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TRACING THE EVOLUTION OF NURSE-PHYSICIAN COLLABORATION

NURSE-PHYSICIAN COLLABORATION: FACT SHEET III OF IV

This fact sheet (III of IV) presents selected content from a report entitled *Nurse-Physician Relationships – Solutions and Recommendations for Change*. The full report is available on line at www.nhsru.com.

THE NURSE-PHYSICIAN GAME

Nurse-physician relationships have long been the focus of ongoing debate. The nurse-physician relationship has been compared to a game model, with nurses making recommendations for patient care in such a way that it appeared as if the physician initiated them (Stein, 1967). The major drawback with this sort of interaction is that it has an "inhibitory effect on open dialogue which is stifling and anti-intellectual. The game is basically a transactional neurosis" (Stein, 1967, p. 703). Stein (1967) reported that the game, like any other, was not without rewards and penalties. If the game were played correctly, both sides would benefit, however any divergence from this openly accepted method of interaction could result in severe penalties.

As a result, nurses were commonly treated as doctors' handmaidens (Williamson, 2003; Trossman, 2003; Pavlovich-Danis et al., 1998), and the interaction between the two disciplines was very carefully structured so as not to disturb the hierarchy. The training of medical and nursing students was believed to be the root of the problem, as this was acknowledged as shaping the future attitudes of nurses and doctors (Stein, 1967).

EVOLVING NURSE-PHYSICIAN RELATIONSHIPS

In the past it was assumed that "there was clear agreement between the two disciplines that the relationship was hierarchical with doctors being superior to nurses" (Stein et al., 1990, p. 546). However, the nurse-physician relationship is constantly evolving and recent changes, as documented by Stein et al. (1990) and Williamson (2003), include:

- Nurses are no longer exclusively female and physicians are more likely to be female.
- Public esteem for physicians has deteriorated.
- There is an increased public awareness of disease treatments and outcomes.
- Commercialization of medical care has undermined public confidence in the physicians' commitment to altruistic concerns.
- Cultural conditioning exists wherein men assume the power roles.
- Media portray nurses as less intelligent, more irrational, and having less input in healthcare decisions than physicians (Pavlovich-Danis, Forman, & Simek, 1998).

Traditional differences in views between nurses and physicians have not only held back advancement in the nursing profession, but they have also affected research into nurse-physician relationships (Corser, 1998).

COLLABORATIVE VS COLLEGIAL

Kramer and Schmalenberg (2003) surveyed nurses from 14 magnet hospitals and identified that power was the underlying theme in nurse-physician relationships. Based on this they developed a 5 category scale to characterize nurse-physician relationships:

1. **Collegial** - "excellent" with an emphasis on equality between the two disciplines and a focus on equal although different power and knowledge to contribute to the interdisciplinary team.
2. **Collaborative** – "good" or "great" relationships based on mutual trust, respect, and power. The nurses described these relationships as having mutual but not equal power.
3. **Student-teacher** – "good", "pleasant", "courteous" are words that were used to describe these types of relationships. Physicians show a willingness to discuss, explain and teach, however the power is unequal. Overall, the outcomes are beneficial.
4. **Neutral** – absence of strong feelings in regards to this type of relationship. Information exchange may take place although nurses felt that physicians rarely acknowledge receiving information, leaving nurses feeling that they don't contribute. Power is unequal and outcomes are neutral.
5. **Negative** – Frustration, resignation, and hostility characterize this relationship. Power is unequal and outcomes are negative due to power plays.

The findings indicated that that the terms 'collegial' and 'collaborative' are sometimes used interchangeably to describe ideal nurse-physician relationships. However, this study differentiates between the two by describing *collegial* as "different but equal knowledge" whereas *collaborative* is defined as "mutual power but not equal". Kramer and Schmalenberg (2003) also mention that the dictionary definition of the two terms makes the same distinction.

Following a review of the available literature, Corser (1998) made the discovery that collegial was commonly described as a "precursor to collaboration, most often derived from the involved parties' formal hierarchical status and organizational authority" (Baggs & Schmitt, 1988; Fieger & Schmitt, 1979; Nugent & Lambert, 1996; as cited in Corser, 1998, p. 327). A report produced by IBM (2003, p. 8) shares this viewpoint and states "a collaborative approach is based on establishing a collegial relationship that evolves over time based on experience". Collaboration was usually described as involving "fewer formal behaviours related to one's organizational status or position" and was usually related to the participant's inherent values and communication skills (Devereaux, 1981; Mailick & Jordan, 1977; Siegler & Whitney, 1994, as cited in Corser 1998, p. 328).

A further observation was that the majority of work published focuses specifically on factors that contribute to collaboration. This focus presents a major obstacle as non-clinical definitions of collaboration fail to take into consideration the fact that nurses and physicians rarely possess the same view regarding what collaborative interaction encompasses (Corser, 1998).

Notably, the outcome in all of the 14 magnet hospitals where nurses and nurse managers were interviewed, regardless of the definition of collaboration used, was a positive correlation between the quality of nurse-physician relationships and the reported quality of care for patients (Kramer & Schmalenberg, 2003). Accordingly, optimizing nurse-physician collaboration is imperative for the achievement of the best possible outcomes for patients and all health system stakeholders.