An Unexpected Opening to Teach the Impact of Interactions Between Healthcare Personnel

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Goold and Stern (2006) offer a much needed dose of insight into the weakness of medical education from the perspective of resident and nonresident physicians. One of their findings pertains not to insufficiencies in existing coverage of particular topics, but to *absence* of coverage of particular topics, including "the learning environment and resident-attending interactions" (Goold and Stern 2006, 9). Although medical ethics education has long attended to the interactions between patient and physician, this finding indicates an unexpected awareness of the significance of interactions between at least some medical personnel. Despite the fact that residents specifically target only the resident–attending physician interaction, this is an excellent opportunity to initiate ongoing physician education about the impact of physician interactions with nursing and administrative personnel. Such interactions can greatly impact patient care as well as organizational welfare; they do not always proceed in perfect harmony and can only do so if all parties are aware of the nature and import of their interactions.

A critical interaction for organizational welfare, professional satisfaction, and patient outcomes is that between physicians and nurses. In 1985, Prescott and Bowen conducted a survey of physicians and nurses that indicated that 70% of the physicians and 69% of the nurses described relationships as mostly positive; however, the greatest number of disagreements reported were related to the patient's plan of care. Resolutions of these disagreements were described as "competitive in nature" according to 65% of physicians and 53% of nurses. Few examples of joint problem-solving (collaboration) were seen. Physician–nurse relationships all too frequently follow this course even today (Rosenstein 2002; Schmalenberg et al. 2005), and have a substantive impact on patient outcomes. A comparison of intensive care unit patient outcomes with reported unit-level collaboration between attending physicians, resident physicians, and nurses indicated a rank order correlation between unit-level collaboration and outcomes. In other words, as competition decreases and joint problem-solving increases, patients are less likely to die and more likely to be released from the intensive care unit to an area of less-intensive care without subsequent readmission to intensive care (Baggs et al. 1999). More recent studies have further confirmed that so-called "collegial and collaborative" nurse–physician relationships demonstrably improve patient outcomes (Schmalenberg et al. 2005). However, patient welfare is not just affected by clinical personnel relationships.

Patient welfare and, indeed, organizational welfare, can also be affected by personnel retention. A survey of 1,200 nurses, physicians, and hospital executives conducted by VHA West Coast, Inc. (Pleasanton, CA) suggested that physician–nurse interactions strongly determine working morale of nursing staff, which in turn affects staff retention. Both physician and nurse respondents indicated mutual concern over the impact of physician–nurse relationships. In the face of the current nursing shortage, neither organizations nor patients can afford preventable loss of nursing personnel. This is especially important because both sets of respondents identified "disruptive" physician behavior as the key impediment to productive interactions between nurses and physicians. When asked whether nurses had ever observed "abusive" behavior by a physician towards a nurse, 97% said yes. Of the respondents, 30.7% said they knew a nurse who had left the system because of such behavior (Rosenstein 2002). However, nurses are not the only clinical personnel whose retention is damaged because of poor physician-nursing relationships. Rural clinics often have high physician turnover resulting from untenable workloads (Mainous, Ramsbottom-Lucier, and Rich 1994). Such high workloads have been traced in part to the degree to which physicians take on work which can be collaboratively done by – and with – others. Given that recent models of demographic trends, economic trends, and healthcare needs have indicated that the United States may face a modest shortage of physicians as soon as 2010 and a major shortage by 2020 (Cooper et al. 2002), physician retention may soon be a concern for rural *and* urban healthcare. Again, it is apparent that neither organizations nor patients can afford preventable loss of personnel—in this case, physicians.

The effects of personnel interactions on patient outcomes and organizational welfare have drawn attention to the need for systemic changes which can improve relationships between individuals. Colorado Permanente Medical Group has instituted a "Preferred Clinical Partner" program that includes training in constructive relationships between physicians and nursing staff. This has improved not only retention of nurses but also the perception by nurses that nurses and physicians work as a team to provide improved patient care (Cochran, Fahy, and Bansek 2004). In a separate example, rural Marathon, Canada (population 5,500) had seen a physician turnover of 75 physicians between 1988 and 1998. With only one physician persistently in place, residents had little reliable long-term care. Thanks to measures which included "training nurses in effective triage

techniques and empowering them to treat patients who fall within their skill sets, they have reduced the demand on physician time," in turn reducing physician burn-out and dramatically increasing physician retention to a permanent staff of seven attending physicians with resident physicians for eight months of the year (O'Reilly 1998, 1517). Such collegial trust between clinical personnel yields benefits for personnel, patients, and organizations.

I have focused on interactions between physicians and nurses as these are the relationships most heavily experienced by physicians in clinical settings, and which most obviously affect patient outcomes and personnel retention. However, physicians interact with other critical individuals in medical systems, including local administrative personnel responsible for billing, scheduling, insurance criteria, and records, and distal personnel working for payers—all key parts of the medical system within which nurses and physicians function. As the Institute of Medicine has observed, the structures of these systems have a marked effect on patient outcomes (Kohn, Corrigan, and Donaldson 2000, p. 2004). Nolan (1998) has argued that for physicians to offer their patients good care, they must be aware of the structure of the healthcare system within which they function so as to deliberately both use and change the system in accord with their purpose. When professionals in a system are ignorant of its nature, the priorities of each professional identity compete against each other. Nolan (1998) asks us to consider a payer who adds an approval step that must be completed before a patient can be referred to a specialist. Other members of the system react by creating informal processes to circumvent the approval step or to resolve conflicts about the referral's appropriateness. This creates an impediment to efficient provision of necessary healthcare services, arguably a healthcare system's unified goal. As Nolan (1998) says, "even a rudimentary understanding of the structures and dynamics of systems combined with clinical knowledge can equip a physician to diagnose the faults of a system and design remedies" rather than workarounds (1998, 293). But first, there must *be* that rudimentary understanding.

Ultimately, social structures that govern relationships between clinical personnel need organizational oversight, structural changes, *and* awareness and deliberate action by the personnel themselves. Only physicians who understand the importance of collegiality will take collegiality training seriously, giving it what philosophers call "uptake" and integrating it into future behavior and existing clinical relationships. The understanding and the collegiality, itself, must be taught *and learned* if we are to see healthier patients and healthier organizations. Moreover, physicians need to understand the impact of their interactions with non-medical personnel in their healthcare system in order to fulfill their obligations. We must not miss the opportunity revealed by Goold and Stern's timely study to use resident physicians' express interest in relationships with other clinical personnel to expand professional education not only to resident-attending interactions but also to healthcare personnel interactions, more generally. ■

REFERENCES

Baggs, J. G., M. H. Schmitt, A. I. Mushlin, P. H. Mitchell, D. H. Eldredge, D. Oakes, and A. D. Hutson. 1999. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Critical Care Medicine* 27(9): 1991–1998.

Cochran, J. H., P. K. Fahy, and J. C. Bansek. 2004. Physician as healer, leader, and partner: Tackling the nursing shortage. *The Permanente Journal* 8(1): 89–92.

Cooper, R. A., T. E. Getzen, H. J. McKee, and P. Laud. 2002. Economic and demographic trends signal an impending physician shortage. *Health Affairs* 21(1): 140–154.

Goold, S. D., and D. T. Stern. 2006. Ethics and professionalism: What does a resident need to learn? *American Journal of Bioethics* 6(4): 9–17.

Kohn, L. T., J. M. Corrigan, and M. S. Donaldson. 2000. Executive Summary. *To err is human: Building a safer health system.* Washington, DC: Institute of Medicine, National Academy Press.

Mainous, A. G., M. Ramsbottom-Lucier, and E. C. Rich. 1994. The role of clinical workload and satisfaction with workload in rural primary care physician retention. *Archives of Family Medicine* 3(9): 757–759.

Nolan, T. 1998. Understanding medical systems. *Annals of Internal Medicine* 128(4): 293–298.

O'Reilly, M. 1998. A Marathon session: A town's MDs develop a philosophy to call their own. *Canadian Medical Association Journal* 158(11): 1516–1517.

Page, A. 2004. *Keeping patients safe: Transforming the work environment of nurses.* Washington, DC: Institute of Medicine, National Academy Press.

Prescott, P. A., and S. A. Bowen. 1985. Physician-nurse relationships. *Annals of Internal Medicine* 103(1): 127–33.

Rosenstein, A. H. 2002. Nurse-physician relationships: Impact on nurse satisfaction and retention. *American Journal of Nursing* 102(6): 26–34.

Schmalenberg, C., M. Kramer, C. R. King, M. Krugman, C. Lund, D. Poduska, and D. Rapp. 2005. Excellence through evidence: Securing collegial/collaborative nurse-physician relationships, part 1. *Journal of Nursing Administration* 35(10): 450–458.

DOI: 10.1080/15265160600755516