MD vs. RN: The Patient Always Loses

Kathleen Bartholomew RN, RC, MN

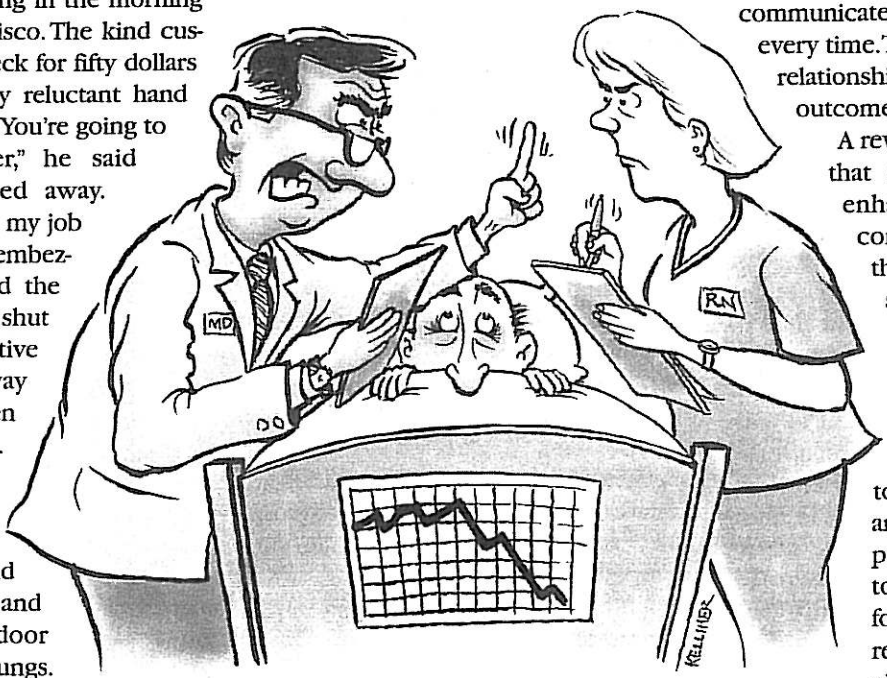
In the beginning...

I have always wanted to be able to say that I chose nursing. But the truth is, I won my profession in a trade.

One day a frequent customer at the telephone answering service where I worked saw my swollen eyes and asked, "What's the matter?" I explained that after two years of marriage counseling, my husband was leaving in the morning for a job in San Francisco. The kind customer wrote out a check for fifty dollars and shoved it into my reluctant hand with a business card. "You're going to need a good lawyer," he said adamantly and walked away. That same week, I lost my job because the treasurer embezzled all the funds and the business was forced to shut down. My nearest relative was 3,000 miles away and I had five children under the age of 11. Time to see the lawyer.

The Seattle office building was musty and dark, and as I knocked and opened the office door cigar smoke filled my lungs. The very first question the lawyer asked was, "How are you going to take care of those five kids Bob says you have? Do you like nursing?" I stammered, wondering where this conversation was going when suddenly he took out a worn leather book. "Tell you what", he said abruptly, "I will do your whole divorce for this fifty-dollar check if you promise me that you will be a nurse." Without a moment's hesitation, I put my hand on the Bible and bartered my career for a divorce.

I worked very, very hard to manage five children in a single-wide trailer, and attend nursing school full time while working 35 hours a week. This feat required that I drive almost a hundred miles every day since we lived in the country. So when the dean of the school of nursing ceremoniously pinned me at graduation, I could not stop sobbing with relief. All I could think of was sleep. I was really looking forward to being a nurse, but I was shocked when in my first position the physicians treated the nurses so badly. I watched a nurse call in a temperature of 102.6 on her post op patient. And then I watched her jump because the doctor slammed down the phone without ever speaking a single word. I witnessed a physician verbally abusing a nurse and then found her crying in the locker room. At 38 years old, I seriously questioned my choice of profession.



Every nurse I know can narrate at least one disturbing physician-nurse scene, and research validates that subjective observation. More than 90% of nurses witnessed disruptive behavior in the workplace on an average of 6-12 times a year. When asked if they knew of a nurse who left the workplace specifically because of verbal abuse by a doctor, 35% responded "yes". Many of these conflicts have left deep scars. They are extremely personal and have been extremely hurtful to our integrity and to our profession. Research shows a direct link has been shown between negative relationships and morale (Rosenstein, 2002).

After four years as a staff nurse we moved to Seattle. As the manager of a large surgical unit, I witnessed poor RN/MD relationships from another perspective and there was no shortage of examples. When rounding one morning, I discovered from the patient's husband that his wife had been in excruciating pain for three hours. I immediately sought out the night nurse and asked for an explanation.

"I gave every drug I could. I just didn't want to be yelled at again by the doctor. He is so degrading and irate, and screams at me if I call before 7 a.m."

When nurses and physicians don't communicate, it's the patient who loses every time. The bottom line is: negative relationships equal negative patient outcomes.

A review of the literature shows that neither collaboration nor enhancing opportunities for communication improves these relationships. Studies show that poor physician-nurse relationships impact morale, job satisfaction and retention. A survey of over 1200 physicians, nurses and administrators showed that physicians and nurses do not agree on potential solutions, barriers to progress or responsibility for the problem. The main reason for this is that physicians do not understand the nurses' role. The most significant finding in all of the literature is that units with good relations have decreased mortality rates (Knaus 1986, Baggs 1992). In a study of 13 ICU's, patient risk adjusted mortality increased 1.8 fold due to poor nurse-physician communication (Knauss, 1986).

The reason that collaboration and communication attempts to improve physician-nurse relationships have failed is because neither group understands the power difference. The dominant role of physicians and the subordinate role of nurses have its roots in the history of our profession. Early in the 1900's, physicians argued that "the nurse does not need an

Continued on page 12

MD vs. RN: Nurses Often Tolerate Disruptive and Verbally Abusive Physicians

Continued from page 7

education because the physician already has one". This belief in superiority was further compounded because of gender issues and because nurses were from the middle class while physicians were from the upper class. Based on the military model, nurses learned not to act independently unless given an order and not to question superiors (Charge Nurse, Post-op Orders, and General Surgeon, etc.)

The major problem is that neither group - nurses nor physicians are aware of the power play that keeps the nurse subordinate, and the physician in the dominant position. For example, physicians ignore nurses, make poor eye contact and quite frequently don't know the nurses' names. When a physician walks up and the nurse is in the middle of charting, she stops immediately to hand him the chart. Likewise, nurses often begin a late night call to physicians with "I am sorry to bother you" inferring that the critical order they need is an imposition. And most of all, nurses tolerate and do not report disruptive and verbally abusive physicians.

What can you do? Change your response and speak your truth. If the physician does not know your name, introduce yourself - if he forgets, then remind him. Hold the expectation that as a professional you require this courtesy. If a physician is abusive, pull him aside. State the behavior and the way it made you feel.

When the doctor approached the main desk with a loud voice shaking his finger at the nurse shouting, "I don't know how many times I have to tell you...", she calmly said, "Can I see you for a minute in private?"

"First of all, I am very bright and you only have to tell me something once and I will remember it. I have no idea what you were talking about. And secondly, please don't ever shake your finger in my face again."

What happened next is what happens every time a physician is confronted. He apologized. Physicians don't realize the behaviors they have picked up in school

Continued on page 13

Managing Phone Contact

Nurses state that telephone calls are often a source of conflict. Make it a point to always have the chart and the most recent labs and vital signs ready. Learn the SBAR tool for physician-nurse telephone conversation. Each letter represents a single sentence. While nurses were taught to paint the whole picture and speak narratively; physicians receive information better if it is brief, and to the point.

S- Situation - In one sentence, state the name, age, doctor, and diagnosis.
B- Background - State any significant history, and current reason for hospitalization
A - Assessment - Relay the clinical signs and symptoms that concern you
R- Recommendation - Tell the doctor what you want. For example, "I want you to come and look at this patient", or "I need a chest tube now."

The "R" is the hardest part of this tool for nurses. Yet many physicians in root-cause analysis have stated, "If only I knew she wanted me to come in..." Therefore, the SBAR tool should be introduced to both physicians and nurses and supported with education.

MD vs. RN

Continued from page 12

and unless we point this out, the behavior will continue. Only a new response to old behavior will build the collaborative relationships we so desperately need to provide a healing environment for ourselves and our patients.

Research shows us that good nurse physician relationships are ego boosting for both nurses and physicians. And the safest environment of the patient is one where staff openly communicate - where no one is afraid to speak, and where relationships are solid. Great working relationships add meaning, depth and purpose to our everyday life. In the end, both nurses and physicians want the same thing: to be valued, respected, to belong and to provide excellent clinical care.

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You can contact the author at Kathleenbart@msn.com .Her book "Speak Your Truth: Proven Strategies to Improve RN/MD Communication" is available on Amazon.com.

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President's Message: Advocacy Helps Care

Continued from page 2

ly, patient-centered quality care. I'm reminded at every meeting I attend that these are all concepts that oncology nursing has embraced and practiced for a very long time.

Advocacy, on behalf of both our patients/families and our profession is one of the most important things we can do to ensure quality care. The Oncology Nursing Society (ONS) is the most politically active of all specialty nursing organizations.

The quote by Sir William Osler at the beginning of this column may be a bit dated in its wording, but what an honor to be considered a blessing to humanity by the most influential physician in history.

Now that I think about it, the thoughts aren't so random after all...oncology nurses are active in projects on local, regional, and, national levels with the common cause of improving cancer care. If you have not already done so, I encourage all of you to find and pursue your individual passion in this cause. And I request that you let us know what we as a chapter can do to assist you in achieving your goals.

Thanks for all that each and every one of you does in your uncommon commitment to oncology nursing. Happy Oncology Nursing Month!

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McCorkle Lecture

Continued from page 10

middle of my nursing shift.

I want to find a nurse to fill my shoes, long before my children find me filling my pants!

We have much to offer, let's pass it on before we pass on!

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PSONS Newsletter

Editor: **Cathleen Goetsch**
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Assistant Editors:
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Creative Solutions (253) 529-2883
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