advanced practice nursing, Susan Schrand, MSN, CRNP writes an op-ed essay questioning the need for enforced collaboration between physicians and nurses. She says the mandate is applied to nurse practitioners but not to dietitians, physical therapists, and other medical professionals who practice independently without physician supervision. She argues that such collaboration occurs naturally as part of professionalism and warns that this mandate will hurt nurses more and more as the need for primary care grows and physicians are further outnumbered by advanced practice nurses.

Part of the solution to ineffective teamwork culture is to address it at the administrative and organizational level by introducing a standardized system for giving a voice to nurses, who often feel powerless to advocate for their patients. The third clinical case depicts the clear need for such a system. Commentary by organizational ethicist Becket Gremmels offers a helpful framework for case analysis that focuses on employee rights. Physician Lisa Cannada's commentary describes how physician-nurse drama can cause patient care to recede from focus and outlines types of policies that hospitals might implement to protect medical institutions from the harms of workplace romance.

In this month's medicine and society piece, Beth Ulrich, EdD, RN, discusses gender equality in medical and other professions. She then outlines some gender stereotypes that contribute to physician/nurse conflict but concludes that they are certainly not the sole cause of conflict. She, like many contributors, believes that understanding the knowledge and skills other medical professionals bring to patient care is an essential component of a high standard of professionalism. The op-ed piece by Lisa Rowen, DNSc, RN, also explores the role of gender in the traditional nurse-physician relationship. She goes on to examine the unique relationship between women physicians and women nurses and explain how women's status in both professions has changed as egalitarian organizational structures have become more widespread.

Allison Grady's commentary on Makary et al.'s 2006 article in *The Journal of the American College of Surgeons* highlights the importance of teamwork and the great divergence of perceptions between physicians and nurses on teamwork itself. It brings to the forefront both the fact that teamwork is viewed as a proxy for patient safety and that, currently, there is no standardized or effective tool to achieve many team functioning goals.

In the health law section, physicians and nurses are reminded of their respective codes of ethics. Krishna Lynch, RN, MJ, and Rita F. Morris, RN, MJ, then summarize interesting case law on medical malpractice and liability for physicians and nurses working together, and they establish that effective communication is crucial to successful and litigation-free teamwork.

A principal goal of this issue is to give voice to both nurses' and physicians' perspectives on topics of mutual concern. Physicians and nurses share a core knowledge base and an ultimate commitment to the highest standard of patient care. Yet their many differences, caused by a multitude of factors, generate tension as they share the responsibilities of patient care and ethical advocacy. Understanding each other's knowledge and scopes of practice better will improve both teamwork and communication and provide better experiences for patients and the medical professionals themselves.

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CLINICAL CASE

Moral Distress and Nurse-Physician Relationships

Commentary by Ann B. Hamric, PhD, RN

Gerard was a registered nurse in the intensive care unit (ICU) at a large city hospital. Mrs. Smith was admitted to his unit with chest pain and shortness of breath. At 80, Mrs. Smith had no significant past medical history, apart from mild hypertension and arthritis. Upon admission, she was hypoxic and subsequently received supplemental oxygen. Otherwise her vital signs were stable. On physical exam, Mrs. Smith was noted to have bilateral rales, and the presence of an S3 was noted upon cardiac auscultation. Pertinent laboratory results included cardiac biomarkers (troponin, CK and CK-MB), which were elevated; a portable CXR revealed pulmonary edema; and a 12-Lead ECG demonstrated normal sinus rhythm with T wave inversions noted on the anterior precordial leads. Mrs. Smith was admitted for a non-ST elevation myocardial infarction, and started on standard medical therapy, which included a heparin drip.

Soon after admission, Mrs. Smith's hemodynamic status began to deteriorate. She became hypotensive and had evidence of cardiogenic shock and altered mental state. The physician updated Mrs. Smith and her family on her condition, and, considering her cardiogenic shock, recommended taking her to the cath lab. He argued that, despite her advanced age, Mrs. Smith had no significant underlying comorbidities and had been in good health. He believed that opening a closed artery could make her feel better and would give her the best chance at living the longest. Considering Mrs. Smith's previous health and the promised benefit of catheterization, her three children decided to consent to this invasive procedure.

Shortly after her catheterization, Mrs. Smith went into respiratory distress, and flash pulmonary edema (often a result of acute myocardial infarction) was diagnosed by the attending physician. Mrs. Smith was intubated and sedated, and Gerard became her primary caretaker, making sure her vital signs were good, administering medications, and speaking with her three children about her care.

Mrs. Smith had completed an advance directive several years before, expressing her desire not to be resuscitated or kept alive on a ventilator if she were "in the process of dying." The attending physician was confident that Mrs. Smith would recover, arguing that the intubation was temporary and that she would be extubated when her lung function improved. Consistent with his prediction, Mrs. Smith improved and was extubated the following morning. Gerard had a talk with Mrs. Smith, in which she stated that she felt terrible, thought it was close to her time, and was at peace with what was to come.

Although stable for a short period during which the conversation occurred, Mrs. Smith soon relapsed, her vital signs destabilized, and she was reintubated. That night, she spiked a fever. Antibiotics were started, and the lab cultures revealed *Streptococcus pneumoniae* as the cause of infection. During this time, Mrs. Smith consistently shook her head “no” whenever new drugs were introduced or intravenous lines were inserted. Realizing her discomfort, Gerard asked Mrs. Smith directly if she wanted to continue life-saving measures, and she continued to shake her head “no.” Gerard reported this to the attending physician, who brushed him off, still maintaining her status as a “full code.” The physician was certain she would recover; the antibiotics appeared to be working, he said, and her ejection fraction was steady at 45 percent. The physician believed that Mrs. Smith’s desire to discontinue treatment only reflected her misunderstanding of the situation.

The next day, Mrs. Smith’s children told both Gerard and the attending physician that their mother was clear in her advance directives and that she would not want to be kept alive on a ventilator. Mrs. Smith’s heart measurements were steadily declining, as were her vital signs and consciousness. The physician maintained his hope for her recovery, so the family backed off, trusting his medical judgment.

Gerard was not sure what to do. When a similar situation had occurred the year before, Gerard had called an ethics consult, the result of which ultimately favored the physicians. At that time, the hospital instituted a policy stating that only physicians or family members could call ethics consults. Gerard wanted to voice his concern to the physician again or approach another administrator, but feared getting in trouble with his supervisors for being unprofessional or impeding patient care. He felt that he understood Mrs. Smith’s situation better than anyone, because he had cared for her since her hospitalization and had talked with her during the brief period during which she was off the ventilator. He saw himself as Mrs. Smith’s advocate, and was deeply troubled to see her suffering so greatly and, in his mind, needlessly. Gerard reflected upon how often he ran into situations like this in the ICU, and wondered what he could do about it.

Commentary

Registered nurses and physicians bring both shared and distinct perspectives to the teams within which they practice. Differences in nurses’ and physicians’ perspectives are often brought into sharp relief in end-of-life patient situations. In the case of Mrs. Smith, Gerard believes that his patient has made clear her wishes to discontinue aggressive treatment, having stated them to Gerard and to her children. Gerard has an ethical obligation to advocate for Mrs. Smith; nursing’s *Code of Ethics* requires nurses to take action in situations where they believe patients’ rights or best interests are in jeopardy [1]. Gerard believes that remaining silent when he should speak up about his patient’s desire to refuse treatment compromises his moral obligation and professional integrity as a nurse. This compromise is at the heart of the experience of moral distress, a phenomenon that is receiving increasing attention in the literature as well as in the lay press [2-5]. Moral distress occurs when health

professionals know, or think they know, the ethically correct course of action, but constraints prevent them from carrying out that action [2]. Moral distress has been shown to lead to anger, guilt, self-blame, and withdrawal from patients, resulting in some cases in nurses leaving their positions or the profession [6-7]. It is arguably this latter consequence that is increasing the attention paid to this phenomenon, as the health care system can ill-afford to lose more nurses given the severe and ongoing nursing shortage.

Gerard has been in this situation before and fears repercussions if he continues to press the issue—a fear that is not unfounded. In one study [8], nurses who called for ethics consultation in problematic cases experienced physician anger, strained relationships with other team members, and even threats to their continued employment. In Gerard's case, the institution's new policy allowing only physicians or family members to call ethics consultations sends a clear message that nursing's voice is not valued. But Gerard will also pay a price if he remains silent: the erosion of his moral integrity has harmful consequences for his continued practice. In the study just mentioned [8], nurses who wanted to call ethics consultations but did not do so experienced significantly higher regret than those RNs who did call, and reported damaging moral residue (negative feelings that remain when core values or duties are compromised) that lingered years after the situations occurred. So Gerard is between the proverbial rock and hard place.

But what of the physician? Though little information is provided about his reactions, he may actually be experiencing moral distress, too, as the challenges to his plan for continued aggressive treatment of Mrs. Smith mount. We are beginning to find evidence that physicians as well as other health care professionals experience moral distress. In one study that included attending ICU physicians [9], while overall physician moral distress was significantly less than that of nurses, some physicians had higher moral distress levels than some nurses. The case indicates that the attending physician's judgment that Mrs. Smith will recover from this myocardial infarction is unwavering, even though there is some indication that her clinical situation is deteriorating rather than improving. The clinical facts are important here: ethicists are fond of noting that good ethics begins with good clinical facts. But even apart from this clinical information, it is clear that the attending MD feels the burden of responsibility for ordering a withdrawal of treatment and the attendant possibility that such withdrawal could end Mrs. Smith's life prematurely. He may associate this with a moral obligation to extend Mrs. Smith's life by whatever means possible.

A physician colleague and I [9] have referred to this perspective as the physician's focus on "the survival of the few," in contrast to the nurse's focus on "the suffering of the many." We view this key difference as legitimate—who among us would *not* want our physicians focused on maximizing our meaningful survival and our nurses focused on minimizing our suffering? These differing views, however, give rise to tension. Situations like Mrs. Smith's require explicit discussion among caregivers over the course of a patient's illness. Such discussions, with the mutual respect for differing views that they require, is clearly not occurring in this case: Gerard's

information about the patient's desire to stop treatment is "brushed off," and the physician presses his hopes on the family, leading to their withdrawal of the request to discontinue treatment. These features reveal two critical elements of almost every moral distress case: the presence of a power gradient and system issues that complicate the individual patient situation.

Persistent hierarchies in medical teams lead to power differentials between attending physicians and nurses, as well as between physicians and other members of interdisciplinary teams such as social workers, chaplains, and resident physicians. While there is much discussion of the moral imperative for collaborative teamwork in which all members are partners in the care of their patients, in reality many teams are headed by physicians who believe that decision making is their role and responsibility alone. This is both an historic and present reality; the shift in the nursing profession's expectation that nurses advocate for patients, as opposed to loyally follow the physician's orders, is a relatively recent change [10].

Some physicians, as well as some institutional settings, do not yet expect or accept this advocacy to be part of a nurse's role. The fact that the power gradient is alive and well in the clinical setting of this case is apparent: (1) Gerard did not talk with the attending physician about Mrs. Smith's initial statement that she wanted to die in peace, (2) the physician shows disregard for Gerard, and (3) Gerard hesitates to take further actions due to his fear of "getting in trouble." Had this been a truly collaborative team, Gerard would have brought Mrs. Smith's concerns to the physician when she first voiced them and was competent to discuss her wishes directly with the physician. In fact, Gerard would have been *expected* to raise Mrs. Smith's concerns as important information needed to guide ongoing clinical decision making in Mrs. Smith's case.

The system issues are evident in the hospital's response to similar situations, namely instituting a policy prohibiting nurses from calling ethics consultations. Most institutions allow any clinical staff or family member involved in a patient's care to call an ethics consultation, and there is little if any justification for limiting such access. In fact, preventing nurses and other direct-care professionals from being able to call an ethics consultation is a serious violation of an organization's obligation to promote ethical practice. Gerard has experienced these troubling situations before and they seem to be a regular feature of practice in this ICU. But his institution has not established clear procedures for him to follow in exercising his moral agency in such situations—he "wonders what he can do."

Three patterns of response to ongoing situations of moral distress are described in the literature [11]. The first response is a numbing of moral sensitivity and withdrawal from involvement in ethically challenging situations. Were Gerard to manifest this pattern, he would probably say nothing and withdraw physically or emotionally from Mrs. Smith, perhaps requesting that he no longer be assigned to her. It is difficult to see this as a desirable response. Do physicians really want nurses who are silent

nonparticipants on their teams? Surely patients do not want nurses to abandon their advocacy obligations just to survive in their jobs.

In the second pattern, nurses leave their positions or leave the profession itself. In response to the *New York Times* column on moral distress [5], one nurse noted that she was leaving nursing because the pressures on caring nurses and physicians were unbearable. She said, further, that while she came to nursing because she cared so deeply for her patients, she was leaving because she needed a profession that did not hurt her as a person [12]. There is some real risk here that Gerard may choose to leave his position, or the profession altogether, if these situations continue. In one study [9], 45 percent of ICU nurses at one institution responded that they had left or considered leaving a position because of moral distress; significant percentages are noted in other studies as well. Gerard may be among those nurses who choose to leave this ICU or nursing altogether.

In the third pattern, RNs resort to conscientious objection to advocate for their patients. In one study [13], nurses continued voicing their opinions to physicians, documented their dissent with the treatment plan, called for ethics consultation, or refused to follow physician orders. Given the information provided on this case, Gerard would put himself at some risk by taking any of these actions. An important first step in dealing with moral distress, however, is for nurses to speak up, and for other nurses, managers, administrators, and physicians to recognize and support their concerns. Those nurses most deeply concerned for their patients' welfare are precisely the ones we can't afford to lose.

Ethics consultants familiar with moral distress know that consultation in situations of moral distress is not a matter of analyzing single cases. Recent work [11] describes three levels of intervention needed in cases such as this one: a patient-level intervention to bring team members together for frank discussion; a unit-level intervention to identify changes needed to prevent or minimize such situations in the future; and an organization-level intervention to examine policies or modes of operation that compromise health care professionals' moral integrity. Addressing organizational systems that give rise to repeated instances of moral distress with specific attention to interprofessional collaboration will be necessary to create a climate in which Gerard can fulfill his obligations as a professional nurse without compromising his integrity.

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CLINICAL CASE

Physicians and Advanced Practice Registered Nurses: The Supervisor-Employer Relationship

Commentary by Erin L. Bakanas, MD

Ms. Nolan was a nurse practitioner approved by the board of nursing in her home state as an advanced practice registered nurse (APRN). After 15 years' experience, she decided to team with another local nurse practitioner and establish an independent practitioner clinic. The law in the state where Ms. Nolan practices requires physician supervision of APRN-run clinics. A written collaborative agreement establishing the supervisory relationship must be registered with the state medical board and must contain a plan for addressing the technical requirements of supervision as set forth by the state, including the duration of the collaborative agreement; the roles, duties, and tasks the nurse practitioner can perform; and the medical treatments and prescriptions he or she can provide. APRNs may expand their scope of practice only as delegated and supervised by a physician. Supervision must be continuous but does not necessarily require the physical presence of the supervising physician every time service is rendered to a patient.

Ms. Nolan and her partner hired a physician, Dr. Roberts, who wished to decrease the level of stress in his life as part of his path to retirement a few years away. He was excited to have an administrative role that would still afford great responsibility but was much less demanding than employment as a partner in a bustling family practice. The collaborative agreement signed by the APRNs and Dr. Roberts outlined their new relationship and settled on a yearly salary for the latter's involvement with their practice.

About a month into the job, Dr. Roberts began to recognize differences in the way he and Ms. Nolan practiced. While confident in Ms. Nolan's abilities in matters of routine care, he was concerned about her base of clinical knowledge and diagnostic skills, noting that she often did not consider important possible diagnoses in certain cases. She would ask him to sign off on recommendations for treatment without offering him as much information as he would have liked. When Dr. Roberts voiced this concern, Ms. Nolan responded, "We apparently have differences in our approach to patient care." Dr. Roberts disagreed, and thought that Ms. Nolan was dangerously unaware of the limits to her medical knowledge. Otherwise happy in his job, Dr. Roberts worried that if he repeatedly questioned some of Ms. Nolan's recommendations, she would find another supervisor.

Soon after their first discussion of their practice differences, Ms. Nolan approached Dr. Roberts and requested his approval to expand her scope of practice to include the prescription of controlled substances. The idea seriously worried Dr. Roberts.

Commentary

Dr. Roberts has voluntarily assumed the position of an employee who is also serving as the supervisor of his employer. Such a relationship departs from the usual physician-as-employee dynamic. Physicians certainly have a history as employees, most typically in the context of institutions like HMOs, hospitals, or group affiliations which seek to organize and promote physician services in the clinical setting. What is unique to this case is the employer's dependence on her employee to function in her role. Without the supervising physician, the nurse practitioner is unable to practice. In this example, Dr. Roberts experiences a conflict of interest in his role as supervisor-employee who is receiving financial compensation from his supervisee.

If we look closely at the conflicting interests, Dr. Roberts' choices are clear. In the short description above, it is apparent that the "collaborative" aspect of their agreement is not being honored. "Collaborative practice" has been defined as "an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided" [1]. We are told that Dr. Roberts has confidence in Ms. Nolan's routine skills, but is unconvinced when the scope of her practice broadens to new clinical presentations requiring diagnosis and treatment. It is at this juncture that the knowledge- and skill-sharing of collaboration should occur. Yet such information is not willingly received by Ms. Nolan, and Dr. Roberts' supervision is challenged.

As a physician, Dr. Roberts has accepted a professional commitment to beneficence in patient care [2]. The patient's good is the focus of his professional activity. Any patient encounter, whether it be taking a history, doing a physical exam, or formulating and launching a treatment course must always be motivated by concern for the patient's well-being. This requirement logically extends to the actions of any party Dr. Roberts has agreed to supervise in his professional capacity. If he questions whether the patient's best interest is being served, he must respond immediately on the patient's behalf. He believes that Ms. Nolan is not providing him with the information he needs to supervise effectively; if true, this situation is dangerous. He also worries that the patients are not receiving the highest level of care. Dr. Roberts should pause and evaluate whether their practice arrangement remains tenable.

As a professional, Dr. Roberts has also committed to maintaining a license and practicing in a manner consistent with standard medical practice. He is required to keep up with the medical literature and best practices guidelines and give care in line with evidence-based medicine recommendations. He must be able to demonstrate that he has met these requirements or he is at risk for accusations of substandard

practice and formal legal action against him. Yet here again he is challenged; the practices he supervises may be leaving him vulnerable to malpractice liability.

The relationship between Ms. Nolan and Dr. Roberts comes to a critical point when she requests his approval on the expansion of the scope of her practice to include the prescribing of controlled substances. The authority to prescribe controlled substances is highly regulated by the Department of Justice via the Drug Enforcement Administration (DEA). The reasons for this heightened scrutiny of prescription activity are many. Controlled substances typically have addictive potential and require scrupulous clinical monitoring and adjustment. Misuse of these medications carries ominous risks, including poisoning or death from overdose. Many of these substances are diverted and become the currency of illegal drug transactions. Indeed, there is evidence that a major source of drugs for illegal trafficking is prescription medications [3]. Therefore professionals who prescribe these substances must be registered with the DEA, maintain meticulous records of these prescriptions, and provide adequate documentation of adherence to practice standards. Dr. Roberts' approval for the expansion of his supervisee's scope of practice to include the prescribing of controlled substances would imply that he is confident she will meet the stringent requirements put forth by the DEA. But he is conflicted about her ability to interpret and share information. It would be unwise to sign off on her request given the magnitude of his concern.

A final obligation that Dr. Roberts must fulfill comes from the profession's responsibility for self-regulation. This responsibility carries with it the expectation that a health care professional who believes another professional is impaired and putting the good of patients at risk will make his or her concern known. Dr. Roberts thinks that Ms. Nolan seems "dangerously unaware of the limits to her medical knowledge." Lack of knowledge itself is not the problem. Patient care is inherently uncertain because the focus of the activity is the individual person. Each patient encounter takes in the entirety of the individual, including not only medical diagnoses but also individual preferences, values and goals. It is no surprise that a health care professional feels uncertain about the best approach in a particular clinical situation. Professionalism requires, however, that this uncertainty be addressed by seeking information, whether by consulting the right resource or referring the case to someone with more expertise. If Ms. Nolan is truly unaware of her limitations, she is not meeting the requirements of her practice. Dr. Roberts cannot simply dismiss this as "differences in their approach to patient care," and must consider the next appropriate step in registering his concern.

The case poses the question of whether the physician-supervisor-employee role inevitably creates a conflict of interest, and it is true that a potential financial conflict of interest always exists in this setting. But it is the relationship between this particular MD and APRN that is the real source of conflict. Dr. Roberts must acknowledge that his financial status may be endangered if he asserts his authority, but his professional commitments demand that he not allow concerns for his financial security to compromise his obligations as a physician. The potential

financial conflict of interest in this instance is best managed by the two parties adhering to their professional commitments to patient care. If these two are unable to create a practice environment in which they can collaborate effectively, then they must admit the agreement has failed and dissolve their association.

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CLINICAL CASE

Zero-Tolerance for Hospital Romance?

Commentary by Lisa K. Cannada, MD, and Becket Gremmels

Romantic relationships were common at Healer Hospital, and the administration's lenience was a gesture of trust in the professionalism of its employees. After numerous complaints from patients, staff, and students about distracted patient care and favoritism, along with claims of gender-based discrimination and sexual harassment, the hospital administration met to discuss the possibility of new policy.

"We have received some very disturbing complaints about physicians showing favoritism to certain nurses, or nurses and physicians carrying on tense and destructive interactions following romantic relationships that went sour," the hospital president, Dr. Rhodes, noted. "Such issues corrode collegial relationships and teamwork, and, ultimately, it's the patients who suffer. That's unacceptable if we are committed to putting patient care first, not to mention the morale of our employees and the standard of professionalism that we want to maintain."

Dr. Rhodes suggested a zero-tolerance policy, meaning that no inter-staff dating or romantic relationships of any kind would be allowed among hospital personnel. He proposed penalties for those who violated the policy, including transfer from a department or even dismissal from the hospital.

Others at the meeting argued that such a policy would not stop romantic relationships but would only drive them underground, creating tension between employees forced to conceal their relationships and fellow workers deciding whether to protect them in violation of hospital policy or bring their relationships to the attention of administration. "We will be investigating possible relationships left and right," opponents of the proposed policy said. "It will be a nightmare, and further undermine trust and teamwork among our employees!" They continued, "We will be punishing people for having relationships with each other—relationships that should be none of our business anyway!"

Dr Rhodes responded, "Their bad behavior makes it our business. Driving them underground protects our patients."

Commentary 1

by Lisa K. Cannada, MD

Healer Hospital is considering a zero-tolerance policy for physician-nurse relationships, which will presumably extend to physician-physician relationships and

those between other hospital personnel. The workplace is frequently the site of consensual romantic relationships between adults. Television has gone to extremes in portraying relationships in hospital settings, oftentimes making the romance the central point of primetime “medical” dramas. Trysts occur in ambulances and hospital supply rooms; extramarital affairs are commonplace. Though these dramas exaggerate, they do demonstrate the range of problems that workplace relationships can create. Depending on the people involved and their roles, there may be favoritism in assigning cases or rotations or in promotion and advancement throughout training or employment. When a TV relationship goes sour, patient care is affected, spurned partners seek revenge, and their colleagues choose sides. Patient care becomes a distant second-place interest in such a drama.

It’s easy to understand how strong relationships can develop in hospitals. Staff work together under stressful circumstances and observe each other making decisions and acting in situations that critically affect patient outcomes. Working well together is satisfying, and respect for one another can grow to a friendship and then a romance. But the intense developing stages of a relationship can distract the romantic partners from patient care, and, if the relationship falls apart and becomes hostile, patient care suffers all the more.

So what sorts of ground rules can be put in place that recognize the inevitability of hospital relationships while informing workers of extremes that will invoke disciplinary action? Dr. Rhodes’ proposal doesn’t seem workable: staff members are adults, relationships will form, and a zero-tolerance policy will merely drive them underground. In a 2004 article in *Journal of Medical Practice Management*, attorney Bob Gregg described four types of policies concerning workplace romance [1]:

1. The no-fraternization policy prohibits all romantic advances, overtures, and relationships by anyone in the organization. This model, consistent with Dr. Rhodes’ zero-tolerance policy, seems impractical on many levels. Does such a policy violate personal privacy? As Gregg points out, the First, Fourth, Fifth, and Fourteenth Amendments of the U.S. Constitution provide basis for privacy, free association, and equal protection against government intrusions into personal decisions concerning procreation, marriage, and family relationships. If the policy is so restrictive that constitutional rights are felt to be violated, employees could challenge it. Some courts have upheld an employer’s restrictions on romance as long as the restrictions were reasonable and did not intrude too far into the employee’s relationships with nonemployees. At the hospital level, forcing all relationships to become secret can cause healthy people acting in normal ways to feel immoral and guilty, which is bound to lead to overall weakening of staff morale, certainly not Dr. Rhodes’ intent.
2. A power model prohibits romantic overtures and advances in relationships where there is power asymmetry; that is, relationships in which one person has authority over (or, in some places, is merely at a higher level than) the other person. If it becomes apparent that such a relationship exists, changes

are made to ensure that the two parties are not working where one can affect the performance, rating, or promotion of the other. The power model would be very difficult to employ in the hospital where the structure of roles is so hierarchical. Nurses could have relationships only with other nurses at the same level. The same would be true for residents and attending physicians.

3. The third policy prohibits anyone from being part of a relationship in which one or both parties is married to someone else. Like policies one and two, this is difficult to enforce.
4. The fourth policy permits all consensual relationships, requiring only that the parties notify the organization, so it can confidently verify that the relationship is welcome and consensual. If one person is in a supervisory role, the company would want to assure that no job discrimination took place.

In addition to driving relationships underground, policies 1-3 introduce ethical dilemmas for those who are not in a prohibited relationship but become aware of it. Should co-workers remain loyal to the couple or to the hospital? Does the policy include sanctions for those who knew about the relationship and did not inform the administration? Must the administration investigate every bit of information about a relationship that comes to its attention?

After examining these options, Dr. Rhodes' "zero-tolerance" policy is not one that I agree with. Consensual relationships should be allowed, but written policies against sexual harassment and discrimination must be in place and available to all employees, with methods for reporting and procedures for handling complaints clearly spelled out. Zero-tolerance is not necessary where and when adults understand what they are getting into, have seen the persons they are involved with under conditions of extreme duress, and are attracted to those individuals. Such experiences can be the bases for a stronger relationship, and it is difficult to hide such a relationship, especially when one is overworked and stressed. At the same time, it is important that relationship communication and affectionate displays take place outside the workplace. Particular care must be taken in today's communication-rich work environment. In a 2003 petition of the Board of Commissioners of Arapahoe County, Circuit Court appeal, for example, it was found that 101 romantic and sexually explicit e-mail messages between a county clerk and a girlfriend were public record as they were sent and received on a work computer during work hours [2].

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Commentary 2

by Becket Gremmels

The patient is typically at the center of all that health care does, and a hospital's primary ethical concern is the patient's well-being. The zero-tolerance case, however, perfectly highlights the fact that patient caregivers are also employees.

The issue of workplace relationships is at the intersection between health care and business, and patient care is not the only ethical concern. James Dubois proposes a framework designed specifically for situations in which "a proposed action conflicts with certain legitimate values or prima facie norms." [1]. His framework seems ideal for this case because Dr. Rhodes' proposal conflicts with respect for the autonomy of physicians and employees, clearly a legitimate value.

Dubois' Framework

According to Dubois, proposed actions that clash with a legitimate value can be justified if they meet the following five criteria: (1) Necessity: is it necessary to violate the value in question to achieve the desired goal, or would an alternative achieve the goal without that violation? (2) Effectiveness: will the action actually achieve the desired goal? (3) Proportionality: is the desired goal proportionate to the violated value? Do the positive effects of the action outweigh the negatives of violating the value? (4) Least infringement: Is this the least-infringing option? Is something done to minimize the violation? (5) Proper process: is the decision a result of an appropriate process? [1] This framework is not an algorithm; legitimate disagreements can and will exist over the answers to each of the five points. What one person believes to be necessary or proportionate, another might not. This framework offers neither infallibility nor certainty, but an approach to delving deeper into the complex moral issues of a difficult case.

Analyzing Dr. Rhodes' Proposal

Before applying these criteria, the desired goal of the zero-tolerance policy must be established. The immediate goal is the prohibition of dating in the workplace, but it seems overly simplistic to call this the "desired goal." After all, Dr. Rhodes only desires such a prohibition because he believes it will reduce or eliminate some harmful effects these relationships have on the work environment, harmful effects that include distraction from patient care, favoritism toward certain employees, the "tense and destructive" relationships that develop after breakups, claims of gender-based discrimination, and sexual harassment. Thus, it can be assumed that the policy's desired goal is to avoid these five harms, inasmuch as they result from romantic relationships between physicians or staff.

Now let's apply Dubois' criteria. First, is the zero-tolerance policy necessary to achieve this goal? To answer this, one must determine if alternatives exist and then argue that at least one would achieve that goal without violating the autonomy of the physicians and staff at Healer Hospital. Interstaff dating is frequent in the business world—according to one article, 58 percent of workers have dated a co-worker, 14

percent have dated a superior, and 19 percent have dated a subordinate [2]. Thus, it seems reasonable to look to businesses for alternative approaches. A poll of 40 insurance companies in the Fortune 500 found that 21 had a policy restricting employees' freedom to date [3]. These companies take various approaches to the topic. Among these policies, alternatives to Dr. Rhodes' suggestion include (1) prohibiting fraternization only between superiors and subordinates; (2) prohibiting dating only if it would result in a conflict of interest because one employee has responsibility for something that affects the other; and (3) consensual-relationship contracts in which the dating parties declare that the relationship is consensual, agree to review the company's policy on sexual harassment, and agree to transfer departments if necessary [4]. This last provision protects the company from a future sexual harassment suit, might protect against distracted patient care, and could reduce the likelihood that the employees would interact after a break-up. These alternatives, the third of which avoids violating employee autonomy, should be discussed in addition to Dr. Rhodes' zero-tolerance proposal.

The second criterion is effectiveness. Will the zero-tolerance policy effectively reduce or eliminate these five harms? It is not possible to answer this question definitively until the policy is applied, since the answer depends on empirical evidence. Effectively prohibiting private behavior between two consenting adults is always difficult. Several members at the Healer Hospital meeting even doubt their ability to implement the policy, arguing that it "will only drive [the relationships] underground." Moreover, many relationships begin with romantic attractions or crushes, and the harms Dr. Rhodes wishes to circumvent could arise from one person's attraction for another in the absence of any response on the part of the other person. Attempting to monitor mere attraction would be ludicrous. Even though a definitive answer cannot be given here, Dr. Rhodes bears the burden of proving that the zero-tolerance policy could or would be effective in reducing harmful effects of attraction and romance.

Next, is the zero-tolerance policy proportionate to the harms caused by relationships? This is arguably the most controversial of the five criteria because judgments of proportionality are subjective [5]. Certainly there are many advantages to improving attention to patient care, fostering a collegial atmosphere, and reducing bases for claims of favoritism, sexual harassment, and discrimination. But do these advantages outweigh infringement of employee autonomy outside the workplace? If one views this case primarily as a *clinical* ethics case, the benefits will likely outweigh the harms because the patient is of primary concern in the clinical realm. (Even in this framing of the situation, though, there are legal limits to the infringement of employee autonomy in the name of patient safety. A recent example is the injunction by a New York judge overturning the mandate that health care workers receive influenza vaccinations [6]). On the other hand, if one sees this primarily as a *business* ethics question, the harm might outweigh the good; the employee, employer, or customer might come first depending on the scenario [7]. Given that this case is at the crossroads between health care and business, there is not a definitive answer to this question of proportionality. Yet the burden of proof again

seems to fall on Dr. Rhodes. He must show that the benefits of the policy are proportionate to such a significant infringement of employee autonomy.

Moving to criterion four, is the zero-tolerance policy the least-infringing option? The alternative policies mentioned above—allowing dating except between superiors and subordinates and in cases where it would cause conflict of interest—infringe less on the employees' autonomy than the zero-tolerance policy. Adopting any of these alternatives would minimize the violation of the employees' autonomy. What we cannot know is the degree to which each alternative will accomplish Dr. Rhodes' goals. But we cannot know whether the zero-tolerance policy will either.

Lastly, is the zero-tolerance policy the result of a proper process? In general, a proper process is one in which decisions are made by the appropriate authority and involve the relevant stakeholders. For public health decisions, a proper process would involve public justification, explanation, and transparency [8]. In human subjects research it would involve approval by an IRB and the informed consent of the research participants [9]. In this case, a unilateral decision by Dr. Rhodes would not constitute a proper process because supervision of employees is under the purview of multiple sections of the hospital administration. The human resources department should have some input into the decision as it relates to staff behavior. Dr. Rhodes might also need the approval of the medical executive committee or a similar body that governs the medical staff. If Healer Hospital employs or contracts with most of its physicians, he might be able to enact this policy contractually. Yet even that involves contract negotiation, not a unilateral decision. At the very least it would likely require the approval of other hospital administrators. Without more knowledge of the administrative structure at Healer Hospital, a definitive determination of the proper process is not possible. Regardless of the structure, a unilateral decision does not seem to constitute a proper process for an issue of such magnitude.

Conclusion

Healer Hospital has experienced serious problems as a result of its permissive policy toward relationships between physicians and other employees. The above analysis, however, shows that there are alternatives to swinging the pendulum all the way in the opposite direction. Dr. Rhodes' zero-tolerance policy does not meet the criteria of necessity or least infringement, and, although it could result from a proper process, it does not appear to do so at the moment. While we cannot decisively determine here if it would be effective or proportionate, due to the severity of infringement in question, it is up to Dr. Rhodes to show that his policy meets these criteria. Given these factors, Dr. Rhodes should pursue a third option, like consensual-relationship contracts. This would help avoid some of the harms associated with these relationships and minimize infringement on employee autonomy. Ultimately he should pursue an option that lies somewhere between the extremes of zero-tolerance and total permissiveness.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

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THE CODE SAYS

AMA Code of Medical Ethics Opinion on Nurses

Opinion 3.02 - Nurses

The primary bond between the practices of medicine and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to hear the nurse's concern and explain those orders to the nurse involved. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies, when prompt action is necessary and the physician is not immediately available, a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations. Report updated June 1994.

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Journal Discussion

Perceptions of Teamwork in the OR: Roles and Expectations

Allison L. Grady

Makary MA, Sexton JB, Freischlag JA, et al. Operating room teamwork among physicians and nurses: teamwork in the eye of the beholder. *J Am Coll Surg.* 2006;202(5):746-752.

Teamwork—the word brings to mind motivational speeches, great sports teams, and corporate slogans. In fact, the word has almost become a cliché—overused, unoriginal, and diluted in meaning. But in the field of medicine, as Makary and colleagues note in “Operating Room Teamwork among Physicians and Nurses: Teamwork in the Eye of the Beholder,” teamwork is not just a buzzword or fuzzy concept [1]. Rather, it “is an integral component of a culture...and, accordingly, is an important surrogate of patient safety” [2]. Makary et al. focus specifically on the operating room (OR), providing pointed insight into an environment that requires many players to be involved in a single high-stakes procedure.

The operating room has long been known to be hierarchical. Led by a physician-surgeon, anesthesiologists (also MDs), nurses, certified nurse-anesthetists, and surgical technicians all play important roles in successful surgery on an unconscious patient. Due to the high professional-to-patient ratio, the importance of maintaining a sterile field, and the need to complete the surgery in a timely fashion, leadership, direction, and communication are all vital to a well-run OR. Traditionally, the physician-surgeon has given orders and dictated the pace, an approach that has not always proved to be ideal. In 1998, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) identified “breakdowns in communication as the leading root cause of wrong-site operations, and other sentinel events” [2]. To help correct this problem, JCAHO and the Institute of Medicine recommended that hospitals “promote effective team functioning” and “measure culture” [2]. No specific tool has been designed to achieve these goals in the OR.

Makary and colleagues set out “to measure teamwork in the surgical setting...to compare ratings of teamwork within and between OR caregivers” [3]. Using the Intensive Care Unit Management Attitude Questionnaire as a template, the authors created the Safety Attitudes Questionnaire. Particularly interested in the ratings that OR staff members gave each other, the authors asked responders to describe on a scale of 1 (very low) to 5 (very high) the quality of communication and collaboration they had experienced with surgeons, anesthesiologists, surgical technicians, certified registered nurse anesthetists and OR nurses [3]. The survey was sent to all OR staff of Catholic health systems in 16 states (for a total of 60 hospitals) and had a response

rate of 71 percent, with 79 percent of nurses returning the completed survey, and 67 percent of certified nurse anesthetists participating. The other disciplines fell between these two percentages.

The survey results showed a major difference between physicians' and nonphysicians' perception of teamwork. Makary et al. found that, while physicians rated their disciplines the highest for teamwork, they were given the lowest ratings by their colleagues. OR nurses were awarded the highest marks for teamwork by others. OR nurses gave teamwork with surgeons an average 3.53, while surgeons rated OR nurses at an average 4.42 [4]. The authors also found that each discipline perceived its members as effective team workers and that the majority of physician-surgeons believed that "everyone in the OR is doing a good job in terms of teamwork" [4].

The most striking finding from this study was how differently nurses and doctors viewed communication and teamwork. The authors suggest that this could be part of a long-standing discrepancy between nurses and physicians with regard to "status, authority, gender, training, and patient-care responsibilities" [4]. They also astutely point out that the disconnect between the professions may have less to do with these historical problems and more to do with the fact that they have different definitions of teamwork. In the discussion portion of the survey, "nurses often describe good collaboration as having their input respected, and physicians often describe good collaboration as having nurses who anticipate their needs and follow instructions" [4]. These differences are significant, because if nurses do not believe that physicians value their input, and if physicians expect nurses to be focused on the surgeon, then the likelihood is slim that nurses will speak up when they sense something going wrong with the patient. This hesitancy to voice concerns or confront a surgeon—for whatever reason—leads to greater career dissatisfaction, compromised patient safety, and poorer patient outcomes.

This study, while interesting, was also limited. The authors acknowledge that "perceptions of communication can vary over time and can be influenced by acute events within the OR" [5]. This variable is, to me, the most significant and has the greatest chance for affecting opinions. Another limitation the authors point out is that these responses to the survey are possibly "tainted." In other words, many hospitals have already initiated patient-safety measures that may have had an effect on the way staff and caregivers described effective communication [6].

Overall, I think that the authors have identified an important aspect of the culture of the OR—communication—and have demonstrated how that culture can adversely affect patient outcomes and safety and lead to higher levels of professional dissatisfaction among OR staff. I would be interested in a study that took this research to the next level by suggesting ways to change the culture of the OR. The authors do discuss a program at Johns Hopkins in which pre- and post-surgery conferences bring caregivers together beforehand to discuss the expectations and goals of the surgery and, following the procedure, to debrief and share impressions

of the case. I believe that this could be helpful, but the climate of each OR is different, and I would be interested in seeing the outcomes of various approaches measured.

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CLINICAL PEARL

To Cath, or Not to Cath?

Michael Bui, MD, and Meghan Tinning

Few phrases in the English language are so readily recognized as Hamlet's reflection on existence: "To be, or not to be: that is the question ... To die, to sleep—/No more—and by a sleep to say we end / The heartache and the thousand natural shocks / That flesh is heir to." Shakespeare's oft-quoted soliloquy owes its timelessness in part to a questioning of the worth of existence in the face of personal calamity. Hamlet raises perennial and universal questions about life, death, and quality of life. In the realm of medicine these questions have both personal and professional implications. The medical field's many advances over the past few decades have made it possible to improve both length and quality of life, and, as a result, medicine can mitigate suffering and perplexity in times of crisis. The exciting field of cardiology provides a prime example of the promise and peril of medical technology. To that end, we turn to coronary angiograms and the complexities of heart catheterization.

A coronary angiogram (also called a heart catheterization or simply a "cath") is a diagnostic imaging procedure. A patient's artery—usually the femoral artery—is cannulated and a sheath is placed at the entry site. Next, diagnostic catheters are placed over a guide wire into the ostium of the major coronary arteries. Utilizing fluoroscopy, contrast dye is then administered through the catheters, and the epicardial coronary arteries are visualized. Typically, once the images are obtained, one of three scenarios occurs: (1) there are no major blockages to explain the patient's symptoms or condition, and the procedure is completed; (2) there are a few blockages that are amenable to mechanical revascularization with either a balloon angioplasty or a stent; or (3) there are either too many blockages, or blockages that are critical (e.g., left main disease, three vessel disease in a diabetic patient) and the patient would benefit most from coronary bypass surgery.

Indications for Coronary Angiography

In general, indications for coronary angiography include angina, heart failure, myocardial infarction, and the need to delineate coronary anatomy for prognostic information. The treatment of coronary blockages can involve three different modalities with varying degrees of invasiveness: (1) medical therapy with medicines such as aspirin, beta-blockers, statins, ace inhibitors, and nitrates, (2) percutaneous coronary intervention (PCI) with stents or balloons, and (3) surgical revascularization with coronary bypass. Medical therapy can be used alone, or in combination with either PCI or surgical bypass.

In patients with angina (chest pain with negative cardiac biomarkers), stents offer no greater mortality benefit or reduction in future risk of heart attack than medical therapy [1]. In this scenario, stents do the same thing as medical therapy: alleviate symptoms. A meta-analysis of several studies comparing angioplasty to medicine, however, suggests that angioplasty may be better at improving symptoms when compared to medicines alone [2].

In the setting of a non-ST elevation myocardial infarction, there are generally two approaches: (1) early invasive approach—that is, performing a coronary angiogram within 48 hours—or (2) a conservative approach that involves treating the patient with medical management.

Some studies, such as the TIMI 3B and the VANQUISH trials, favor the conservative approach with medical therapy [3, 4]. More recent trials, however, such as FRISC II, TACTICS-TIMI 18, RITA III, and ISAR-COOL, demonstrated the benefits of an invasive approach [5-8]. To aid clinicians in decision making grounded in evidence-based medicine, the American College of Cardiology and American Heart Association released guidelines that support performing a coronary angiography on patients who have an acute myocardial infarction, ECG changes suggesting ischemia (new ST depression), continuing symptoms of ongoing chest pain, heart failure, or evidence of hemodynamic or electrical instability (e.g. ventricular tachyarrhythmias) [9].

Lastly, there is the patient with an ST elevation myocardial infarction, a potentially life-threatening condition in which a coronary artery is completely occluded. The current standard of care is to open the artery as soon as possible, either by using medicines with fibrinolytics or with mechanical revascularization provided by coronary angiography. Several studies have demonstrated a mortality benefit with the utilization of mechanical reperfusion in this particular form of myocardial infarction [10].

Risks of Coronary Angiography

As technologically dazzling as coronary angiograms can be, it is crucial to recognize the risks inherent in the procedure. These risks include, but are not limited to, pain and discomfort, bleeding, infection, life-threatening arrhythmias, renal failure, perforation or dissection of a vessel or of the heart itself, stroke, heart attack, and death. Given the serious nature of the potential complications, one must carefully weigh these risks against the potential benefit of a coronary angiogram for each particular patient. For some, the potential benefit of relieving angina or of mechanically restoring blood flow in the setting of a major heart attack outweighs the risks. In other patients, underlying serious conditions, such as chronic kidney disease, brain tumors, or malignancy may significantly increase the risks of the procedure. Furthermore, placement of stents requires dual antiplatelet therapy with aspirin and a thienopyridine, and this requirement must be factored into the decision-making process for patients who may not be able to take anticoagulants due to underlying conditions.

Thus the decision to take a patient to the cath lab can be a confusing one. To add to the complexity, one must acknowledge that practice styles vary from conservative to more aggressive among cardiologists, institutions, and regions throughout the United States. Furthermore, the magnitude of the decision can frighten and overwhelm the patient and his or her family. Therefore, I advocate two principles: communication and education. Patients should fully understand the potential benefits they may realize from the procedure and must also be made aware of the risk of an adverse event. Doctors must clarify expectations of what the procedure will accomplish.

It is not overstating the case to say that clinicians should, like Hamlet, contemplate the quality of existence, as well as existence itself, for each patient. They must then individualize the decision “to cath, or not to cath” to each patient, weigh the potential benefits of coronary angiography against the risks for that specific patient, and communicate these factors to the patient and to the rest of the medical staff and support team. When used appropriately, coronary angiography has the power to be a potent diagnostic and therapeutic tool.

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HEALTH LAW

Safety in Collaboration: Upholding Standards of Care

Krishna Lynch, RN, MJ, CPHRM, Rita F. Morris, RN, MJ

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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POLICY FORUM

The Primary Care Shortage, Nurse Practitioners, and the Patient-Centered Medical Home

Randy Wexler, MD, MPH

The issue of how to address the acknowledged shortage of primary care physicians is at the center of many health policy questions. One question that has been discussed with increasing frequency is whether nurse practitioners are the solution. In my judgment, nurse practitioners are a part of the answer, but not the whole answer, as some have suggested.

Primary care serves four important functions in the delivery of health care: (1) first contact access for each new medical need, (2) long-term, person-focused (not disease-focused) care, (3) comprehensive care for the majority of a person's health related needs, and (4) coordination of care when it must be sought elsewhere [1]. Primary care physicians are the only medical professionals who provide patient-centered, integrated, accessible health care that addresses the large majority of patients' needs in the context of a sustained partnership with the patient and the community [2]. Such comprehensive and coordinated care yields improvement in health-related outcomes at reduced expense [3]. Primary care physicians account for 52 percent of annual office visits made to physicians, although they comprise only 35 percent of the physician work force [4, 5].

Starfield et al. have demonstrated that primary care services—whether measured in terms of primary care physician supply, source of primary care delivery, or the components of primary care that are utilized—reduce morbidity and mortality [3]. Furthermore, they found that primary care is more often associated with more equitable distribution of health resources than specialty care and with improved outcomes at reduced cost.

The contributions of primary care to improvements in many aspects of population and individual health are well documented. In addition to the health benefits, there are reductions in health system costs and in disparities in health across population subgroups. These findings are robust over time and across areas and health systems. International comparisons show that countries with health systems based on strong primary care have better health at lower costs [3].

Being under the care of a primary care physician is associated with improved health outcomes in cancer, heart disease, stroke, infant mortality, low birth weight, and life expectancy [4]. To quantify this relationship, an increase of one primary care physician per 10,000 population is associated with an average mortality reduction of

5.3 percent as well as a reduction in cost [4, 6]. Patients who have a personal primary care physician (rather than a specialist as a personal physician) have 33 percent lower health costs and a 19 percent lower mortality rate, even when results are adjusted for age, sex, ethnicity, insurance status, reported diagnoses, and smoking status [7]. Finally, when evaluating Medicare data, Baicker and Chandra found that states with more primary care physicians per capita had lower per capita cost and higher quality care [6]. The opposite was seen in states with more specialists per capita.

Policy discussions about ways to increase the primary care physician workforce have considered utilizing nurse practitioners to address the shortage of primary care physicians. Nurse practitioners are part of the answer, but they are not the solution. Although nurse practitioners provide some types of care that primary care physicians do, their training is very different. There are limits to a nurse practitioner's ability to deliver the full-service, comprehensive care delivered by primary care physicians.

A 2004 Cochrane review attempted to assess patient health outcomes when nurses were substituted for primary care physicians [8]. They found that nurse practitioners received high scores in patient satisfaction, but studies of outcomes were limited and had methodological problems. Of the studies reviewed, more than half occurred in the 1960s and 1970s, and only four were recent (the latest was in 2001). The Cochrane reviewers opined that all studies had methodological shortcomings, most notably a lack of statistical power [8]. The reviewers concluded that, although the findings "suggested" that nurses may produce care of the same quality as primary care physicians, their conclusions should be "viewed with caution given that only one study was powered to assess equivalence of care, many studies had methodological limitations, and patient follow-up was generally 12 months or less" [8]. By comparison, the studies cited above on outcomes in primary care have demonstrated improved patient outcomes with an increased primary care physician workforce [4, 6].

Some assume that, for those who claim nurse practitioners' care is not equal to that delivered by primary care physicians and that, therefore, NPs are not the answer to the primary care workforce shortage, the matter is a turf issue. It is not. Setting the lack of outcomes research aside, nurse practitioners themselves do not have the workforce necessary, based on full time equivalents (FTEs), to provide the amount of care that will be needed as the population ages and the chronic disease burden increases.

Robert C. Bowman, professor of family medicine at the A.T. Still School of Osteopathic Medicine in Mesa, Arizona, has published numerous articles on physician workforce issues, especially as they relate to rural medicine. He also maintains large public data sets and research literature on primary care workforce issues [9]. Bowman has found that, since 2004, the number of nurse practitioners entering primary care has declined by 40 percent (as has the number of physicians entering primary care) [10]. Moreover, a nurse practitioner who enters primary care

now spends an average of 3 standard primary care years, a decline from the 9 standard primary care years common a decade ago [10, 11]. This compares to 29.3 standard primary care years for a family medicine residency graduate [11]. The standard primary care year is based on a number of variables including time spent in primary care delivery, active years in career, and time remaining in career [12]. Nurse practitioners spend only 33 percent of their careers in primary care, compared to 90 percent for family physicians [11, 12]. Based on such workforce studies, it would take 10 nurse practitioners to equal the contribution of one family medicine resident [11].

The benefits of primary care physicians to patients and society are clear. The current predicament of the primary care physician workforce and the need to care for patients with ever-increasing chronic care needs demand a solution. Fortunately, there is a solution. The answer lies in a team-based approach that includes primary care physicians, nurse practitioners, and others working together—the patient-centered medical home.

The patient-centered medical home (PCMH) was first described by the American Academy of Pediatrics in 1967 [13]. For the last few years, the PCMH concept has been the focal point of primary care redesign and encompasses joint principles agreed to in 2007 by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association [14]. These principles are: (1) every patient should have a personal physician, (2) physicians direct and lead the medical practice, (3) care is coordinated and integrated, (4) quality and safety are hallmarks of the PCMH, (5) patient access to care is enhanced, and (6) the payment system is reformed to reflect the value of primary care services.

There is ample evidence that the principles of the PCMH are able to deliver as promised [15-19]. The Group Health Cooperative of Puget Sound found that patients cared for in a PCMH had better HEDIS (Healthcare Effectiveness Data and Information Set) quality measures and a reduction in hospital admissions [19]. Community Care of North Carolina implemented a PCMH for Medicaid patients and improved the quality of care for people with asthma and diabetes and reduced hospitalizations, cost, and emergency room use [20, 21]. Geisinger Health System in Pennsylvania implemented PCMHs in 2007 and, after two years, found improvements in prevention and in care for patients with diabetes and coronary artery disease [21, 22].

There is an answer to the primary care physician shortage: the patient-centered medical home, where a physician-led health care team, incorporating nurse practitioners as vital team members, coordinates care and manages most of the needs of the patient.

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MEDICINE AND SOCIETY

Gender Diversity and Nurse-Physician Relationships

Beth Ulrich, EdD, RN

You see a picture of a man and a woman, both dressed in scrubs. Your first reaction is probably to assume that the man is a doctor and the woman is a nurse, and odds are that you would be correct. U.S. Bureau of Labor Statistics for 2008 indicate that 68 percent of physicians are male and 90 percent of registered nurses (RNs) are female [1].

Perception, it has been said, is reality. Maybe it is more accurate to say that perception influences reality or creates a self-fulfilling prophecy. The original question posed for this article to the author was “Why does the nursing profession seem to be slower in achieving equal representation of male and female practitioners than law, teaching, the military, the clergy, or other sectors of medicine?” In actuality, none of these professions has equal representation of men and woman—65 percent of lawyers and 89 percent of clergy are male, 86 percent of the active military is male (though within the military, the percentage of RNs who are male is three times that of the civilian population [2]), and 81 percent of elementary and middle school teachers are female [1]. While gender diversity has improved in many professions, we are far from reaching gender equality.

Johnson & Johnson’s Campaign for Nursing’s Future has produced television ads, movies, and promotional materials that show nurses of diverse backgrounds and of both sexes and is credited with helping to turn around the overall decline in nursing school enrollments in the last 10 years. After talking with guidance counselors who said the “warm and fuzzy” materials promoting nursing as a career choice did not resonate with male students, the Oregon Center for Nursing developed a poster that features nine practicing male nurses (fireman, Navy Seal, snowboarder, motorcycle rider, executive, etc.) with the question “Are you man enough to be a nurse?” Programs in other states send male nurses to middle and high schools and community groups to talk about careers in nursing. As a result of these and many other similar efforts, the number of male graduates from schools of nursing has recently increased from 5.8 percent in 2004 [3] to 12 percent in 2007 [4].

Specialty and Subspecialty Choices

In addition to gender disparities between nurses and physicians, there are imbalances within specialties and subspecialties of both professions. While it is generally accepted that female nurses can take care of almost any patient (with some religious beliefs creating exceptions), such is not the case with male nurses. There are anecdotal reports of resistance, for example, to men who want to specialize in

obstetric and gynecologic nursing. In medicine, pediatrics is one of the few specialties in which the majority of the practitioners are women. American Medical Association (AMA) data for specialty practice by gender indicates that in 2006 (most recent data available), only 15.6 percent of internists and only 12 percent of general surgeons were women [5]. Gender diversity progress in medical specialties is evident, however, in areas such as obstetrics and gynecology (36.8 percent female physicians in 2006), with 77 percent of the 2008-2009 residents being women [6]. Female residents are also in the majority in pediatrics (63 percent), dermatology (62 percent), and medical genetics (59 percent). Based on resident data, however, surgery specialties are on a path to continue to be overwhelmingly male-dominated (neurosurgery and orthopedic surgery-88 percent, thoracic surgery-85 percent) [6].

Is It Really Just about Gender?

Given that the majority of physicians are male and the majority of nurses are female, are the conflicts between doctors and nurses just or even mainly a gender struggle? Certainly, gender is a contributor. But if it were the only answer, or even the greatest influence, one would expect some of the traditional RN-physician problems to have decreased as more women became physicians. Evidence does not seem to support this.

Sexual harassment reported by RNs has actually increased in the last decade, with 28 percent of hospital RNs in a recent national study reporting that they had personally experienced sexual harassment in the past year [7]. Another national survey of critical care RNs found that 27 percent had personally experienced verbal abuse from a physician in the past year [8]. In both of these studies, respect for RNs by physicians—another longstanding issue—was rated as excellent by only 11 percent of the respondents and fair or poor by 39 percent, slightly worse than in the same studies conducted in 2006.

In a recent survey by the American College of Physician Executives on doctor-nurse behavior, physician executives and nurse executives were asked who most often exhibits behavior problems—45 percent said physicians, 7 percent said nurses, and 48 percent said “a pretty even mix of both doctors and nurses” [9]. The top behavior problem was degrading comments and insults followed by yelling and cursing. There were many descriptions in the comments of the survey about patients and families being caught in the middle.

Alan Rosenstein, a physician who has done extensive research on disruptive behavior and its outcomes to physicians, nurses, and patients, notes that there are many potential contributors to disruptive behavior—gender, cultural beliefs, personality, education and training experiences, and situational characteristics (i.e., high intensity/high stress areas and specialties) to name a few [10]. Most important is the research that shows the direct effect that disruptive behavior has on patient outcomes [10. 11].

Interprofessional Respect and Understanding

Perhaps a larger contributor than gender is a lack of understanding about and respect for each other's knowledge and scope of practice. Both professions share a core knowledge base. The basics of anatomy and physiology are the same in both nursing and medical textbooks. Both professions use the same *PDR* as a reference. Beyond the basics, knowledge diverges according to specialty and level of care, but understanding and respecting the knowledge that each profession brings to the table and that both professions share could go a long way towards fostering positive relationships. With the steady increase in the number of advanced practice nurses in hospitals and practicing independently, opportunities for potential partnership and collaboration between nurses and physicians are increasing.

For more than 30 years, research has shown that when nurses and physicians collaborate, patients have better outcomes, and both physicians and nurses are more satisfied in their work. Several Institute of Medicine reports concerning improving patient safety and outcomes have recommended actions that support interdisciplinary collaboration such as shared education and input from both physicians and RNs in patient care processes.

Conclusion

Increasing gender parity in medicine and nursing is a worthy goal, but it is not the only or perhaps even the best method for increasing mutual respect and value between the professions. There are so many other issues—too little time, too few resources, sicker patients and pressure to move them through the system faster, struggles with insurance companies and lawyers, and working with patients and families at what is often the most stressful and vulnerable times of their lives.

Gender is one of the many aspects of cultural diversity, and the overall cultural sensitivity of a profession is enhanced by the diversity of its practitioners. Diversity that reflects the diversity of the population served is associated with improved access, patient satisfaction, communication, research, and positive outcomes [12]. In perhaps the best of all worlds, the gender diversity of medicine and nursing would more closely resemble that of our patients. As professionals, however, we must be able to do what is best for our patients (in their minds as well as ours) regardless of our own personal characteristics. We cannot become more diverse overnight, but while we strive for that goal, we can respect and value each others' knowledge and expertise, collaborate for the good of our patients and each other, and treat each other with civility.

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OP-ED

The Medical Team Model, the Feminization of Medicine, and the Nurse's Role

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Ask a group of people who do not work in health care about the qualities of a good nurse, and you'll be likely to hear words like "caring," "compassionate," and "nurturing." Patients frequently mention these as qualities they hope their nurses will have. They expect competence from nurses, but they hope for more; they hope for genuine caring and compassion during their most vulnerable times. Patients also want caring and compassion from their physicians, but are more tolerant of a physician's dispassionate attitude if they believe the physician is an expert in his or her field. There is not so much tolerance for a dispassionate nurse. The public wants to be "nursed back to health," and there is a reason the expression is not "doctored back to health." Two trends in medicine—the growing number of women physicians and the increasing importance of the medical team model—are altering patients' expectations of their doctors and nurses and doctors' and nurses' expectations of each other.

The Public's View of Nurses

Since being included in Gallup's Honesty and Ethics of Professions survey back in 1999, nurses have been rated the most trusted professionals every year but one, 2001, when firefighters were added to the survey on a one-time basis after the September 11th attacks. Nurses topped pharmacists, teachers, police officers, clergy, and medical doctors in the survey. In 2008, 84 percent of Americans surveyed rated nurses as very high or high for honesty and ethics, with pharmacists ranking a distant second at 70 percent, high school teachers ranking third with 65 percent, and medical doctors ranking fourth with 64 percent [1].

This trust in nurses is based on the belief they will act in nonmaleficent and beneficent ways, behave with kindness and care, and advocate for the best interests of the patient. People believe nurses will honor the wants, needs, and desires of patients and families as much as humanly possible, even when those wishes differ from the choices the nurses might make for themselves or family members.

Patient advocacy appears to be embedded in the DNA of good nurses, rooted in their ability to listen actively, observe keenly, analyze and process various types of information, and communicate skillfully. We expect nurses to practice with evidence-based knowledge, proficiency, skill, and integrity.

Physicians' View of Nurses

Ask a group of physicians what makes a good nurse, and the answer might be quite different. In a variety of studies on the relationships between nurses and physicians, some physicians described a good nurse as one who carries out the physician's orders without question or challenge, informs the physician of important and nontrivial information about patients in a timely way, treats the physician with respect, solves problems, provides the supplies and equipment needed by the physician, cleans up after the physician, and is cooperative and competent [2-7]. If we ask a female physician the same question, she is likely to add that good nurses treat her the way they treat her male colleagues, don't challenge her authority or expect her to be friends just because both are women, offer help without her having to act as though she's trying not to bother them, and call her "doctor" rather than using her first name [2, 4-6].

Today, 28 percent (or 266,972) of the 941,304 physicians in the United States are women [8]. In 2008, nearly half of U.S. medical school graduates were women [9]. Many studies have investigated what happens when women physicians and women nurses relate to each other [3-5]. Gjerberg and Kjolsrod described the perceptions of both male and female physicians, concluding that relationships with nurses are influenced by the physician's gender [3]. Zelek and Phillips studied female nurses' attitudes toward male and female physicians and found that the differences they reported were based as much on gender as on professional hierarchy [4]. Wear and Keck-McNulty looked at attitudes of female nurses and female residents toward each other by documenting the qualitative statements each group made about the other. The results reflected conflicted relationships characterized by both appreciation and deprecation [5].

The results of the Wear and Keck-McNulty studies revealed that, for women nurses, gender was a more important connection with women physicians than was occupation; for women physicians, gender was secondary to occupation or occupational status in their connection to female nurses. Women physicians believed women nurses offered them less help and accorded them less respect and confidence than they accorded male physicians, a difference the women physicians explained as due, in part, to the nurses' wish to reduce the status and power of the female physicians. The women physicians in the study believed the nurses attempted to minimize the difference in status between the two professions by focusing on the gender similarities to female physicians. Finally, female physicians spoke about the sexual "game" and flirting between male physicians and female nurses that made women physicians unable to relate to either group.

The female physicians, who saw themselves not belonging to the male physician network or the nursing group, felt like a third group that was somewhat disenfranchised. In the qualitative data collection, these physicians commented that the nurses challenged them by asking such questions as, "Do you really mean that?" which they interpreted as a lack of trust in their judgment, adding that nurses did not challenge male physicians in this way. They sensed that, because they were women, they were viewed and treated differently than their male colleagues were. A final

measure of disrespect, the women physicians said, was that the nurses called them by their first names, which they did not do to the physicians who were men.

Traditional Physician Behavior toward Nurses

For decades, women nurses have been oppressed by a hierarchical structure and a power imbalance with male physicians. If you think the word “oppressed” is too strong or reactionary, consider the following. Well into the 1960s, nurses had to rise from their seats when a physician entered the nurses’ station as a show of respect as well as to offer the chair to the physician; physicians have, without censure, pushed and shoved nurses and, at times, even thrown objects at them (this still occurs infrequently and is now severely disciplined); physicians yelled at nurses, called them names, and made disparaging remarks (this still happens but is now reviewed and documented); and physicians traditionally called nurses by their first names while nurses addressed physicians by the formal title Doctor followed by their last names (a convention still observed in every type of health care setting). For a long time, these behaviors were related to the roles of superordinate and subordinate; the physicians gave orders and the nurses carried out the orders, a view that fit with the stereotypic power imbalance in our society between men and women.

Women Enter Medicine as Physicians

The studies I’ve cited seem to suggest that, as greater numbers of women become physicians, women nurses begin to relate to them as women first and as doctors second. Possibly the nurses think the women physicians have struggled with some of the same gender and role challenges they have faced and that physicians of their sex will relate to them on that basis, understanding what it is like to be regarded as less important because of one’s gender. Women nurses may also feel more comfortable asking questions, challenging orders if necessary, and calling female physicians by their first name. Many women think that other women “get it,” whereas men don’t; women can understand, relate, and share more easily.

Some authors describe this shift as a convergence of the medical and nursing professions and view it as an increase in status for women in medicine and in society in general and a diminished status for physicians—the power and rights they formerly enjoyed have been challenged by the concept of egalitarianism.

The Medical Team

Health care is increasingly emphasizing clinical quality, desired outcomes, and patient safety. Since the Institute of Medicine’s classic call for action to foster safer medicine, much has been written about factors that contribute to improved clinical outcomes, especially in surgical areas [10–15]. Teamwork and communication are considered cornerstones in a safe foundation for health care, and safety concepts and practices from the aviation industry—a leader in systems analysis of error—have been integrated into medical training to improve how team members relate to each other.

A key concept from aviation safety is that each member of the team has a critical role in the quality and safety of the project outcome. This egalitarian approach creates an environment in which any member can ask questions, offer information, be listened to and respected, and be addressed by first name (when not in front of the patient and or family). A nurse who feels free to call a physician by his or her first name is more likely to communicate safety concerns, to the ultimate benefit of the patient and the entire caregiving team.

Schmalenberg et al. describe a model of collegial and collaborative nurse-physician relationships as a method of improving patient outcomes [16]. Collaboration is interdependence that requires complementarity of roles [17]. The notion that physician and nurse roles complement each other is essential to the process of patient care. Collaboration is built upon trust, respect, communication, and teamwork, with each member valuing what the other brings to the table. Collegial relationships take collaboration a step further by acknowledging the equality of collegial group members. Whether called peers, colleagues, or equals, physicians and nurses in a collaborative and collegial team view themselves and each other as professionals who have and do different and important jobs to achieve the best outcomes for the patients.

The changing landscape in health care, with more women entering medicine and women nurses feeling more free and comfortable about asking them questions or challenging their decisions, is a good thing. It has been suggested that increasing numbers of women in medicine—the so-called feminization of medicine—may improve health care outcomes for patients [18]. Evidence has revealed that women physicians in primary care spend more time in patient-centered conversation with patients than do their male colleagues [19]. Female primary care physicians have also demonstrated higher levels of emotionally focused talk, positive talk, psychosocial question asking, and psychosocial counseling than their male colleagues, all of which contribute to active partnering between clinician and patient. To the degree that evidence from these studies can be generalized, the feminization of medicine can be said to be promoting strategies that will improve patient outcomes.

We are in a phase change, where excellence in patient care quality and outcomes are dependent on diverse individuals in a variety of roles, as well as multidisciplinary teams whose members function as collaborative and collegial partners. Physicians and nurses can capitalize on the changing gender landscape through an appreciation and trust of each other's strengths, abilities, and qualities. It's time to integrate a deeper understanding of these factors into a shared curriculum for nursing and medical students.

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State-Mandated Collaboration for Nurse Practitioners

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Consider the following: a registered nurse with a decade of experience excels in a nurse practitioner graduate program and, after becoming board-certified by a national credentialing body, decides to establish a practice in a medically underserved rural area where it is common for health care professionals of all stripes—nurses, physical therapists, dieticians, pharmacists, dentists, physicians—to consult with each other regularly in order to provide the best care possible.

This informal arrangement benefits patients and professionals alike, and a growing number of states allow nurse practitioners (NPs) to practice without physician involvement as licensed independent providers. Many states, however, still impose some pharmacy restriction or limit on prescribing authority and mandate some form of collaboration with or supervision by physicians. (The 2009 Pearson Report lays out a state-by-state analysis of requirements for nurse practitioner independent practice [1].) In some states, this supervision is required to take the form of a written collaborative agreement.

For a rural NP, meeting this requirement may be difficult due to the shortage of physicians in the area, and, if the physician collaborators require a fee, the agreement may present financial obstacles to establishing the practice and keeping costs low for patients. Furthermore, the formality of the relationship, the limited choice in collaborators, and the fact that the agreement is mandated can inhibit truly collaborative work.

The other professionals in the community are free to practice within their own professional jurisdiction, based upon their own licensure, and are not required by statute or regulation to have a professional from another domain contract with them to practice. Why should a professional with advanced graduate education, certification, and expertise, who collaborates regularly with other health care professionals, be held to a different standard than they are?

This requirement is already a hardship for rural NPs, and if the collaboration requirement continues, soon there will not be enough physicians to collaborate with all the practicing NPs. Nurse practitioners are the fastest growing segment of primary caregivers in the United States. In fact, the number of primary care NPs is increasing at a rate of 9.44 percent per capita, compared to 1.17 percent per capita increase for physicians [2]. If the covert intent of this legislation is to minimize the number of nurse practitioners who are licensed to practice, then it will succeed.

As of this writing, the literature fails to document whether legally mandated collaboration between nurse practitioners and physicians (1) increases collaboration between the two professions or (2) promotes patient safety or positive public outcomes. Nurse practitioners do not need a legally mandated tie to physicians to continue to work jointly with their colleagues in all disciplines; patients are best served by voluntary and willing collaborations, regardless of the background and educational domain of the person being consulted. Discussing cases and gathering other perspectives on treatment and care plans occurs daily in every setting of health care, both within and across professional disciplines. When necessary, formal consultation occurs.

The exchange of knowledge, expertise and judgment is a vital part of the process any practitioner, whether nurse or physician, must use to render excellent patient care. All primary caregivers should collaborate when addressing questions beyond their scope of practice or current level of expertise. To do otherwise, is, for all intents and purposes, medical malpractice, with or without a legislative mandate. Mandated legal affiliations can erode the spirit of collaboration (when, for example, physicians must approve prescriptions written for patients they have never met), continue to marginalize the nurse practitioner profession, and undermine the goal of increasing access to care. In addition, a system of paid collaboration cannot help but lead to higher medical costs, as this obligation increases NP practices' business expenses.

According to a comprehensive review of the literature, all studies of NP care have concluded that NPs provide safe and effective care, even when practicing independently from physicians [3]. Since 1965, there have been no documented findings of poor patient outcomes when a NP is designated as a licensed independent practitioner. Moreover, the increase in the number of medical malpractice claims against nurse practitioners is no greater than the corresponding increase in claims against physicians [4]. Nurse practitioners practice safely and effectively in states that do not legislate physician involvement. The role of nurse practitioners is distinctive, in that we are trained to deliver care that blends the sciences and philosophies of both medicine and nursing, and the end result has been holistic, high-quality, and evidence-based care that has satisfied patients across the country [5]. It is a goal of the National Council of State Boards of Nursing to license Advanced Practice Registered Nurses (APRN), a category that includes NPs, as independent practitioners with no regulatory requirements for collaboration, direction or supervision [6].

Just as we excel in counseling and educating our patients, nurse practitioners and our professional organizations are committed to demonstrating to the public, lawmakers, and our colleagues in other areas of health care that we are a viable and trusted profession that has proven itself over many decades. By doing so, we can remove these persistent barriers that prevent us from practicing to the full extent of our education and clinical expertise.

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