Teresa A. Savage, "Physician-Nurse Relationships and their Effect on Ethical Nursing Practice," *The Journal of Clinical Ethics* 17, no. 3 (2006): 260-5.

# Physician-Nurse Relationships and their Effect on Ethical Nursing Practice

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In this issue of *The Journal of Clinical Ethics,* Gordon and Hamric conducted an elegant study exploring why nurses do not use ethics consultation (EC) more frequently. They identify power inequities in terms of nurses' access to EC and describe discouragement by physicians. Nurses in their study reported experiencing moral distress, but the distress needed to rise to the level of moral outrage before nurses could summon the moral courage to request a consultation. They reported that the nurses' concerns were dismissed as emotional responses to a situation, or were not seen as an "ethics" concern. Their findings resonated with my many years of nursing practice, my years as an ethics consultant, and with findings in my own research. I believe the underuse of EC services by nurses rests on nurse-physician relationships. For my dissertation, I conducted in-depth and multiple interviews with 18 nurses (all female, hence the use of the "she" pronoun exclusively) at an academic, tertiary medical center.[1] I began with an open-ended question, "How do you get things done for your patients?" The stories unfolded to reveal that nurses act to "prevent the preventable" from happening (nonmaleficence) and their actions are dependent upon the nurse-physician relationships within their organizations.

## ADVOCACY

I agree with the authors that nurses are taught to be patients' advocates, and the *Code of Ethics for Nurses* expects nurses to be advocates.[2] Advocacy often requires nurses to interact with physicians, either to seek clarification for and/or the rationale for an order or plan of care. As Gerald Winslow pointed out, advocacy requires courage, and nurses may not feel secure enough to demonstrate their courage and exercise their advocacy role.[3] I recall being disappointed when I analyzed my dissertation data and realized that nurses often avoided a direct approach in resolving ethical issues for their patients. They vigorously pursued an issue, going through the medical hierarchy of intern, resident, fellow, up to the attending physician, *only* if

they had been socialized to do so. If they observed that a fellow nurse suffered repercussions from advocating for their patients, they were reluctant to take the risk of advocating. Instead, they found other less direct ways, such as playing the "doctor-nurse game,"[4] working through their nurse manager, or bullying a resident. Below are some excerpts from their interviews.

This nurse was unaware that she played the "doctor-nurse game" until a social worker who observed her interaction with a physician pointed it out to her.

RN: I usually say . . . this person's potassium is low, should we treat them for this? I always put it so they'll answer yes to what I want them to do . . . I lead them. I've been a nurse 11 years and I think now, you can call it collaboration, but when I . . . what do I want to say? I don't consider it collaboration. I just consider it politics that this is the way you have to say it to get things done for your patient, so your patient gets what he needs. And a woman who's too pushy or knows too much or tries to tell the doctors what to do doesn't get very far. A woman who's tactful and polite, phrases things appropriately gets a lot further . . . make them think, yeah, I should have thought of that, or, oh yeah, I meant to do that . . . you have to talk to them in a certain way, because you know what you want to get done, and you're trying to do it in the most effective way. Sometimes you can't just be real straightforward about it, saying, we have a low potassium, I'd like to hang potassium, they feel like you're telling them what to do, you want to handle it in whatever way to get it done.[5]

Another nurse described how she was socialized to work through the housestaff or her nurse manager; she was discouraged from contacting surgeons directly. She said:

RN: You're dealing with surgeons. You find a real different relationship between specialties and general practice who are not surgeons as opposed to surgeons, because surgeons are very elitist and I think from what I've seen on other floors or heard nurses talk about, there is a much more collegial relationship between internists or family practice, pediatricians, or even some of the specialty groups than there is between nurses and surgeons. If I went up the ladder, even up to the senior resident, much less to the attending, I was likely to get progressively more hell as opposed to be appreciated for questioning what's going on. So that was a very real consequence to have to consider. And granted, that compared to if I thought the patient was really in danger, I think I would make that decision, but most of the time I could squeeze by until 6 in the morning, until somebody else came around, either the attending on rounds or somebody that could give me a hand to straighten the situation out. I would probably have called my head nurse at home in the middle of the night before I would have called an attending because you just can't imagine the havoc that could be wreaked on you by some of those people.[6]

Another nurse relates an example of her interactions with a second-year surgical resident. This narrative illustrates the unpleasant interactions nurses wish to avoid with physicians:

RN: I get a phone call from an irate surgeon screaming at me, saying, you idiot, do you know how hard I worked to get this [X-ray] set up stat? I said, but the [jejunostomy] tube's working. He said, of course it is, I changed the tube. I was up there and I put in a new tube. And this was a J-tube we're talking about. And I said, excuse me? He said I put in a new tube, how dare you cancel this X-ray? I said, well you didn't tell any of us. You didn't tell the resident, you didn't tell me, I've been on the floor within 30 feet of the room this whole evening. I've been running around like [a] crazy person, but I've been here. You could have paged me. There's a clerk at that desk all the time I've been here. He just continued to yell at me. This was actually a resident on the surgical staff who had changed the tube and not told anybody. I guess he had gotten the order right at change of shift and had come right up and done it which is highly unusual, and he goes, what was very frustrating to me, he said, this is your fault because you didn't read my note. It's in the chart. There's an order there for that patient to come down and have the tube checked to make sure it's working fine. And my impulse is to scream and yell, and I said, excuse me, but right at change of shift, I'm very busy. I have not had time to go and just look through my six patients' charts to see if any notes have been written. He absolutely would not do anything but blame me for this situation. And he said I want your name. I want it spelled, and I want your license number. Excuse me, you want my what? He wanted my ID number and he was going to report me to hell and back. I've got visions of my job being yanked away, and I was very polite and I said what would you like me to do with this patient? He said, you get her on that cart down to radiology right this

minute, don't you dare go against any order I say ever again. So I said, thank you very much, be glad to, I hung up the phone. I went and checked the chart and sure enough, there's an order for the patient to be sent to radiology [that] I did not see which had been written right before 3 o'clock, which is not a time I'm usually sitting reading charts. I went immediately to the charge nurse, here's the situation, here's what is going on, where we left it, and about 10 minutes later the surgeon was up looking for me in person to yell at me some more and make sure I got that patient on the cart, to make sure the tube was working and, um, it was just horrible, but, so the charge nurse called, made all the arrangements to get the patient down to . . . because the surgeon had also asked me that could I also call and get transport all set up for the patient to go down there, and I told him, no, I said actually now, I can't. I was in a patient's room and had things going on that I could not leave. And I can't remember exactly the things I was in the middle of, but I vaguely remember wishing I had six other arms and there were two other nurses on staff that night . . . the surgeon came up on the floor to find me and was following me into patient rooms as I was giving pain medication and turning people and cleaning up diarrhea, and would berate me while I was in the room. It was one of those things where I felt, this guy is just not going to let me off of this. He's not. I turned to him and I was kind of proud of myself because I was thinking this was one of those things maybe two years ago right out of school I would have been a little more freaked out about it. I said, I talked to my charge nurse, the charge nurse took care of getting transport up for me, and was very pleasant and the transporters were all upset that that stupid nurse up there cancelled the transporter, and done all this. She was very good, was very diplomatic in handling that so I could take care of patients, when the surgeon came up I said it had all been taken care of and if he had any further questions he could talk to my charge nurse. And he said, no I'm just up here to see that you get that patient on the cart . . . the patient was not alert in any way at all, but that was one of those situations where I felt like I could not handle the situation, and I don't know, maybe somebody with a lot more years would be able to field this thing. . . . It was really upsetting to me . . . this was one of those situations where I felt like even if I had jumped through hoops, I wouldn't have really been handling this doctor very well.[7]

This is another example of how a nurse manages the relationship with housestaff.

RN: What we're here for is to prevent the preventable things. If there is a piece of data or something we can do to prevent a bad outcome, it should be done . . . if you as somebody who comes here for a diagnostic test and runs a V-tach [ventricular tachycardia] and there's no 'lytes [electrolytes] sent from yesterday, then I think it's only reasonable you should get electrolytes drawn. So that we know your potassium, then your potassium comes back, then I'll say [to the physician], so-and-so just had a run of V-tach, I looked up her potassium, and we don't have one from the last 24 hours, so I think we need one. So why don't you draw it? Or maybe I'd just leave it that we don't have a potassium. So I guess, I'd lead him. . . . and if they don't get up (laughs), say they go "Uh huh," and I'll say, "Are you going to draw the potassium?" and then they'll say, "We don't need it" and I'll say "You know, we do need it because she doesn't usually have these symptoms, this is atypical of her . . . if they say "No" then I'll say "Then I'll call your resident."[8]

Another tactic she would use when an intern would not do as she asked was to embarrass the intern during rounds:

RN: I have said . . . to interns . . . that I don't think you know what you're doing and there's nothing wrong with that, but there is a problem with your making decisions not knowing what you should . . . they stomp off usually, sometimes we get into a heated debate . . . you go to off-shifts [evening and nights] and that's where you can really get into bigger fights so you've got to really be assertive and go up the chain of command where on days [day shift] people are there. A real passive-aggressive trick to avoid all this is when you could wait for rounds, 'cause you have the whole chain of command there, and just talk about, so this is what's happening . . . what do you want to do? And then they tell the intern what to do, so you've sort of avoided that whole confrontation.[9]

## TRUSTING NURSES' KNOWLEDGE

These nurses said that physicians often dismiss their concerns because the nurses are acting on subjective data — the patient just doesn't "look right," the nurse has a "funny feeling,"

a "gut instinct." The objective data do not support the nurse's sense of dread. In my own experience, and as nurses in my study agreed, attending physicians have learned to rely on the experienced nurses' clinical insight, even if there are no supporting objective data.[10] Because of the medical hierarchy, though, nurses must first interact with the most junior person in the hierarchy, the intern (and occasionally the medical student). Interns may not appreciate or trust nurses' insight, may want to wait for more objective data, and nurses must "go over their heads" to prevent potential harm from coming to the patient. Depending upon how nurses have been socialized on that particular unit in the hospital, they may or may not pursue their concerns. Nurses may alert the nurse manager and have the nurse manager pursue the concern, or they may doubt their own assessments, defer to an intern's judgment, and wait to see what happens.

## THE ATTRACTION OF ETHICS CONSULTATION

The cumulative effect of communication games, moral distress, and fear of repercussions make ethical consultation an attractive avenue for resolving ethical issues. However, barriers to access or lack of available services can stifle that route as well. In my experience as an ethics consultant, nurses often wish to "sound out" their concerns before making any kind of formal request for consultation, and often I encourage them to coordinate a patient care conference, to seek to clarify the goals for the patient. (Hospital policy at the time required that the attending physician be notified that an ethics consultation was requested, and that the attending had to agree to the consult before a note could be entered in the medical record. The consult could be done, but a note could not be entered in the chart without the permission of the attending physician.)

It often surprised me that nurses needed encouragement and support to take what seemed to me to be an obvious and appropriate step to facilitate communication with all of the persons involved in a patient's care. The nurses had access to my informal ethics consultation because I was a nursing instructor in that department, with clinical students on their unit between three and four days a week. (When I worked as a clinical nurse specialist in the same institution, and my office was located in a suite of subspecialty physicians' offices, I had physicians "drop by" to informally discuss ethical issues that they were currently facing.)

Proximity and open accessibility seemed to facilitate nurses' requests for ethics discussions; occasionally informal discussion would lead to a more formal request for an ethics consultation and documentation in the medical record. Whether or not a formal consultation evolved from these discussions, nurses were able to strategize with me on how they could address the ethical issues that were bothering them.

## RECOMMENDATIONS

I wholeheartedly support Gordon and Hamric's recommendation that nurses should be made aware of EC services. I also agree that nurses do not always identify an issue as an "ethical" concern, but, if asked to describe their concern, they use language of "right and wrong," "harm," and "acting on the patient's behalf." Nurses' clinical concerns are rooted in the nurses' ethical obligations to the patient. But as Gordon and Hamric found, having access to an EC does not mean the nurses will feel safe in using one. Interdisciplinary ethics education, as suggested by Gordon and Hamric and others, may hold the key to empowering nurses.[11]

Finding a common point for interdisciplinary ethics education is challenging. Usually undergraduate nursing students do not take any course work with medical students. Graduate nursing students may take ethics courses with medical students, but medical students are just

beginning to get a sense of the clinical arena, so having graduate nursing students and medical students together makes for an uneven foundation on which to analyze clinical ethical issues. However, interdisciplinary education at this point would be a start.

At my current institution, we have an 11-month program in which employees (and a limited number of professionals who are not employees, usually MD or PhD faculty from other institutions) apply to be accepted in our ethics scholars program.[12] Their application includes a letter of support from their supervisor indicating that efforts will be made in scheduling to facilitate their attendance; the day and time of the weekly tutorial is negotiated with all of the scholars once selected. The scholars meet weekly for 90 minutes for guided discussion on assigned readings and work toward completion of a focus project. The focus projects vary between studies approved by the institutional review board (IRB) to literature reviews, posters, quality improvement projects, graduate-level course development, or in-services on their units, for example. For the tutorials, the four part-time faculty (physician, social worker, psychologist, and myself) in the ethics program take turns in leading discussion, and guests are often slated to make presentations and join in the discussion. Since employees from all departments are eligible to apply, we have had diverse groups, ranging in size from three to 10 scholars, including nurses, therapists, administrators, technicians, physicians, social workers, security guards, administrative assistants, pharmacists, chaplains, vocational rehabilitation counselors, public relation and development associates, volunteer directors, and researchers. There is a collegial atmosphere, and, although there are passionate disagreements, the discourse remains civil and respectful. We have "graduated" 55 scholars in 10 years and most of them have remained at our institution. The "ripple effect" of having a critical mass of employees with ethics education is felt throughout the institution. Scholars have stated that they feel better prepared to facilitate discussion of ethical issues in their units and more likely to contact us or refer others to us in the ethics program. Scholars who have left our institution serve as ethics resources for their new institutions.

Our scholars program is one way to provide ethics education. We also have monthly ethics seminars planned and conducted on the units with input from the unit staff regarding the topic; quarterly ethics grand rounds that are usually attended by physicians, medical students, and nurse practitioners; a monthly film series focusing on a brief (60 minutes or less) video to stimulate discussion; a newsletter highlighting an activity or topic; and invited community round tables that function as "mini-think tanks," devoted to a particular topic that is relevant to our patient population or a disability community. These various avenues provide forums for ethics education, and permit more employees and community members to learn who we are and what we do. We hypothesize that this type of education and open accessibility to our program will improve our visibility, and, over time, build trust in our capacity to address ethical issues and empower our employees to take steps to prevent or reduce moral distress.

## NOTES

1. T.A. Savage, "Nurses' Negotiation Processes in Facilitating Ethical Decision-Making in Patient Care," (PhD diss., University of Illinois at Chicago Health Sciences Center, 1995).

2. American Nurses Association, *Code of Ethics for Nurses,* accessed 31 July 2006 at *www.nursingworld.org/ethics/code/protected _nwcoe303.html.*

3. G.R. Winslow, "From Loyalty to Advocacy: A New Metaphor for Nursing," *Hastings Center Report* 14 (1984): 32-40.

4. L.I. Stein, "The Doctor-Nurse Game," *Archives in General Psychiatry* 16 (1967): 699-703; L.I. Stein, D.T. Watts, and T. Howell, "The Doctor-Nurse Game Revisited," *Nursing Outlook* 38, no. 6 (1990): 264-86.

5. See note 1 above.
6. Ibid.
7. Ibid.
8. Ibid.
9. Ibid.
10. P. Benner, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (Reading, Mass.: Addison-Wesley, 1984).
11. W. Austin et al., "Moral Distress in Healthcare Practice: The Situation of Nurses," *HEC Forum* 17, no. 1 (2005): 33-48.
12. Our ethics scholars program is actually called the Disability Ethics Scholars Program, and is uniquely devoted to ethical issues related to disability. The scholars have readings in traditional bioethics as well as disability studies literature; narrative ethics; legal documents of classic cases such as Elizabeth Bouvia, David Rivlin, Michael Martin, and Larry McAfee; a variety of articles from professional discipline journals, and first-person stories. It is described here in the generic sense so that other institutions may consider adopting a similar style of program and shaping it to serve their patient populations and communities.