The doctor–nurse relationship: time for change?

Introduction

As members of the health profession, our relationship with patients is at the heart of everything we do. But what about our relationship with members of our own team? How can enhancing these improve patient care? This article explores the doctor–nurse relationship, how it has changed over time, the current situation and how we can make things better.

The history of the doctor–nurse relationship

Doctors and nurses have always had to work together whether in the community or in hospital, but their relationship has changed markedly over time.

> **'A nurse must begin her work with the idea firmly implanted in her mind that she is only the instrument by whom the doctor gets his instructions carried out; she occupies no independent position in the treatment of the sick person.' (McGregor-Robertson, 1902)**

Today, such a statement sounds abhorrent, but in the past, doctors had a lot of control over nurses to the extent that they would even train nurses to fulfill the jobs they wanted them to do (Keddy et al, 1986).

This continued into the 1930s when it was not unusual for doctors to set the exams for nursing students. The nurse's role was therefore seen as the performance of a physician's orders, rather than as a separate role relating to patient care and outcomes.

Things have progressed slowly since those days, but despite some of these attitudes persisting, the role of nurses is changing.

Present day

The boundaries between doctors and nurses are becoming less clear-cut. Nurses are becoming increasingly involved in more specialized care that was previously performed by junior doctors (Moss, 1999).

Mr Ahmir Ahmad *is 4th Year Medical Student, University College London Medical School, London WC1E 6BT*

This can reduce the burden on doctors, and increase the professional status of nurses. However, some have argued that there is the risk that nurses take on roles without the necessary training (Doyal and Cameron, 2000). The evidence shows that nurse stress is increased and patient care can be affected. However, some studies have found that where doctors have delegated tasks there have been no major problems, and health-care costs have reduced (Fagin and Garelick, 2004).

Some have said that the nursing profession is making a mistake by following the medical profession in producing nurse consultants and practitioners. This could distract from the nurse's role of 'nourishment, problem solving, and easing the experience of suffering, medical invasion, or death' (Radcliffe, 2000). But such a move is helping to fill the void between the medical and nursing professions.

Barriers to change in the doctor–nurse relationship

There is an extremely strong sense of hierarchy in the medical profession. This will most likely always exist within the medical profession (as in the nursing profession) as the more experienced individual trumps the less experienced. But between the professions, the sense of hierarchy is a major barrier to improving the doctor–nurse relationship.

The traditional view borne out in sociological studies is that gender roles influence the doctor–nurse relationship to the extent that the female is passive, while the male is decisive and active (Savage, 1987). Today, the majority of medical students are female and there is an increasing proportion of male nurses. The effect of these demographic shifts is that gender roles are becoming less significant.

Collaboration is made harder because of differences in class, the value placed on academic rather than manual activity, and level of education (Fagin, 1992). These factors contribute to a public perception that doctors 'are educated whilst nurses are trained' (Warelow, 1996). A consequence of this hierarchy is that it may be more difficult for nurses to voice their concerns with doctors, particularly if these are critical.

A lack of understanding between the professions is also a barrier to improving the doctor–nurse relationship. A study conducted by the *Nursing Times* in 1991 found that more than two thirds of nurses felt doctors did not understand the nature of their work. In addition, 50% felt that doctors had never read their notes and 60% did not feel they were consulted about clinical matters (Heenan, 1991).

Positive changes for the future

To improve the doctor–nurse relationship, we need to make changes at individual and system levels.

Both professions need to:

- Be open to the idea of collaboration (rather than division)
- Treat each other with respect and dignity
- Value each others' experiences
- Learn about the roles of other health-care professionals.

Doctors can take practical steps to improving the relationship such as:

- Knowing the names of nurses and health-care assistants
- Making opportunities to discuss issues with nurses, e.g. by arranging joint meetings
- Ensuring decisions are relayed carefully (e.g. with neat hand writing) to the right member of the team (usually the charge nurse)
- Being prepared to listen to the expert views of nurses, e.g. about the patient's experience in hospital
- Recognizing that nurses already play an important role in supporting and guiding junior doctors.

Nurses can take practical steps to improving the relationship such as:

- Discussing concerns about a doctor's behaviour with the ward sister so these can be addressed
- Carrying out joint clinical audits, presentations and publications with doctors
- At induction, showing medical students and junior doctors how the ward works and explaining the role of nurses
- Arranging nurse-led teaching of medical students in teaching hospitals

- Spending some time learning about the work of doctors and other health professionals by work shadowing
- Being aware of government plans to break down barriers and check progress.

Changes in the system are also essential

The government's *NHS Plan* recognized that 'unnecessary boundaries exist between the professions which hold back staff from fulfilling their true potential' (NHS Executive, 2000). A key step to addressing these is changing the education that nursing and medical students receive. The plan says 'there will be new joint training across professions in communication skills and in the NHS principles and organisation' which is part of the new core curriculum for NHS staff. In addition, 'nurses, midwives or therapists who want to become doctors, will no longer have to start training from scratch.' These are ambitious plans, and we are slowly seeing changes emerging.

At St George's (University of London), a new programme has been developed where students from nursing, medical and allied health professions work together to run a rehabilitation ward. This has helped students to gain an awareness and understanding of each other's profession (Reeves et al, 2002).

At university level, common modules in areas such as communication skills would be an invaluable tool in engaging trainee nurses and doctors at grassroots level. Joint training and assessment would help breakdown barriers. On the wards, this can continue by organizing joint meetings, audits and presentations. Training between the professions could be shared to show students that we work as a multidisciplinary team. One suggestion could be senior doctors explaining the role of doctors to student nurses, and senior nurses training student doctors about the role of nurses. More specifically, nurses could teach medical students how to take observations while doctors could explain to student nurses the medical background to pressure ulcer formation and how nurses intervene to prevent them.

The good news is that we are already seeing more flexible teams within the NHS, which are starting to shatter the old hierarchical ways. For example, midwifes are 'leading a more responsive health service' and accident and emergency nurses are 'treating patient with minor injuries and ailments, freeing up doctors' time and so delivering shorter waits for treatment' (NHS Executive, 2000). Gone are the days where the nurse was considered merely an instrument of the doctor. In fact, there is growing research suggesting that increased collaboration between doctors and nurses can improve outcomes for patients (Stein-Parbury and Liaschenko, 2007).

Conclusions

If we can implement changes in ourselves as individuals, we open the door to making improvements in our own teams and systems. Within the professions, senior doctors and nurses need to appreciate the value of the newly qualified doctors and nurses. Even more importantly, nurses and doctors need to work together on equal terms. Any change is accompanied by resistance. But at no time has this been more important to overcome. With our increasingly complex NHS and increasing patient expectations, failure to do this will sacrifice our shared goal – to meet the best interests of the patient. BJHM

Conflict of interest: none.

Doyal L, Cameron A (2000) Reshaping the NHS workforce. *BMJ* **320:** 1023–4

Fagin CM (1992) Collaboration between nurses and physicians: no longer a choice. *Acad Med* **67**(5): 295–303

Fagin L, Garelick A (2004) The doctor-nurse relationship. *Adv Psychiatr Treat* **10**(4): 277–86

Heenan A (1991) Working with doctors: uneasy partnership. *Nurs Times* **87:** 25–7

Keddy B, Jones M, Jacobs P, Burton H, Rogers M (1986) The doctor-nurse relationship: an historical perspective. *J Adv Nurs* **11**(6): 745–53

McGregor-Robertson J (1902) *The Household Physician.* Gresham Publishing, London

Moss F (1999) Junior doctors: waving or drowning? *BMJ* **318:** 1639

NHS Executive (2000) *The NHS plan: a plan for investment, a plan for reform.* Department of Health, London

Radcliffe M (2000) Doctors and nurses: new game, same result. *BMJ* **320:** 1085

Reeves S, Freeth D, McCrorie P, Perry D (2002) 'It teaches you what to expect in the future…': interprofessional learning on a training ward for medical, nursing, occupational therapy and physiotherapy students. *Med Educ* **36**(4): 337–44

Savage J (1987) *Nurses and Gender.* Open University Press, Milton Keynes

Stein-Parbury J, Liaschenko J (2007) Understanding collaboration between nurses and physicians as knowledge at work. *Am J Crit Care* **16**(5): 470–7

Warelow P (1996) Nurse-doctor relationships in multidisciplinary teams: Ideal or real? *Int J Nurs Pract* **2**(1): 33–9

KEY POINTS

- The relationship between doctors and nurses has not always been positive and, even today, there are barriers to progress.
- Doctors and nurses need to value each other and take action to promote collaboration rather than division.
- Improving the doctor–nurse relationship is critical in meeting the best interests of the patient.