



TEMENOS INC.

37 Kawanakoa Place, Honolulu, Hawaii 96817
Tel: +1 (808) 528-2433 temenos@lava.net

Sarah W. Fraser & Associates

5 Cuddington Rd, Dinton, Aylesbury, Bucks, HP18 0AB, UK

Tel: 01296 747543

Fax: 07092 344044

Email: sfraser881@aol.com

VAT No. GB 768 4847 67



Communication between health care professionals

A Literature Scan

by
Shelley Lees
2003

Keywords

Communication, health/care professionals, health/care workers, communication techniques, manager, verbal abuse, doctor-nurse game, relationship, doctors, physicians, nurses

Searches

Search engines

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British Medical Journal
Health Service Journal

Websites

www.doh.gov.uk
Kings Fund
NHS Modernisation Agency

This document is organised into three themes:

Communication
Nurse – Doctor Interactions/Relationship
Verbal abuse

Communication

Barriers to effective communication in skilled nursing facilities: differences in perception between nurses and physicians

Authors: Cadogan M P, Franzi C, Osterweil D & Hill T

Jn: Journal of the American Geriatrics Society, 1999, 47 (1), 71-5

Abstract: Notes that effective communication between nurses and physicians is central to the clinical care of nursing home residents. Compares perceptions of potential communication barriers among nurses and physicians in four California nursing homes.

Before the paradigm shift: Concepts and communication between doctors and nurses in a burns team

Authors: Burd A, Cheung KW, Ho WS, Wong TW, Ying SY & Cheng PH

Jn: Burns, 2002, 28(7), 691-5

Abstract: The evolution of care delivered by a multidisciplinary burns team is a function of the effectiveness of the professional communication between team members. In this exercise, we have explored concepts and communication between nurses and doctors in a burns team. Loosely structured weekly meetings were held over a 4-month period. The explicit objective was to determine and define the current model of burns care in a regional burn centre. The implicit objective, however, was to develop a mutual appreciation of actual and potential problems in communication. Consensus task identification was achieved at the end of each meeting with full compliance in completing the tasks before the next meeting. Although there was a unanimous commitment to the team concept, traditional, professional, paradigms persist. For nurses, the concept of holistic modelling predominated, whilst the disease centred paradigm remained the focus of medical modelling. Linguistic, cultural and professional barriers to effective communication were identified but did not readily conform to prior expectations. Experience in burns care can transcend these barriers more effectively than a common culture or profession. In conclusion, team work and team building is a complex process that can benefit from an ongoing process of re-evaluation. An obvious yet common error is to assume a level of mutual understanding that does not in fact exist. Stepping aside to re-explore fundamental principles on which team members base their personal and professional practice can help in elucidating and determining new paradigms of care, which can be evaluated and appropriately implemented. The consensus conclusion was that this approach was a very valuable investment in time in pursuing excellence in the field of burns care.

Communication among health professionals

Author: Gosbee J

Jn: British Medical Journal, 1998, 316, 642

Last year, my father was told by his family doctor that the cardiologist had found aortic stenosis during a diagnostic evaluation for hypertension. Some time later it transpired that the specialist's diagnosis had been wrongly transmitted. Instead of a major valve defect, my father actually had atherosclerosis, a much more benign diagnosis. The kind of culture that makes this sort of unfortunate miscommunication possible is examined in a paper in this week's *BMJ* and a recently published government report. Their conclusions will come as no surprise to many *BMJ* readers - that communication between health professionals is a mess. Both sets of authors offer a series of insightful recommendations on what might be done to improve things. However, there is also a pressing need to define the role of applied research in this area and to accept that other disciplines have a lot to teach health professionals on how to design, evaluate, select, and set up efficient communication systems. Without this dialogue between disciplines, useful concepts and theories will simply languish in journals instead of being used by doctors and managers to improve efficiency and reduce mishaps in medical practice. Coiera and Tombs' observational study confirms that face to face, telephone, or pager based communication is common in hospitals and often driven by events. They found that hospital communications commonly interrupt tasks, including patient consultations, and are

inefficient. They suggest that we evaluate and consider investing in asynchronous methods of communication, such as electronic mail or message boards, which are potentially less disruptive to professionals' work and patients' welfare. The Clinical Systems Group, set up in 1996 to advise the NHS on information management, used questionnaires to study patients' and doctors' views on how health professionals talk to each other and what they say. Despite finding that both groups wanted most types of patient information shared freely, doctors estimated that most of the time important patient details were missing. Similar to Coiera and Tombs, the authors recommend procedural and educational measures to improve communication and urge the NHS to pursue research in this area. A further study in the same report also concludes that documentation in several healthcare delivery systems, and communication between the health professionals in those delivery systems, is chaotic. The authors' recommendations to doctors include more training in information technology, more structured data collection, and adoption of new technology. These authors should be congratulated for trying to inform and improve policy, education, and deployment of technology. The inefficiencies they uncover may even be enough to prompt some action in the most deficient areas. Poor communication is not only a waste of time, it can threaten patient care and is the chief culprit behind avoidable errors in clinical practice, which can lead to injury and even death. We should therefore push for more and better research into clinical communication and, of course, more funding. We should also heed the Clinical Systems Group's advice for education to fill the gaps in doctors' knowledge about collecting, sharing, and analysing clinical information. The authors of the study and report agree that their methods were limited (small unrepresentative samples) or potentially misleading (reporting anecdotes and self reported survey data), but once again other disciplines can help. We must be more open to the theories and methods used in subjects like cognitive psychology and linguistics. Methods that go beyond questionnaires and interviews, like applied ethnography, are often unfamiliar to medical informatics researchers. Human factors engineering, also known as cognitive ergonomics or usability engineering, is another discipline that applies knowledge of human capabilities and limitations to the design of devices and software. Such methods of research and development have been useful in high risk domains (aerospace), complex systems (nuclear power), and consumer products. You, as purchasers and users of information systems as well as the guardians of patients' interests, hold the key to changing this situation. Your influence will encourage researchers, administrators, and developers to base their projects on your information needs and use human factors engineering methods that result in usable and useful systems. My father seems to think that your influence surpasses his.

Communication behaviours in a hospital setting: An observational study

Authors: Coiera E & Tombs V

Jn: British Medical Journal, 1998, 316, 673-676

Abstract: *Objective:* An exploratory study to identify patterns of communication behaviour among hospital based healthcare workers. *Design:* Non-participatory, qualitative observational study. *Setting:* British district general hospital. *Subjects:* Eight doctors and two nurses. *Results:* Communication behaviours resulted in an interruptive workplace, which seemed to contribute to inefficiency in work practice. Medical staff generated twice as many interruptions via telephone and paging systems as they received. Hypothesised causes for this level of interruption include a bias by staff to interruptive communication methods, a tendency to seek information from colleagues in preference to printed materials, and poor provision of information in support of contacting individuals in specific roles. Staff were observed to infer the intention of messages based on insufficient information, and clinical teams demonstrated complex communication patterns, which could lead to inefficiency. *Conclusion:* The results suggest a number of improvements to processes or technologies. Staff may need instruction in appropriate use of communication facilities. Further, excessive emphasis on information technology may be misguided since much may be gained by supporting information exchange through communication technology. Voicemail and email with acknowledgment, mobile communication, improved support for role based contact, and message screening may be beneficial in the hospital environment.

Communications between community nurses and GPs

Author: Cutting JH

Jn: Practitioner, 1987, 231(1433), 1030-1

No abstract

Communication ethics: Principle and practice

Author: Beckett R

Jn: Journal of Communication Management, 2003, 8 (1), 41-52

Abstract: Communication ethics, this paper argues, is a discipline ready for application to communication management and is particularly relevant as we enter an 'age of information'. With a moral foundation firmly set in the social and human sciences, communication ethics offers managers a means to face unpredictable futures with greater certainty and purpose. This paper outlines an approach in which all decision making and its communication are understood as having an ethical grounding. Such an application empowers managers to act with integrity across the spectrum of their varied communication roles: through management and internal communications, public affairs and marketing; in advertising, media and publishing, and in the use of information technology. Positioned independently from the professional bodies of communication, an interdisciplinary ethics offers practitioners skills and moral frameworks that can be shared across professions and used to compare and evaluate their practice. This paper concludes by presenting a model of communication ethics that individual managers can use to prescribe a more sensitive and dynamic human-ethical environment.

Communication in the hospital setting: a survey of medical and everyday language use amongst patients, nurses and doctors.

Authors: Bourhis RY, Roth S & MacQueen G

Jn: Social Science and Medicine, 1989, 28(4), 339-46

Abstract: Forty physicians, 40 student nurses, and 40 hospital patients were surveyed regarding their usage and evaluations of medical and everyday language use in the hospital setting. Medical language (ML) and everyday language (EL) were operationalized as distinct speech registers that doctors, nurses and patients can use in their encounters with each other. A complex interaction of speaker characteristics (bilingualism in ML and EL) motivational factors (accommodation theory), situational language norms in favor of communicative effectiveness, as well as status and power differentials that exist between health professionals and patients were hypothesized to influence language switching strategies in the health setting. While doctors reported using mostly ML with health professionals, they did report converging to the EL of their patients. However, patients and student nurses did not perceive doctors converging to the EL of their patient. Student nurses reported using an equal mixture of ML/EL with each other, while converging to the ML of the doctor and converging to the EL of their patients. The 'communication broker' role of the nurse was corroborated by perceptions of nurses' language use from all groups. Patients reported using mostly EL with each other while attempting to converge to the ML of the health professional. Nurses perceived these attempts to converge by the patients, but doctors did not report a change in the patients' register as a function of conversants. Regarding the evaluation of language use strategies, all groups felt that it was more appropriate for health professionals to converge to the EL of patients than to maintain ML. In conversations with health professionals, patient use of EL was seen as more appropriate than ML.

Communication in the NHS: Using qualitative approaches to analyse effectiveness

Authors: Tourish D & Hargie O

Jn: Journal of Management in Medicine, 1996, 10 (5), 38-54

Abstract: Argues in favour of utilizing qualitative methods to assess the effectiveness of internal communications in the National Health Service (NHS), as a supplement to the more standard quantitative measures normally employed. Presents a case study from an NHS Trust, demonstrating the type of data which is generated. Compares these data to findings derived by quantitative methods. Argues that the qualitative findings both confirm and supplement those derived by quantitative

methods, and that both can identify the types of major problems prevalent within the NHS at present. Suggests that the further study of these issues should become an important part of efforts to create national standards for communication effectiveness in the future.

Communication problems between doctors and nurses

Authors: MacKay RC, Matsuno K & Mulligan J

Jn: Quality Assurance in Health Care, 1991, 3(1),11-9

Abstract: Communication difficulties between hospital doctors and nurses are well documented. A survey undertaken jointly by medical and nursing administration at Sir Charles Gairdner Hospital in Perth, Western Australia, verified difficulties in doctor-nurse communication as perceived by doctors and nurses, as well as by ward clerks as impartial observers. Questionnaire responses revealed some impediments in the flow of communication. Both nurses and doctors perceived less frequency of difficulties in communicating with members of their own professional group than with members of the other group. Nurses with university preparation and other special clinical qualifications perceived significantly fewer communication problems with doctors than nurses with less education. Interns perceived greater frequency in difficulty communicating with nurses than did more highly qualified doctors, and female doctors who were not interns claimed fewer problems than their male counterparts. Moreover, more highly qualified male doctors who had a previous occupation acknowledged fewer doctor-nurse communication problems.

Confirming communication of nurses in interaction with physicians

Authors: Garvin BJ & Kennedy CW

Jn: Journal of Nursing Education, 1988, 27(4), 161-6

Abstract: Communication is an essential component of the theory and practice of nursing. This study used a confirmation/disconfirmation framework to describe the communication characteristics of 40 registered staff nurses videotaped in a decision-making task with a resident physician. Nurses were found to be confirming in 87% of their discourse. Differences in confirmation proportions were not found when educational preparation and sex were examined. Older nurses and nurses with more years of professional experience were more confirming in their communication than younger and less experienced nurses. Implications of the study are discussed.

Doctors Behaving Badly

Author: McKinney M

Jn: American Journal of Nursing, 2002, 102 (7), 26-34

Abstract: Even though the US is in the middle of nursing crunch, with an estimated 126,000 unfilled nursing positions, many physicians do not realize that their own bad behavior may be driving some nurses from the field, according to the results of a new survey. "One of the things we are concerned about is the nursing shortage," the report's author, Dr. Alan H. Rosenstein, the medical director of VHA West Coast in Pleasanton, California, told Reuters Health. As administrators struggle to deal with the ramifications of the nursing shortage, they must focus not only on recruiting new nurses to the field but also on retaining current nurses, he said in an interview. The relationship that physicians have with nurses can have a "profound" effect on whether nurses choose to stay in the field, he said. Many doctors seem unaware of that, suggest the results of the survey of 1,200 nurses, physicians and hospital administrators. Though nearly 93% of all respondents had witnessed disruptive behavior by a physician, doctors were significantly less likely than nurses and executives to believe that such incidents have an important influence on nurses' morale, according to a report in the June issue of the American Journal of Nursing. About 31% of all respondents knew of a nurse who had left their hospital as a result of a physician's disruptive behavior. Nurses were also more likely than physicians to believe that doctors do not value their input and collaboration as much as they should. And nurses were more likely than doctors and executives to feel that nurses do not have enough administrative support to deal with conflicts with physicians. Nurses reported several barriers to reporting problems with physicians, including intimidation, concerns about retaliation and a belief that nothing would be

done about the complaint, the report indicates. Solving the problem will require a "multifaceted approach," according to Rosenstein. Doctors and administrators "must make an effort to cultivate a more supportive environment, one in which nurses and nursing care are valued and respected." However, other factors that contribute to low morale among nurses, such as cutbacks, scheduling issues and mandatory overtime, must be dealt with, the California physician added. Educational programs aimed at fostering better relationships between nurses and physicians "can't be successful if the underlying factors aren't first addressed," he concludes. But Dr. Diana J. Mason, the editor of the journal, disagrees that troubles in the nurse-physician relationship cannot be worked out until other problems are tackled. There are several steps that can and should be taken right now, she notes in an editorial that accompanies the study. Among other things, Mason suggests that hospitals study the state of nurse-physician relationships on their own wards and adopt a "zero-tolerance" policy towards all abusive employees. And nurses should be helped to develop the skills needed communicate effectively with physicians, Mason suggests. In addition, Mason states, "Nurses should stop referring to physicians as 'Doctor So-and-So' while physicians address them by first names. Whether we use last or first names, we must stop perpetuating such inequality." And nurse-doctor relationships can also affect patient care, Mason told Reuters Health in an interview. "We have research documenting that communication between nurses and physicians strongly shapes patient outcomes." She cited a 1986 study that found the nurse-physician communication was the leading predictor of patient mortality in intensive care units. "Nurse-physician communication is not just a matter of 'let's be polite to each other,'" Mason said. "It's a matter of true teamwork with mutual respect for each provider's expertise that he or she brings to a patient's care." In the interview, Rosenstein said that he did not mean that immediate steps should not be taken to improve relations between nurses and doctors. Instead, he said it is important to realize that this issue is just one of several related to nurses' morale. "This is one piece," according to Rosenstein. "Other pieces have to be dealt with" as well, he said.

Doctor-nurse communication in the neonatal intensive care unit: An anthropological analysis

Author: Greenall FM

Jn: Journal of Neonatal Nursing, 2001, 7 (4), 110-114

Abstract: Different paradigms of working by neonatal intensive care unit (NICU) medical and nursing staff can lead to conflict. This study explores these issues using an anthropological approach to analyse information gained during participant observation and interviews on the NICU. One theme was the nature of the caring but unquantified work of the nurses in special care, which often went unacknowledged. This is described as emotional labour. The personhood of the preterm infant was conceptualised differently by doctors and nurses. Doctors saw the infants as objects, partly as a coping mechanism due to the nature of their work, whilst nurses saw the infants as people, even when extremely premature.

Human communication is an essential tool in legal and ethical issues concerning doctor and nurse relationships

Author: Saku M.

Jn: Medical Law Review, 1994,13(5-6), 531-9

No Abstract

Improving Clinical Communication: A View from Psychology

Authors: Parker J & Coiera E

Jn: Journal of the American Medical Informatics Association, 2000, 7, 453-461

Abstract: Recent research has studied the communication behaviors of clinical hospital workers and observed a tendency for these workers to use communication behaviors that were often inefficient. Workers were observed to favor synchronous forms of communication, such as telephone calls and chance face-to-face meetings with colleagues, even when these channels were not effective. Synchronous communication also contributes to a highly interruptive working environment, increasing the potential for clinical errors to be made. This paper reviews these findings from a cognitive

psychological perspective, focusing on current understandings of how human memory functions and on the potential consequences of interruptions on the ability to work effectively. It concludes by discussing possible communication technology interventions that could be introduced to improve the clinical communication environment and suggests directions for future research.

Improving intensive care: Observations based on organizational case studies in nine intensive care units: a prospective, multicenter study

Authors: Zimmerman JE, Shortell SM, Rousseau DM, Duffy J, Gillies RR, Knaus WA, Devers K, Wagner DP & Draper EA

Jn: Critical Care Medicine, 1993, (10), 1443-5

Abstract: *Objective:* To examine organizational practices associated with higher and lower intensive care unit (ICU) outcome performance. *Design:* Prospective multicenter study. Onsite organizational analysis; prospective inception cohort. *Setting:* Nine ICUs (one medical, two surgical, six medical-surgical) at five teaching and four nonteaching hospitals. *Participants:* A sample of 3,672 ICU admissions; 316 nurses and 202 physicians. *Materials And Methods:* Interviews and direct observations by a team of clinical and organizational researchers. Demographic, physiologic, and outcome data for an average of 408 admissions per ICU; and questionnaires on ICU structure and organization. The ratio of actual/predicted hospital death rate was used to measure ICU effectiveness; the ratio of actual/predicted length of ICU stay was used to assess efficiency. *Measurements and Main Results:* ICUs with superior risk-adjusted survival could not be distinguished by structural and organizational questionnaires or by global judgment following on-site analysis. Superior organizational practices among these ICUs were related to a patient-centered culture, strong medical and nursing leadership, effective communication and coordination, and open, collaborative approaches to solving problems and managing conflict. *Conclusions:* The best and worst organizational practices found in this study can be used by ICU leaders as a checklist for improving ICU management.

Information exchange between physicians and nurses

Authors: Tange HJ & Smeets RP

Jn: Computer methods and programs in biomedicine, 1994, 43(3-4), 261-7

Abstract: The need for communication between physicians and nurses in clinical practice is undisputed. However, they keep separate patient records. In this article a case study is reported on the needs for, and present state of, information exchange between physicians and nurses. Both groups kept paper patient records. The common information needs that were found were not covered by the formal structure of both records, nor by the exchange of written, structured messages. It is likely that most of their common needs are satisfied beyond the formal structures, particularly in unstructured text and verbal conversation. The advantages and disadvantages of these ways of communication are discussed. As the impact of quality assessment grows, the role of formal communication will enlarge.

Interpersonal communication satisfaction and biologic sex: nurse-physician relationships

Author: Glenn TH, Rhea J, & Wheelless LR

Jn: Communication Research Reports, 1997, 14(1), 24-32

No abstract

Nurses and doctors communicating through medication order charts in critical care

Authors: Manias E & Street A

Jn: Australian Critical Care, 2001, 14(1), 17-23

Abstract: The structure and content of written forms of communication dynamically interact with the social and historical conditions underlying critical care nursing activities. One important form of documentation regularly used in the critical care area is the medication order chart. This paper considers the ways in which medication order charts are used to structure interactions among nurses and between nurses and doctors. The critical ethnographic study upon which this paper is based

involved a research group of six nurses who worked in one critical care unit. Data collection methods involved professional journalling, participant observation and individual and focus group interviews. Data analysis identified four major issues for consideration: imbalance between medical knowledge and legal authority; the nurse as go-between and medication expert; coaching the doctor; and the self policing nurse. The critical care nurse's role extends beyond the traditional passive activity of medication administration. By exploring the power relations underlying this role, there is greater opportunity for improved nursing relationships and patient care.

Nurse-doctor communication. A study on interprofessional communication

Author: James JL

Jn: Curationis, 1984, 7(1), 13-6

No abstract

Nurse-physician communication

Authors: Kennedy CW & Garvin BJ

Jn: Applied Nursing Research, 1988,1(3),122-7

No abstract

Nurse-physician communication and quality of drug use in Swedish nursing homes

Authors: Schmidt I K & Svarstad B L

Jn: Social Science and Medicine, 2002, 54 (12), 1767-77

Abstract: The objective was to explore the impact of nurse-physician communication on the quality of psychotropic drug use in Swedish nursing homes, while controlling for resident mix and other nursing home characteristics. As predicted, the quality of drug use was positively associated with the quality of nurse-physician communication and with regular multidisciplinary team discussions addressing drug therapy and negatively associated with prevalence of behavioural disturbances among residents.

Nurse-physician communication: Perceptions of nurses at an Army medical center

Authors: Anderson FD, Maloney JP, Oliver DL, Brown DL & Hardy MA

Jn: Military Medicine, 1996, 161(7), 411-5

Abstract: The purposes of this study were to describe nurses' perceptions of their communication with physicians, as related to the openness of the communication, the accuracy of the information communicated, and the timeliness of the interaction; and further, to determine if specific demographic characteristics of nurses are associated with perceptions of positive communication. The sample (N = 112) consisted of professional nurses working on one of nine inpatient units at a major military medical center. Shortell's ICU Nurse-Physician Communication subscale was used to measure the nurses' perceptions of the degree to which openness, accuracy, and timeliness described their communication with physicians. Overall findings were that the nurses perceived a poor quality of communication between themselves and the physicians with whom they interacted. Results from this study further indicated that the perceived quality of nurse-physician communication was not related to a nurse's educational level, length of nursing experience, or length of time assigned to a specific unit. Finally, findings provided no evidence that perceived levels of nurse-physician communication were greater among permanent staff than temporary nursing staff, or in intensive care units versus general ward areas.

Nurse practitioner and physician communication styles

Authors: Potter PT & Lawson MT

Jn: Applied nursing research, 2002, 15 (2), 60-66

Abstract: No empirical studies of nurse-patient relationships have focused on interpersonal communication and its effects on patient outcomes. In this study, 124 provider-patient interactions of five nurse practitioners (NPs) and four physicians (PHYS) were audiotaped. Communication patterns

were examined to determine whether the practitioner's predominant style was informational or controlling and whether style affected patient satisfaction and perceived autonomy support. All providers used predominantly informational styles of communication. Significant differences in communication styles existed between provider groups ($F = 5.90$, $df = 1/8$, $p = .05$) and among individual providers ($F = 4.28$, $df = 8/123$, $p < .0001$). All providers were more controlling in their communication patterns when attempting to make decisions and plan patient care. Examination of communication styles can help NPs develop the skills necessary to provide patient-centered care.

Observations on methodological and measurement challenges in the assessment of communication during medical exchanges

Author: Roter D.L.

Jn: Patient Education and Counseling, May 2003, 50 (1), 17-21

Abstract: By focusing attention almost exclusively on a single encounter, researchers have adopted a rather restricted view on studying communication in health care. After all, communication does not take place in a vacuum but is influenced by the context in which it takes place. We would therefore strongly recommend to broaden the perspective of communication research. In this respect, four lines of investigation are proposed, each guided by different theories. In the first, context is determined by the goals or targets aimed at by both parties in the medical encounter. The second concerns the context of time, referring to the influence of previous and future medical encounters. The third is set up around the organizational context in which an interaction takes place and the last defines context by looking at a medical encounter as a meeting between two multifaceted parties. Studying a medical encounter in its broader context is expected to provide answers to intriguing questions such as why health care professionals do not always act in conformity with the general approved standards of high quality communication and how the factor time span can be used more effectively in the medical encounter. Eventually, a broader context view will bridge the existing gap between theory and practice.

Perceived information needs and communication difficulties of inpatient physicians and nurses

Authors: McKnight L, Stetson PD, Bakken S, Curran C & Cimino JJ

Source: AMIA Symposium, 2001 (<http://www.amia.org/search/fsearch.html>)

Abstract: In order to understand the differing perceptions of information needs and communication patterns of healthcare professionals as they relate to medical errors, we conducted a survey and 5 focus group sessions of inpatient physicians and nurses. Although nurses and physicians stated differing information needs, both groups expressed significant problems with obtaining patient, domain and institution-specific information in a timely manner. Identification of appropriate providers and establishing contact with those people was perceived as the most pressing communication need. All focus group participants felt that communication difficulties were common and could give examples in which such difficulties led to adverse events. Our studies suggest that information needs and communication difficulties are common and can lead to medical errors or near misses. Many of these problems may be amenable to information technology solutions.

Perspectives on power, communication and the medical encounter: implications for nursing theory and practice.

Author: Lupton D

Jn: Nursing Inquiry, 1995, 2(3),157-63

Abstract: Over the past few decades there has been an increasing push towards 'enhancing' communication in the medical encounter, with a focus on moving towards a 'mutuality' of patient and health care professional that reduces a perceived 'power imbalance' between the two. Doctors in particular have been constructed as dominating and coercive, either consciously or unconsciously repressing patients' capacity for autonomy. Nurses have typically been represented as less authoritarian in their dealings with patients in their idealized role as caring, kindly and empathetic health professionals. It is therefore often argued that the nurse-patient relationship is more 'equal' and

less repressive than the doctor-patient relationship. This article explores critically these assertions in the context of the Foucauldian perspective on the role of power in the medical encounter, and draws out implications for nursing theory and practice.

Physicians and nurses: partners in communication

Author: Hirsh HL

Jn: Med Law, 1986, 5(6), 463-75

No abstract

Physician-Nurse communication. Perceptions of Physicians in Riyadh

Authors: Al-Doghaither AH, Mohamed BA, Abdalla AE, Magzoub ME & Al-Doghaither MH

Jn: Saudi Medical Journal, 2001, 22(4), 315-9

Abstract: *Objective:* The need for communication between nurse and physician in clinical practice is undisputed. The objectives of this study were to describe doctors' perceptions of their communication with nurses, as related to the openness of the communication and the accuracy of the information communicated and to examine if specific sociodemographic characteristics concerning physicians were associated with perception of communication. *Methods:* The sample consisted of 200 physicians selected randomly from 6 randomly selected hospitals representing both general and private. A modified Shortell's Intensive Care Unit physician-nurse communication subscale was used to measure the physician's perceptions of the degree to which openness and accuracy described their communication with nurses. Data was collected via a self-administered pilot questionnaire, which also included sociodemographic characteristics. *Results:* The overall mean score for openness was 2.61 and 3.19 for accuracy out of a maximum score of 5. For openness the highest mean score was obtained for "listening to physician (4.31)" and the lowest mean score was obtained for "hospital environment (1.84)". For accuracy, the highest mean score was obtained for "use of medical language (4.37)" and the lowest mean score was for "feedback (1.84)". The results showed a significant difference for experience, age and gender for both types of hospitals. For specialization, title and nationality no significant difference was observed for both types of hospitals for openness and accuracy. Multivariate regression analysis showed that gender, age and experience were the predictor variables for openness and accuracy. With more experienced, older aged females, having the highest mean score. *Conclusion:* Communication between physician and nurses needs not remain only a researchable issue; its viability and vitality are crucial to the changing health care scene. Thus, the development of health delivery models that will enable effective multidisciplinary communication, cooperation and wiser use of limited resources in health care is essential.

Teaching senior oncologists communication skills: Results from phase I of a comprehensive longitudinal program in the United Kingdom

Authors: Fallowfield L, Lipkin M & Hall A

Jn: Journal of Clinical Oncology, 1998, 16 (5), 1961-1968

Abstract: *Purpose:* To determine the communication difficulties experienced by clinicians in cancer medicine and to develop, implement, and evaluate communication skills training courses. *Methods:* One hundred seventy-eight senior clinicians attended 1 1/2- or 3-day residential courses designed to enhance skills development, knowledge acquisition, and personal awareness. Course content included structured feedback, video review of interviews, interactive group demonstrations, and discussion in groups of four led by trained facilitators. The main outcomes were self-rated confidence in key aspects of communication, attitudinal shift toward more patient-centered interviewing, perceived changes in personal practice, and initiation of teaching programs for junior staff. *Results:* Less than 35% of the participants had received any previous communications training. Time, experience, and seniority had not improved skills; before the course, oncologists expressed difficulty with 998 different communication issues. Primary problems concerned giving complex information, obtaining informed consent, and handling ethnic and cultural differences. Confidence ratings for key communication areas were significantly improved postcourse ($P < .01$). Three months postcourse, 95% of the physicians

reported significant changes in their practice of medicine. Seventy-five percent had started new teaching initiatives in communication for junior clinicians. Clinicians showed positive shifts in attitude toward patients' psychosocial needs ($P=.0002$) and were more patient centered ($P=.03$). The courses were highly rated and 97% would "definitely" recommend them to colleagues. *Conclusion:* Oncologists are hampered by inadequate communication skills training and will give up time to correct this. Subjective improvements reported immediately postcourse were maintained at 3 months. Resources for educational initiatives are needed to help both patients and their physicians.

The communication process in clinical settings

Author: Mathews JJ

Jn: Social Science and Medicine, 1983,17(18), 1371-8

Abstract: The communication of information in clinical settings is fraught with problems despite avowed common aims of practitioners and patients. Some reasons for the problematic nature of clinical communication are incongruent frames of reference about what information ought to be shared, sociolinguistic differences and social distance between practitioners and patients. Communication between doctors and nurses is also problematic, largely due to differences in ideology between the professions about what ought to be communicated to patients about their illness and who is ratified to give such information. Recent social changes, such as the Patient Bill of Rights and informed consent which assure access to information, and new conceptualizations of the nurse's role, warrant continued study of the communication process especially in regard to what constitutes appropriate and acceptable information about a patient's illness and who ought to give such information to patients. The purpose of this paper is to outline characteristics of communication in clinical settings and to provide a literature review of patient and practitioner interaction studies in order to reflect on why information exchange is problematic in clinical settings. A framework for presentation of the problems employs principles from interaction and role theory to investigate clinical communication from three viewpoints: (1) the level of shared knowledge between participants; (2) the effect of status, role and ideology on transactions; and (3) the regulation of communication imposed by features of the institution.

'You can't hate them if you know them'

Author: Paul Stephenson

Jn: Health Service Journal, 27/03/2003, II3 (5848), 14-15

Article: Seventy one per cent of managers believe they have a good relationship with their medical colleagues, according to an HSJ survey. But better understanding of each others' roles is essential - and soon. Paul Stephenson reports. When the new consultant contract was rejected by doctors in England and Wales, one of the main reasons for the 'no' vote was believed to be a suspicion that managers would not treat them fairly if the contract was introduced. If they had seen the findings of the HSJ survey on the doctor manager relationship, they would learn that managers take a markedly different view of the current state of play. In fact, 71 per cent of respondents believe they have either a good or very good relationship with doctors working in their trust. Considering that 19 per cent of managers describe their relationship with doctors as 'neutral', that leaves just 10 per cent who say they have a bad relationship. Only 2 per cent say it is very bad. Of the 126 managers, including medical managers, who replied to the survey, more than half believe that where there are difficulties in working relationships with doctors, targets are a major cause. And 47 per cent think that requirements from management have forced doctors to distort clinical priorities - either sometimes or frequently. One medical manager said: 'There is a risk that doctors and consultants will descend into local warfare when the real problem is the unending stream of initiatives, some of which are incompatible with each other.' But not everyone shared this view, and one GP and primary care trust professional executive committee chair said that coping with constant initiatives could bring doctors and managers together: 'Joint working on new and changed systems leads to mutual respect and understanding.' Other popular reasons for breakdowns in working relationships were different professional perspectives - listed by 63 per cent of managers - and heavy workload, cited by 60 per cent. The other major reason that

managers gave for poor working relationships was a general lack of understanding - and doctors agreed. Doctors said they could work far better together by understanding one another's jobs and pressures. They listed training, education and communication as keys to ensure clinicians understand what managers do - and why - and vice versa. As one doctor put it: 'Communication is key. A team based integrated approach, bringing management closer to the point of delivery of the service, would help with understanding of the issues. You can't hate them if you get to know them.' Joint training sessions on clinical and management topics were popular suggestions. One medical manager said: 'We do not educate doctors as trainees and students about the need to manage in their future careers, so how do we expect them to do it?' A nurse manager said: 'I don't remember much on the nursing curriculum about how the NHS works - the structure, accountability and what managers do. I remember thinking that as a nurse I knew the NHS, and the steep learning curve when I moved into management'. Another nurse manager highlighted the fact that managers and doctors sometimes have different agendas: 'Inevitably, there are occasions when their different perspective affects their relationship. If they really understood why the other holds their particular views, it should be possible for each side to understand the professional stance of the other and, where necessary, reach a mutually acceptable compromise.' What this would help overcome was illustrated by one manager who had worked in the private sector for 17 years before joining the NHS. He said: 'Clinicians hide behind the excuse that they alone are the professionals, and how dare anybody challenge their expertise? 'It's very difficult for management to argue against that on a clinical level.' One manager said what was needed was 'to change the management perspective from one of managing doctors to allowing doctors to concentrate on clinical work and working with them'. And an acute trust chief executive said what was needed was 'more collaboration in relation to goal-setting'. Much of it is perhaps best summed up by one manager, who said things would improve with 'honesty, no bullshit and proper explanation to understand difficult decisions'.

Nurse – Doctor Interactions/Relationship

Attitudes toward physician-nurse collaboration: A cross-cultural study of male and female physicians and nurses in the United States and Mexico

Authors: Hojat M, Nasca TJ, Cohen MJ, Fields SK, Rattner SL, Griffiths M, Ibarra D, de Gonzalez AA, Torres-Ruiz A, Ibarra G & Garcia A

Jn: Nursing Research, 2001, 50(2),123-8

Abstract: *Background:* Inter-professional collaboration between physicians and nurses, within and between cultures, can help contain cost and insure better patient outcomes. Attitude toward such collaboration is a function of the roles prescribed in the culture that guide professional behavior. *Objectives:* The purpose of the study was to test three research hypotheses concerning attitudes toward physician-nurse collaboration across genders, disciplines, and cultures. *Method:* The Jefferson Scale of Attitudes Toward Physician-Nurse Collaboration was administered to 639 physicians and nurses in the United States (n = 267) and Mexico (n = 372). Attitude scores were compared by gender (men, women), discipline (physicians, nurses), and culture (United States, Mexico) by using a three-way factorial analysis of variance design. *Results:* Findings confirmed the first research hypothesis by demonstrating that both physicians and nurses in the United States would express more positive attitudes toward physician-nurse collaboration than their counterparts in Mexico. The second research hypothesis, positing that nurses as compared to physicians in both countries would express more positive attitudes toward physician-nurse collaboration, was also supported. The third research hypothesis that female physicians would express more positive attitudes toward physician-nurse collaboration than their male counterparts was not confirmed. *Conclusions:* Collaborative education for medical and nursing students, particularly in cultures with a hierarchical model of inter-professional relationship, is needed to promote positive attitudes toward complementary roles of physicians and nurses. Faculty preparation for collaboration is necessary in such cultures before implementing collaborative education.

Australian hospital generalist and critical care nurses' perceptions of doctor-nurse collaboration

Authors: Chaboyer WP & Patterson E

Jn: Nursing and Health Sciences, 2001, 3(2), 73-9

Abstract: Previous researchers have indicated that collaborative practice between doctors and nurses results in positive effects on patient care, health-care costs and provider satisfaction. Despite these benefits, collaborative practice appears to be the exception, rather than the dominant pattern, within health care. A collaborative relationship cannot evolve if individuals do not value and respect others' competencies. This study, a mailed survey, used the Collaboration with Medical Staff Scale to compare the perceptions of doctor-nurse collaboration held by critical care nurses and generalist hospital nurses. The hypothesis that critical care nurses perceive there to be greater collaboration with doctors than their generalist nurse colleagues was supported even after taking into consideration education and experience. These results suggest that critical care is an area that might be useful when trying to understand the dimensions and implications of collaboration among health professionals.

Collaboration between nurses and doctors in clinical practice

Author: Lockhart-Wood K

Jn: British Journal of Nursing, 2000 Mar 9-22, 9(5), 276-80

Abstract: Several authors have identified collaboration between nurses and doctors as problematic. Benner (1984) stressed that teamwork and collaboration between the disciplines was crucial for both patient care and team morale. The purpose of this article is to evaluate critically and discuss the research studies which have been conducted into the dynamics of the nurse/doctor relationship. A number of characteristics are significant in influencing the collaborative process. These include excellent communication skills, respecting the value of colleagues' roles, the ability to share points of view and trust.

Collaborative practice between Ontario nurses and physicians: is it possible?

Author: Ornstein HJ

Jn: Canadian Journal of Nursing Administration, 1990, 3(4),10-4

Abstract: Numerous historical, psychological, social and cultural factors have caused the development and endurance of an unequal relationship pattern between the physician and the nurse. Nurses have assumed a position of lower status and dependency on physicians, and have been viewed as physicians' helpers or "handmaidens". However, with today's rapid technological changes, ethical and moral dilemmas, and cost constraints, high quality patient care cannot occur without equal contribution of both nursing and medicine. A shift from the traditional physician dominated relationship to a more balanced nurse-physician collaboration is needed. In a collaborative relationship, the physician and nurse jointly assume responsibility and accountability for patient care. This paper addresses the barriers to establishing a nurse-physician collaborative practice in Ontario and how they may be overcome.

Games that professionals play: The social psychology of physician-nurse interaction.

Authors: Tellis-Nayak M & Tellis-Nayak V

Jn: Social Science and Medicine, 1984, 18(12), 1063–1069

Abstract: The paradox of power dictates that though a society segregates its members into stratified groups, society has to bring these socially distant groups together in a collaborative effort in order to make the social enterprise possible. In terms of professional power, physicians and nurses are hierarchically related in a disparity which is firmly grounded in the social structure. But in a hospital setting these unequal professionals share a common environment and a common goal; they collaborate and communicate in deep interrelationships. Power asymmetry and social intimacy are contrasting categories, and when they are brought together, as in a physician-nurse relationship, there arises an elaborate social ritual that makes an effective communication between them possible without diluting the differences in their status and authority. Their social psychological game manifests itself in both institutional and behavioral expressions. The perpetuation of power rests on a structural and symbolic legitimacy. Any attempt to change the status quo would require that one recognize and deal with both these faces of power.

Gender and power: Nurses and doctors in Canada

Authors: Zelek B & Phillips SP

Jn: International Journal for Equity in Health, 2003, 2 (1), 1

Abstract: *Background:* The nurse-doctor relationship is historically one of female nurse deference to male physician authority. We investigated the effects of physicians' sex on female nurses' behaviour.

Methods: Nurses at an urban, university based hospital completed one of two forms of a vignette based survey in January, 2000. Each survey included four clinical scenarios. In form 1 of the questionnaire the physicians described were female, male, female, and male. In form 2, vignettes were identical but the physician sex was changed to male, female, male, and female. Differences in responses to questions based on the sex of the physician in each vignette were studied. *Results:* 199 self-selected nurses completed the survey. The responses of 177 female respondents and 11 respondents who did not specify their sex, and were assumed to be female based on the overall sex ratio of respondents, were analysed. Persistent sex-role stereotypes influenced the relationship between female nurses and physicians. Nurses were more willing to serve and defer to male physicians. They approached female physicians on a more egalitarian basis, were more comfortable communicating with them, yet more hostile toward them. *Conclusion:* When nurses and doctors are female, traditional power imbalances in their relationship diminish, suggesting that these imbalances are based as much on gender as on professional hierarchy. The effects of this change on the authority of the medical profession, the role of nurses, and on patient care merit further exploration.

Getting health professionals to work together

Author: Davies C

Jn: British Medical Journal, 2000, 320, 1021-1022

There's more to collaboration than simply working side by side - Doctors and nurses work together every day. But is there more to working together than making sure that the work of the one profession dovetails with that of the other? Is there really any content in the "co" words, so popular in government policy documents coordination, collaboration, and cooperation? Researchers are beginning to understand what working together can achieve. The settings are different how work groups in the private sector can perform better, how democracies can involve people more directly, how conflict can be resolved but the message is the same. Working "together" rather than working "alongside" can energise people and result in new ways of tackling old problems. We have had glimpses of this in patient participation in the NHS. We know much more than we did even five years ago about giving lay people the support and information they need to have a meaningful dialogue with managers and clinicians and to make an input into how services are run. We need to encourage real "conversations" at work ones that start to create a dialogue between people who have not yet understood what they can achieve in common.

It's the differences that matter - What characterises the new models of collaboration is the recognition that it is not what people have in common but their differences that make collaborative work more powerful than working separately. Working together means acknowledging that all participants bring equally valid knowledge and expertise from their professional and personal experience. Affirmations, acknowledgment, and recognition are important, but it is the questions and challenges that arise from the differences that are vital. A diverse group can arrive at a place no individual and no like-minded group would have reached. When, for example, a social services department decided to bring people with learning difficulties into the heart of its evaluation of quality, staff realised how inaccessible and unnecessary some of their jargon had become. The direct comments of those in residential care about what would help them in their day to day lives gave a simpler and more motivating starting point for change. The same kind of thinking is at work when theorists of leadership urge a move from transactional to transformational approaches. A transactional leader has a strong sense of direction and comes to an agreement with subordinates about what each will do to make a reality of a given vision. A transformational leader is at the centre of a network, allowing a vision to emerge from the dialogue. What does it take to create the conditions for working together in the new collaborative model? Firstly, participants have to welcome challenge. They need to be confident enough to face the unfamiliar, respectful and trusting enough to listen openly to others. Secondly, there must be ground rules. Inequalities of power can make it near impossible for the less powerful members of a group to speak out. Appointing a facilitator and arranging a premeeting to help a minority viewpoint get expressed are ways of organising to redress the balance. Another technique that has been used by teachers when invited speakers with opposing views are addressing a class is to set up a facilitated dialogue. Instead of a traditional debate, where speakers with opposing views defend their own position and attack their opponents', such a dialogue is designed to explore different perspectives, values, and goals and encourages pupils to respect different perspectives on a controversial issue. Collaboration sometimes works spontaneously when established experts are brought together as strangers on a working group or task force. More often, dialogue has to be deliberately encouraged. There are good reasons why doctors and nurses are not far along this road. Traditionally the profession of medicine created doctors who were self reliant and independent. It emphasised expertise, autonomy, and responsibility more than interdependence, deliberation, and dialogue. The ritual humiliations of medical training that instil individual mastery of knowledge help to maintain this. So too do the expectations of patients and colleagues.

Obstinate traditions - Nursing traditions have been different, emphasising hierarchy and bureaucratic rule following. Even if these have diminished, along with deference to doctors, nurses still work "around" others. Individually, nurses and doctors may strive to overcome the lingering images of their professions, but there is a weight of tradition, including a tradition of gender thinking, to contend with. Nursing is no more conducive to collaborative working than is medicine. Both need to change if a

collaborative model is to work. Support comes from strange quarters. The new National Institute for Clinical Excellence refers to "health professionals" rather than singling out any one group. It acknowledges that no one who works alone can stay at the forefront of knowledge given the speed of organisational and clinical change. Just how ready are nurses and doctors to work together in a new way? Is it any accident that collaboration between patients and professionals springs more readily to mind than collaboration between the professions? The tales that nurses and doctors each tell about the other when they are outside work and "among friends" suggest that there is still some way to go.

How to get along with doctors and other health professionals

Authors: Davidhizar R & Dowd S.

Jn: The Journal of Practical Nursing, 2001, 51(1), 12-4

Abstract: All nurses will from time to time find themselves in negative interactions with doctors and other healthcare professionals. By using positive communication techniques the nurse can promote healthy interpersonal interactions and a positive atmosphere. By selecting responses rather than responding spontaneously difficult situations can be managed and a professional environment maintained.

Managing the doctor-nurse game: A nursing and social science analysis

Authors: Willis E & Parish K

Jn: Contemporary Nurse, 1997, 6 (3/4), 136

Abstract: In the struggle to achieve professional status and develop a body of knowledge, nursing has embraced a number of 'sciences' and 'disciplines'. These have included sociology and feminist perspectives. This paper explores the difficulties of drawing on these disciplines independently of everyday nursing practice. Using a case study approach, we illustrate the way in which some nurses draw on sociological and feminist 'definitions of the situation' in the 'doctor-nurse game', while others draw directly on nursing practice. The nursing practice in this case is concerned with pain management. We conclude that 'shared care' requires a collaboration with medicine that draws on nursing practice to demonstrate an integrated nursing knowledge in a way that acknowledges, challenges and asserts issues of power and status.

Nurse - doctor interactions during critical care ward rounds

Authors: Manias E & Street A

Jn: Journal of Clinical Nursing, 2001, 10 (4), 442-50

Abstract: Describes the participation of critical care nurses in ward rounds in Australia, and explores the power relations associated with the ways in which nurses interact with doctors during this oral forum of communication. A critical ethnographic study of 6 registered nurses working in a critical care unit is reported. Data collection methods involved professional journalling, participant observation, and individual and focus group interviews with the 6 participating nurses. Findings demonstrated that doctors used nurses to supplement information and provide extra detail about patient assessment during ward rounds. Nurses experienced enormous barriers to participating in decision-making activities during ward round discussions. By challenging the different points of view that doctors and nurses might hold about the ward round process, the opportunity exists for enhanced participation by nurses.

Nurse-physician collaboration

Author: Taylor-Seehafer M

Jn: Journal of the American Academy of Nurse Practitioners, 1998, 10(9), 387-91

Abstract: The literature indicates that collaboration between nurses and physicians has become more sophisticated as these relationships have become collegial in nature and as nurses have become assertive, autonomous, and accountable. On an individual level, physicians and nurses now entering collaborative relationships are successful at minimizing the obstacles of turf and territoriality as well as at managing practice boundaries. However, both need to consciously examine their patterns of

communication in order to effect clinical interaction styles that maintain unequal or hierarchical relationships. Studies of interprofessional communication, including style of clinical interaction, conflict resolution, use of humor, and negotiation, contribute support for nurses and physicians in collaborative relationships (Balzer, 1993; Campbell, Mauksch, Neikirk, & Hosokawa, 1990; Feiger & Schmitt, 1979; Lenkman & Gribbins, 1994; Pike, 1991). Research on differences in health outcomes of patients cared for in the traditional and collaborative models of health care delivery, identification of the unique product of collaborative practice models, and further identification of the type of attitudinal climate in which collaborative relationships can be nurtured should be undertaken if the elusive nature of collaboration is to be captured (Siegler, Whitney, & Schmitt, 1994). Providing collaborative, interdisciplinary clinical experiences for students, as well as role modeling of collaborative relationships in nurse-physician faculty practice, can contribute to a greater understanding and acceptance of each professional's role in health care delivery (Campbell, 1993; Forbes & Fitzsimons, 1993; Larson, 1995). Tradition and professionalism and progressive concern about practice boundaries continue to be obstacles to collaborative practice. These need to be addressed by medical and nursing professionals on the institutional level and in the political arena. Collaboration between nurses and physicians need not remain only a researchable issue; its viability and vitality are crucial to the changing health care scene. Understanding the issues that affect collaboration, as well as the historical background in which it has developed, can help nurses and physicians in their joint effort to improve health care delivery.

Nurse/physician collaboration: Action research and the lessons learned

Authors: Dechairo-Marino AE, Jordan-Marsh M, Traiger G & Saulo M

Jn: The Journal of Nursing Administration, 2001, 31(5), 223-32

Abstract: *Objective:* Finding time to add to nursing knowledge while solving problems in a fast-paced healthcare environment is the ultimate challenge for nurse executives. At one hospital, use of an action research model to measure collaboration in nurse/physician led interdisciplinary teams improved the intervention and the approach to outcome measurement. *Background:* Many hospital nurse executives promote collaborative practice, and yet, innovations introduced to foster collaboration are rarely studied prospectively. The best-known data on collaboration is predominantly from correlational studies. Within the rapidly changing practice setting, action research may be a more legitimate strategy for studying interventions longitudinally. *Methods:* An action research pretest/posttest design using Baggs' Collaboration and Satisfaction About Care Decisions measured collaboration before and after several interventions to improve nurse/physician collaboration. The sample consisted of 87 pretest and 65 posttest registered nurses working on three medical-surgical units and two intensive care units (ICU). *Results:* Collaboration scores in the ICUs were higher than those in previous research, but the posttest indicated no significant difference in either ICU nurse or medical-surgical nurse scores. Higher ICU scores may have been related to the organizational focus on teams. A strong significant correlation between nurse report of level of collaboration and satisfaction with decision making was uncovered. *Conclusions:* This study contributes to the nurse/physician collaboration literature in that it was longitudinal, used a reliable and valid instrument, and surveyed nurses in medical/surgical units as well as the ICU. Some of the difficulties and benefits of research in today's practice setting are illustrated.

Nurse-physician collaboration: A descriptive study

Author: Jones RA

Jn: Holistic Nursing Practice, 1994, 8(3),38-53

Abstract: The purpose of this research was to investigate the nature of nurse-physician collaboration using four indicators (power-control, practice spheres, concerns, and goals) in a random mail survey of registered nurses (N = 59) and physicians (N = 67) in a midwestern metropolitan county. Subjects completed a nurse or physician communication scale, an adaptation of the Weiss and Davis Collaborative Practice Scales, a practice spheres, and a goals checklist. Nurses and physicians were homogeneous on the power-control indicator, ($\chi^2 = .3(3)$, $p = .98$) and concern indicator ($\chi^2 =$

7.2(4), $p = .13$). Nurses and physicians were inconsistent in their perceptions of responsibilities for practice spheres and patient goals. Relationships of demographic variables to collaboration indicators supported profiles of nurses and physicians who may be less collaborative.

Steps to collaboration

Authors: Coeling HV & Wilcox JR

Jn: Nursing Administration Quarterly, 1994, 18(4),44-55

Abstract: Although collaboration is a much sought-after goal among health care professionals, minimal research has clarified the essential communication elements (behaviors) necessary for collaboration. This series of research studies, grounded in the pragmatic perspective, represents a beginning attempt to identify these behaviors. A total of 270 practicing physicians and nurses responded to open-ended questions and/or a survey assessing the communication elements of content; relationship (aggressive, affirming, and collaborative styles); and opportunity to communicate. Findings suggest elements necessary for collaboration include reliable presentation of relevant data, openness to information presented, and adequate time to communicate. Differences were noted between nurses and physicians as to the relative importance of these behaviors.

The difficult doctor

Authors: Davidhizar R, Policinski H & Bowen M

Jn: Today's OR Nurse, 1990, 12(12), 28-30

Abstract: Nurses in the operating room may find themselves in interpersonal conflict with difficult doctors. It is important to remember that the relationship may be influenced by patterns of thinking and behavior learned in childhood, in one's culture, and through the professional socialization and education process. The nurse may be able to improve communication by assessing the difficult doctor's interaction, using approaches that will elicit cooperation, timing approaches strategically, avoiding approaches that will precipitate defensiveness, and using direct approaches.

The doctor-nurse computer game: Do established relationships of power influence the use of Information Technology in clinical practice?

Authors: Timmons S & Tredoux T

Jn: ITIN, 2000, 12 (2) [Online] Available: <http://www.bcsnsg.org.uk/itin12/timmons.htm> [Accessed October 23, 2003]

Abstract: This paper will look at how relationships of power have possibly influenced the use of IT by doctors and nurses on the hospital ward. While there have been several substantial studies of the working relationships between doctors and nurses, none of them have explicitly addressed the use of IT. Two studies informed this paper. Each study, its methods and findings will be discussed in turn, and then a general discussion, relating to both studies will follow.

The Doctor-Nurse Relationship: How easy is it to be a female doctor co-operating with a female nurse?

Authors: Gjerberg E & Kjolsrod L

Jn: Social Science And Medicine, 2001, 52, 189-202

Abstract: *Method:* A qualitative in-depth interview with 15 doctors plus a nationwide survey of 3,589 doctors. *Results:* In the experience of many doctors, male and female, the doctor-nurse relationship is influenced by the doctor's gender. Female doctors often find that they are met with less respect and confidence, and they are given less help than their male colleagues. The Norwegian research found that many female doctors felt 'different' from male doctors and female nurses, and that they did not belong to either grouping. About half of the women doctors surveyed 'asked themselves where they belong', especially those who were the only female physician on the ward. In describing problems at work, they recognised themselves as a sort of third category. The other categories consisted of their male colleagues or the female nurses. For women medics, there was clearly a feeling of 'we' and 'the others', with 'the others' comprising both male colleagues and nurses of both sexes.

What compounds this problem of social isolation is that female doctors are not necessarily a homogeneous group with strong internal coherence. They are scattered throughout the hospital, often without a network of their own. Some feel they have to work particularly hard to find social ties to their colleagues. This problem could be a cause of significant stress, and could also act as a 'double-whammy' by ensuring a lack of social support when the women doctors are feeling strain. *Conclusion:* In order to tackle the experience of differential treatment, the strategies chosen by female doctors include doing as much as possible themselves and making friends with the nurses. It might be important for the issue of the isolation of female doctors to be more coherently addressed by the profession. Perhaps each hospital should have a 'women in medicine' group that meets regularly, so female doctors can congregate and garner support that way.

The impact of recent primary care reforms in the UK on interprofessional working in primary care centres

Authors: Elston S & Holloway I.

Jn: Journal of Interprofessional Care, 2001, 15(1), 19-27

This study comprises the perspectives of professionals in primary care regarding the impact of the changes in its organisation and interprofessional collaboration in the UK. General practitioners (GPs), nurses and practice managers were interviewed in three primary cares located within a 20-mile radius and in the same health authority. Interviews were analysed using the grounded theory approach of Glaser & Strauss (1967) as developed by Strauss & Corbin (1998). The separate ideologies and subcultures of GPs, nurses and managers influenced their perceptions of reforms in primary care. Professional identities and the traditional power structure generated some conflict between the three groups which affected collaboration in implementing the reforms. Based on the findings of the study, it seems probable that it will take a new generation of health professionals to bring about an interprofessional culture in the NHS.

The nurse-doctor relationship: A selective literature review

Author: Sweet SJ

Jn: Journal of Advanced Nursing, 1995, 22(1), 165-70

Abstract: The disciplines of nursing and medicine are expected to work in unusually close proximity to one another, not just practising side by side but interacting with one another to achieve a common good: the health and well-being of patients. This selective review of literature addresses some of the issues arising from the frequently controversial subject of the nurse-doctor relationship and seeks to draw out the principal themes emerging from the application of sociological theory to the nurse-doctor relationship and research into its operation in clinical settings. Particular attention is paid to the 'doctor-nurse game', a stereotypical pattern of interaction, first described in the 1960s, in which (female) nurses learn to show initiative and offer advice, while appearing to defer passively to the doctor's authority. This pattern of interaction seems less common in clinical practice today but the problem remains of each profession having ideal expectations of one another which inevitably fall short as a result of differing views of qualities of doctors and nurses to be valued.

The technological mediation of the nursing-medical boundary

Author: Tjora AH

Jn: Sociology of Health and Illness, 2000, 22 (6), 721-41

Abstract: Norwegian medical emergency communication (AMK) centres are staffed by nurses, who administer requests for ambulance services or access to a doctor. A two-year study of AMK centres showed that much of the work of these centres proceeds quite independently of doctors, as nurses function as competent suppliers of advice or 'medical oracles'. Data on nursing work in the AMK centres suggest that these nurses have more influence and autonomy in the nurse-doctor interaction than most past studies have indicated.

Verbal Abuse

Verbal abuse and sexual harassment in the OR

Author: Pokalo CL.

Jn: Today's OR Nurse, 1991,13(9), 4-7

No abstract

Verbal Abuse: Another Viewpoint

Author: Bensing K

Source: Advance for LPNs, Aug. 28, 2000

(<http://www.advanceforlpns.com/common/Editorial/Editorial.aspx?CC=9958>)

About a month ago, my editor asked me, "Were you ever verbally abused as a nurse?" I thought about it for a moment and replied, "I'm sure I have been, but no great incident comes to mind." Certainly, I've been involved in negative interactions from time to time in the nursing workplace. But who hasn't? It's the real world. As I dug deeper into my memory bank about this escalating problem, I thought of an old-guard head nurse who I worked with when I was an assistant head nurse years ago on a 52-bed medical unit in a Philadelphia teaching hospital. By today's standards, everyone from physician on down would have reported her for verbal abuse. In fact, the physicians were the ones who often came to me to run interference for them--to avoid Anna's tirades. But no one ever reported her. In fact, she was revered--and her unit had the reputation of providing the best care in the hospital and the best learning experiences for nursing and medical students.

Defining Verbal Abuse - In "Words Can Hurt,"(page 24), Susan Araujo, MSN, RN, and Laura Sofield, MSN, RN, described the results of a study they conducted to determine the prevalence of verbal abuse. Surveying 1,000 RNs in a large multi-hospital system, the nurses found that 91.1 percent of these nurses said that they had been verbally abused, and most of the time the abuser was a physician. A study limitation, noted by the nurse researchers, is the lack of a universal definition of verbal abuse. And, indeed, I questioned this as well. What is verbal abuse in nurse-patient, nurse-doctor or nurse-nurse interactions? Is a psychotic patient in crisis hurling expletives at a nurse who's trying to medicate him verbal abuse? I don't think so. How about a woman who verbally blasts the ED clerk when, after numerous requests, she still can't receive any information about her sister's condition? I don't think so. Consider: A resident physician, the leader in a hospital code, struggles in vain for 30 minutes to save a patient's life. When a nurse can't find the drug he requested in the crash cart he yells, "Get someone here who knows what she's doing." Is this verbal abuse? I don't think so, but certainly an apology from the physician after the incident is warranted.

Unpopular Position - *ADVANCE* recently decided to conduct an informal survey on this hot topic via the Internet. As we prepared the question to post, I pleaded my case to not single out physicians as the abusers. To advance nursing, we need to collaborate with physicians, not continue our skirmishes and turf battles, I posited.

The question on our Web site read, "Have you ever been dressed down by a patient, family or fellow health care provider?" After two weeks, the responses keep coming in--and the overwhelming majority of nurses answered "yes" to the question. To immediately label and blame every negative verbal interaction along the all-too familiar dyad--Me (oppressed nurse) vs. Him (oppressor physician)--doesn't work for me. While there is strength in numbers as far as getting the message across, it also serves to reinforce a victim mentality that nursing doesn't need. By no means am I suggesting that nurses should not deal with workplace conflicts. But, can't every situation be dealt with individually? In Araujo and Sofield's article they include good strategies that you can use to help with conflict resolution.

Personal Responsibility - Not wanting to let any stone go unturned on this issue, I wondered how women physicians felt about it. So, I called two who I have a great deal of respect for--Jill Foster, MD, pediatric infectious disease specialist, St. Christopher's Hospital, Philadelphia, and Kathleen McNicholas, MD, cardiothoracic surgeon, Christiana Care, Newark, DE. Dr. Foster began her career in medicine as a physician assistant and Dr. McNicholas was one of the first women cardiac surgeons

in the country. I thought that these two women might have unique perspectives. "When I was a resident, there were times that some critical care nurses gave residents a hard time. It seemed that they reasoned --'After you finish your residencies, you'll be giving us a hard time.' I'm not sure why anyone has to beat up on anyone," offered Dr. Foster. To my surprise when I talked to Dr. McNicholas, she had already read the article published in the Philadelphia edition of *ADVANCE*. It was posted in a few of the staff restrooms at her hospital. In fact, she said she found it hard to believe that 91 percent of the nurses in the study said they were verbally abused. Candidly, she shared a few incidents about interactions she's had with nurses that have been perceived as verbal abuse. She expressed concern about these perceptions and questioned the definition of verbal abuse, as do I. When a nurse or any health care professional is asked or even reprimanded about the care of a patient, is this verbal abuse, she asked? "It seems to me that nurses need to first take personal responsibility for their actions when they are questioned about them, before a charge of verbal abuse is made," the surgeon offered. By the way, Dr. McNicholas is very pro-nursing. She is Katie's aunt, who I have written about several times, who will be entering Georgetown University School of Nursing in a few weeks. I'm sure the surgeon has told her niece what she tells everyone she works with about working in health care--"This isn't a country club."

Verbal abuse nationwide, Part II: Impact and modifications.

Author: Cox H.

Jn: Nursing Management, 1991, 22(3), 66-9

No abstract

Verbal abuse of female nurses: an American medical form of gender apartheid?

Author: Bruder, P

Jn: Hospital Topics, 2001, 79 (4), 30-4

Abstract: Discusses the verbal abuse of female nurses mostly by doctors. Examines what is known about the extent of abuse, sociocultural explanations for abuse, and what can be done about it. Uses the term gender apartheid to remind practitioners that to exclude 'the other' in an injurious manner is to practice apartheid.

Verbal Abuse - Summary of online survey

Author: Sofield L

Sources: Webpage, May, 2000 (<http://members.tripod.com/laura08723/survey.htm>)

Outline: In 1999 Kean University nurse researchers Susan Araujo and Laura Sofield surveyed 461 nurses regarding their perceptions of verbal abuse. Subsequently, the survey tool was modified for online use and nurses from various organizations, including the International Council of Nurses, California Nurses Association, and Association of PeriOperative Nurses (AORN) were invited to participate. The original academic survey used a descriptive, comparative, correlational design to examine perceptions of verbal abuse as it relates to intent to leave the organization. A randomized sample of 1000 Registered Nurses was obtained from a multi-site hospital system. Cox's 1985 (1987) verbal abuse survey, which consisted of 100 multiple choice questions, and Price and Mueller's 1986 intent to leave scale were the instruments utilized in the study. The original survey was revised to include only pertinent questions regarding prevalence, sources, and perceptions of verbal abuse, oppressed group behavior and demographics, resulting in a final survey instrument consisting of forty questions.

The academic survey yielded a 46.1% usable response rate. Reliability analysis of data was run using Chronbach's Alpha showing an initial reliability of $r = .8521$, $n = 461$. This demonstrated a moderately high reliability of the instrument and was consistent with the pilot study. The online survey yielded 105 responses. Reliability analysis of data was also run and showed an initial reliability of $r = .6598$, $n = 105$. This demonstrates a moderate reliability of the instrument. The ten optional questions (41-50) were only available to the online survey respondents. There was no validity or reliability testing done on these questions.

Online Demographics- One hundred and five (105) nurses from 27 US States, and from Australia, Taiwan, and unspecified countries, completed the survey. These participants differed from the academic study participants in the following respects:

- educational preparation: 34% master's prepared or higher (vs 6.8% academic study)
- clinical area: 41% Operating Room nurses (vs 14% OR/PACU academic study)
- position: 54% staff nurses (vs 90% academic study)

Variables not measured in the academic study were age and ethnicity. Online respondents were most frequently (48%) 41-50 years old and white (77%). Gender was comparable: 90% female, online group; 88% female, academic study.

Online Nurse Experience of Verbal Abuse

General Findings

- 94% experienced verbal abuse during their career
- The most common source of verbal abuse in the preceding 6 months was a physician
- 92% of nurses experienced 0-10 incidents of verbal abuse over the preceding month
- The most common feeling experienced after an incident of verbal abuse was anger
- 80% believe that verbal abuse negatively effected their morale
- 65% believe verbal abuse decreased their productivity for a period of time
- 70% believe verbal abuse increases errors

Witnesses and Reporting

- 89% of nurses report that the incident of verbal abuse was witnessed by another person
- This witness was most commonly a peer (82%) followed by a supervisor (22%)
- The most common reaction of the witness was (26%) supportive and (25%) shock/surprise
- 55% of nurses have reported a verbally abusive incident
- 40% said that their workplace does not have a policy which supports reporting verbal abuse, and 5% didn't know if such a policy exists

Retention

- 35% have left a nursing position due to verbal abuse
- 37% report that it is somewhat likely to extremely likely that they will look for a new job as a result of verbal abuse
- 86% believe that verbal abuse causes increased nurse turnover
- 84% believe verbal abuse contributes to nurse shortages
- 66% believe verbal abuse increases favorable attitudes toward unionization