

TEAM-BUILDING HANDBOOK

IMPROVING NURSE-PHYSICIAN COMMUNICATIONS



Kathleen Bartholomew, RN, MN
Author of *Speak Your Truth*
and *Ending Nurse-To-Nurse Hostility*

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About the Author

Kathleen Bartholomew, RN, MN

Before turning to healthcare as a career in 1994, Kathleen Bartholomew held positions in marketing, business, communications, and teaching. It was these experiences that allowed her to look at the culture of healthcare from a unique perspective and speak poignantly to the issues affecting providers and the challenges facing organizations today.

Bartholomew has been a national speaker for the past 12 years. As the manager of a large surgical unit in Seattle, she quickly recognized that creating a culture where staff felt a sense of belonging was critical to retention. During her tenure as manager, staff, physician, and patient satisfaction reached the top 10% as she implemented her down-to-earth strategies. Despite the nursing shortage, Bartholomew could always depend on a waiting list of nurses for both units.

For her master's thesis, Bartholomew authored *Speak Your Truth: Proven Strategies for Effective Nurse-Physician Communication*,

a book that broke new ground in addressing nurse-physician issues. Now published in an expanded edition, *Speak Your Truth* forms the basis of the handbook you are holding.

In December of 2005, Bartholomew resigned her position as manager to write the first edition of *Ending Nurse-to-Nurse Hostility*, her second book on horizontal violence in nursing. The expression “nurses eat their young” has existed for many years in the nursing profession (and has troubled many in the profession). An expanded, updated edition was released in 2014.

Bartholomew won the best media depiction of nursing for her op-ed in the *Seattle Post Intelligencer*, and in 2010 she was nominated by HealthLeaders Media as one of the top 20 people changing healthcare in America.

Bartholomew’s passion for creating healthy work environments is infectious. She is an expert on hospital culture and speaks internationally to hospital boards, the military, leadership, and staff about safety, communication, cultural change, and power. With her husband, John J. Nance, she coauthored *Charting the Course: Launching Patient-Centric Healthcare* in 2012, which is the sequel to *Why Hospitals Should Fly* (2008).

From the bedside to the boardroom, Bartholomew applies research to practice with humor and an ethical call to excellence that ignites and inspires health caregivers and leaders to unprecedented levels of excellence.

Introduction

Assessing the Situation

In my first nursing job, I was a medical-surgical nurse in a small community hospital. Orientation to the unit covered not only the skills I needed to care for the patients but also the knowledge I needed to survive working with the physicians. I was warned about the egotistical Dr. Keeting, to whom nurses were just another piece of furniture. When nurses spoke, he would glance only for a second in their direction, as if to say, “For a moment, I thought that chair said something.” Then he would resume his charting without ever acknowledging that, indeed, the furniture had spoken.

It was also a well-known fact that if you called Dr. Keeting to notify him of a temperature of 103, he would hang up on you. I took care of his patients for weeks, and during this time his nonverbal communication made it clear that he expected me to be invisible. He would never make eye contact or acknowledge a mere nurse’s existence—unless, of course, he had summoned her himself. As a new nurse walking into a culture that I didn’t understand, I said nothing. I needed time to process this new

environment, the strange interactions I saw between doctors and nurses, and my new clinical responsibilities.

Changing the Dynamic

One day Dr. Keeting decided he needed to speak to me. I had been waiting for this opportunity, like a panther in the grass, for weeks—not because I had anything planned, but because I knew that an interaction would not be meaningful unless he initiated it. At 6' 4" tall, Dr. Keeting used his stature as yet another means of intimidation, so when he said, "I need to speak to you," I responded, "Just a minute." To Dr. Keeting's surprise, I pulled out the nearest chair, stood on it, looked him dead in the eye, and said, "How can I help you?" Stunned, he simply walked away.

Within six months of graduating, I was promoted to charge nurse because of my ability to hold my own with the physicians. In those first few years, I learned that the doctors' barks were worse than their bites. The next time Dr. Keeting came to the floor, I was less apprehensive. I mustered some courage and asked him if he had any children. Everyone was surprised when he stopped and took out his wallet to show us pictures of them—especially me. I had thought for certain that he would yell, "It's none of your business!" but he didn't. That simplest of human gestures seemed to shift the relationship.

With a few successes under my belt, I grew bolder and decided to see what I could do about one surgeon who intimidated the

nurses with his order bellowing and brusque mannerisms. I found out that he was Irish, and the next time he came onto the unit, I softly began to hum “Sweet Rosie O’Grady,” an Irish limerick taught to me during glee club in a convent basement as a child. After a few weeks of this, he lightened up so much that he even began singing to himself as he made his rounds. To this day, the manager talks about how I could get Dr. Sweeney to sing.

How to Use This Book

My early interactions with physicians taught me that simply connecting on a human level is an incredible catalyst for transforming nurse-physician relationships. It was a powerful lesson, and one that I hope you’ll benefit from as you work through this handbook.

As with all nursing processes, the most important first step is to assess the situation. To begin, we’ll take a broad view, looking at different types of work relationships in terms of collegiality and power structure. We’ll then move on to understand methods of communication in our relationships, and learn what works and what doesn’t.

Once we’ve established an understanding of our patterns and the relationship structures, we’ll turn our attention to the *individual’s* standpoint—after all, poor nurse-physician relationships can only improve when you take ownership of and personal responsibility for your role in the problem.

In this handbook, our goal is to work through these four steps:

1. Assessing the quality of your work relationships
2. Assessing your barriers and typical responses to conflict
3. Taking the emotional pulse of the relationships on the unit
4. Learning to respond differently—and change the existing culture

In the process, you'll find that you can improve your work relationships over time by making a few changes in the way you think about nurse-physician relations, the way you present yourself, and the way you encourage others to treat you with respect.

Chapter 1

Understanding Work Relationships

*No one can make you feel inferior without your consent.
—Eleanor Roosevelt*

Taking the pulse of our work relationships is a good starting point for change. Doing so allows you to dissect the current relationships in your facility and make sense of the problems you face.

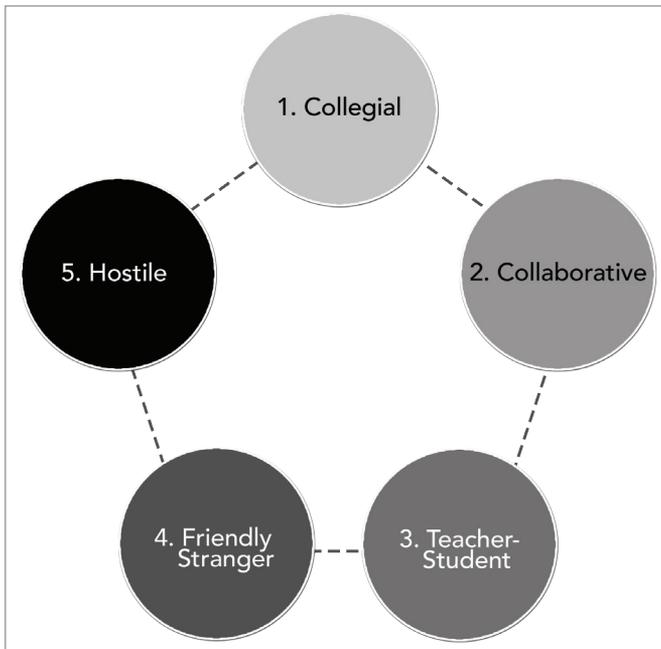
Exploring Relationship Types

In their research surrounding nurse-physician relationships, Marlene Kramer and Claudia Schmalenberg took a closer look at these connections by defining exactly what nurses meant when they described any nurse-physician relationship as “good.” The term meant different things to different nurses, but the researchers did find that power consistently played a large role in the relationships (Kramer and Schmalenberg, 2003). They further developed the following five categories to define

the types of relationships (2004), as shown in the list and illustration below:

1. Collegial—Equal power, trust, and respect
2. Collaborative—Mutual power, trust, and respect
3. Teacher-Student—RN or MD can be either role; both willing to listen, teach, and learn
4. Friendly Stranger—Little trust and acknowledgment; courteous but formal
5. Hostile—Adversarial and abusive; negativity in tone and action

Figure 1.1 | Envisioning the five relationship types



When these researchers looked for a correlation between the quality of nurse-physician relationships and the quality of patient care on a unit, they found that two out of the 14 American Nurses Credentialing Center Magnet Recognition Program® hospitals participating in the study had a formalized collaborative practice structure. Within these two hospitals, more than 75% of nurses rated their relationships as collegial. In other words, nurses rated the quality of care on the units with collaborative and collegial relationships significantly higher than they rated care on those units without such relationships.

The American Association of Critical-Care Nurses' *Standards for Establishing and Sustaining Healthy Work Environments* lays a solid foundation for practice and points out that collaboration must be viewed as a core value. It's important to acknowledge that ***collaboration is a relationship—a dynamic ongoing process.***

Balancing Our Relationships

In our personal relationships as well as our work relationships, we seek a balance. Even the best relationships go through high and low periods, where one friend, one family member, or one coworker supports us, or we do the supporting. Most of the time, though, we seek equilibrium—give and take, sharing, and mutual respect.

When relationships are chronically out of balance, one or both parties become frustrated or unhappy. Think back to your experiences as a child on the playground seesaw: how happy you

were to be paired with someone of the same size who cooperated with the idea of give and take and up and down. Even being paired with someone a bit larger can be fun if that person wants to play cooperatively.

When the other person carries more weight (literally and figuratively), it becomes more difficult to have a good time. And when that person carries more weight and doesn't want to cooperate, you can be held high in the air, feet dangling, and frightened or frustrated beyond words.

Let's apply this seesaw metaphor to our work relationships.

Collegial Relationships

There are great doctors out there, and Jeff is one of them. He is a member of a special class of physicians who believes that exchanging and sharing knowledge with one's colleagues (and yes, that includes nurses) is an integral part of patient care. He treats all staff as if they are on the same team—and they are. He doesn't lash out at the nurses—not even after a patient has lashed out at him. He doesn't make nurses feel stupid when they call him in the middle of the night to inform him of a patient's changing status. His voice is steady, and he listens. Because of Jeff's congenial manner, nurses don't hesitate to ask questions; he makes them feel valued with his sincerity, and everything about him invites a conversation.

When writing orders, Jeff often explains his thought process so that those around him get the opportunity to learn. With this

physician, nurses feel respected and acknowledged for their role as healthcare professionals—especially when he asks for their advice. When Jeff is around, the atmosphere is always comfortable.

Recently, for instance, Jeff had a difficult time determining whether a patient’s pain medicine was working because he had just stepped onto the floor. But after checking the patient’s pain flow sheet and speaking with the nurses, Jeff realized that his patient was always either awake and in pain or asleep. After Jeff shared his findings with a nurse, she suggested switching the pain medicine in the patient-controlled analgesic from morphine to Dilaudid. After seeing improvement—a much more comfortable patient—due to the nurse’s suggestion, Jeff exclaimed to the nurse, “Good call!”

In **collegial relationships**—such as those between Jeff and his nurse colleagues—the nurses and the doctor have equal respect and power. Because of this, all parties feel empowered. When both nurses and physicians have power, they are better able to recognize the value in each other’s education and experience. Doctors are respected for their years of training, and nurses are respected for their years of experience and for their assessment skills, derived from the vast amount of time they spend with patients. Doctors recognize that during an 8- or 12-hour shift, a nurse can pick up on the subtle signs that lead to postop complications.

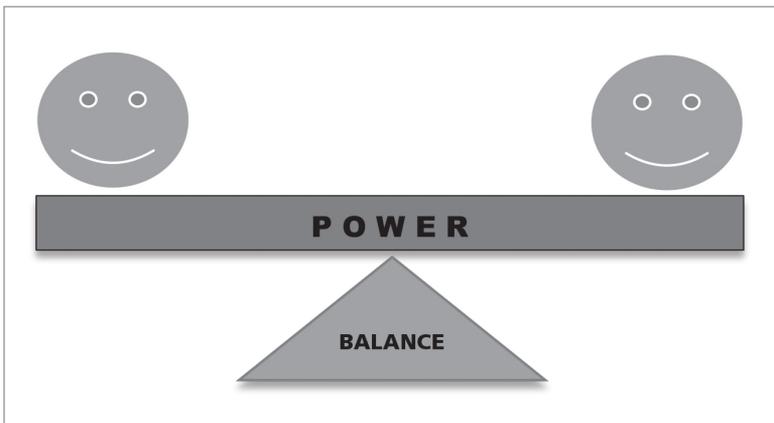
In the collegial environment, physicians and nurses consult each other frequently and seek each other’s advice, to the

full benefit of the patient. The nurses don't hesitate to ask questions or share opinions, and doctors listen and respond in a manner that encourages dialogue. Everyone must remember that knowledge is not solely the doctor's property. In fact, sharing knowledge openly allows for improved care, which is perhaps the most critical outcome of collegial relationships.

The nurse manager also plays an important role in promoting healthy physician-nurse relationships. By virtue of having a supervisory role on the floor, the nurse manager is often responsible for setting the expectation for collegial relationships. He or she is in the perfect position to model the correct behavior and nurture relationships.

Try this

Collegial relationship



If the relationship is collegial:

- Personally thank the physician publicly
- Send a thank-you note to him or her
- Copy the medical director and CEO on an email thank-you
- Be specific; give examples of collaboration that improved patient outcomes

Dr. Kilroy, thank you for reviewing the plan of care with me and the patient at the same time at the bedside this morning. That made a huge difference in her complying with physical therapy and her diet today.

Dr. Franklin, I appreciate your asking me for my opinion with the plan of care for pain control for Mr. Bartley and your willingness to try Toradol instead of opioids. He is moving around so much better today. I want to thank you personally.

Collaborative Relationships

Both collegial and collaborative relationships have their roots in the principles of collaboration—the art of working in partnership. Collaborative relationships promote positive patient health outcomes, decreased lengths of stay, and increased job satisfaction for both nurses and physicians. Collaboration begins with a vision shared by nurses, administration, and physicians, and with clearly stated behavior expectations.

Betina knew that her patient was reacting strongly to her medication, but she also knew that she had given her very little of it. When Dr. Renno arrived on the floor, he too was puzzled. Betina hesitated to offer her opinion because Dr. Renno had disagreed with an assessment she made last week. They brainstormed possible causes for the patient's heightened drug state, discussing everything from increased creatine levels to drug sensitivity.

Finally, Betina said, "I think this patient is taking her own pain medicine." Together, they went into the room and tried to help the groggy patient sit up in bed—and that's when the bottle of Percocet rolled to the floor.

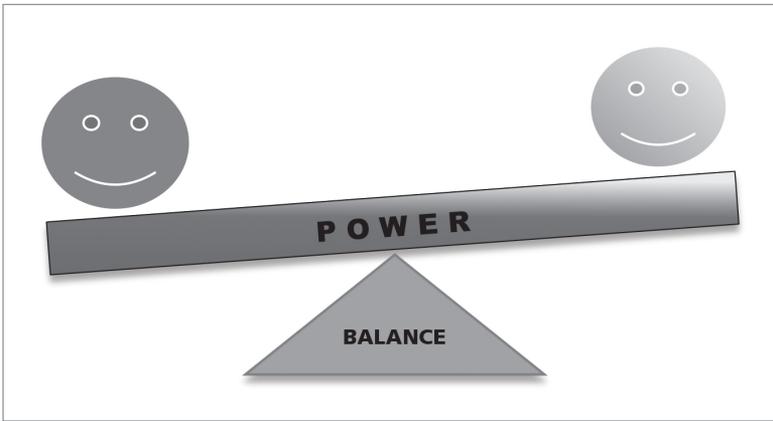
In a collaborative relationship, physicians and nurses participate together in the plan of care to produce positive outcomes for the patients. The nurses and physicians have a mutual respect for each other. *The key difference between collegial and collaborative, however, is that the power is not equal.* The nurses realize that, despite their input, the physicians will always have the final say. For the most part, however, the power difference doesn't interfere with the working relationship, and both parties are able to work together for the benefit of the patient.

Research tells us that collegial/collaborative relationships positively affect patient care, but these relationships don't just benefit the patient; they create an environment that is rewarding and energizing to both parties. People with mutual trust, respect, and open communication take their relationships

beyond the work environment. They want to share a meal, have coffee, or celebrate milestones and holidays together.

Try this

Collaborative relationship



If the relationship is collaborative, the goal is to increase trust and respect. This takes time—you will need to “show your stuff.” For example:

- Use progress notes to indicate that you are aware of the physician’s main concern about the patient, as well as your interventions
- Ask questions and share concerns
- Use every event as a learning opportunity and debrief cases often

Dr. Jefferson, can we speak for a moment? I wanted to make sure you were aware of the amount of bloody drainage from Mrs. Keefer’s wound and her HCT level.

Dr. Dylan, I've reviewed the blood culture results but can't see a reason why you changed antibiotics for Mr. Walton. Can you explain so I can understand and better answer questions from the family?

Teacher-Student Relationships

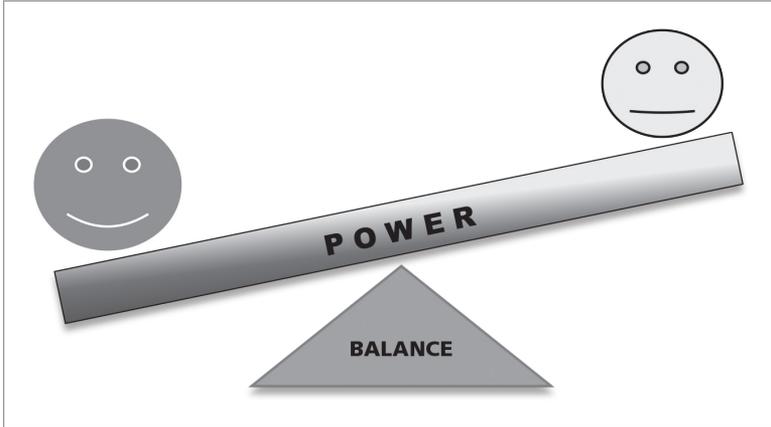
In teacher-student relationships, the physician or nurse takes on the role of mentor. Typically, the doctor educates the nurse. Often, however, the nurse is in a position to teach the physician what she has learned from her experience. Nurses generally have a wider, more holistic picture of patients and, historically, have been better able to consider the emotional and psychosocial aspects of patient care.

Although the nurse appreciates the information being shared, and although the outcomes are still beneficial for the patient, teacher-student relationships fall short of making both the nurse and the physician feel intrinsically good about their roles. Within these relationships, there is less trust, value, and respect than in collaborative and collegial relationships.

Even though the teacher-student relationship may start off as a positive interaction between physicians and nurses, allowing the nurse to learn from the physician's years of schooling and helping the physician to better understand nursing's role in patient care, the relationship eventually wears on the less powerful person involved, and negative feelings develop. The atmosphere may seem courteous and friendly, but teacher and student both lack authentic appreciation and respect for each other.

Try this

Teacher-student relationship



If the relationship is teacher-student, the goal is to develop a relationship that doesn't exist solely around work:

- Learn about each other as human beings—what are the other person's hobbies? Ask about vacations or family.
- Plan joint educational and celebratory events.

Kathy listened closely as Ms. Bryan complained. The patient was requesting a bolus of pain medication, but she had already taken 38 mg of morphine in the past six hours, so Kathy was hesitant to give any more. Kathy did her assessment. Twelve hours postop after an anterior cervical operation, the patient could still not swallow water. "And I am upset with the doctor," the patient continued. "He just walked in the room, said, 'Guess you can't go home today,' and walked out. He didn't even look at my dressing!"

Sure enough, there were no orders written, so Kathy developed a plan of care. If she could get the patient to swallow, then she could start the longer-acting pain pills and get her patient's pain under control. So she called the doctor with a plan, unsure of how he would respond. "Can we get this patient on four doses of 10 mg of Decadron IV to reduce the throat swelling and get her eating?" she asked. "Then I can get her pain under control with some longer-acting pills." He approved of the plan.

By the next morning, the patient had improved dramatically. The doctor stopped Kathy in the hall and asked, "Where did you learn that trick?"

"From the neurology doctors," she replied. "It works great." Thoughtfully, he nodded and left the floor.

Friendly Stranger Relationships

As Dr. Hughes walked by the nursing station, I watched all the nurses' facial expressions suddenly change to subtle smirks. I had seen this particular physician in action before, and I knew there was no threat of a flare-up or any other problematic confrontation—he never spoke to the nurses. Dr. Hughes simply came onto the unit, wrote orders, and left without speaking to anyone.

Relationships that used to require some form of intervention (e.g., used to be more teacher-student) may be replaced with more neutral, low-interaction relationships. "Friendly stranger" relationships evoke indifference. Such relationships originally cropped up in healthcare when, in an effort to increase productivity, hospitals

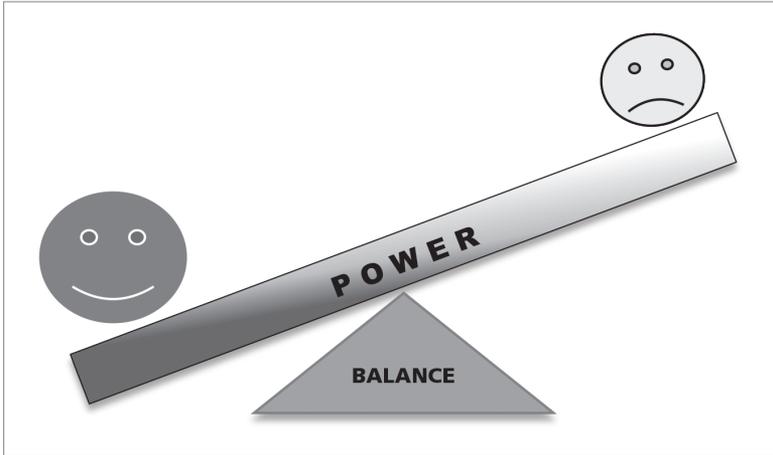
decided to move the patient charts from the main nursing station to outside patients' rooms. Once that move occurred, the decline in communication between nurses and physicians was rapid and obvious.

Nurses and doctors used to congregate at the main hub and discuss potential problems. It was during these daily discussions that nurses could ask the doctors questions about their patients' plans of care, which fostered a learning environment. Now, however, a doctor can come to the floor, write orders, put up the yellow flag on the chart rack, and never speak to anyone. In that small effort to improve productivity, a daily opportunity to communicate was lost.

Linda was hoping to catch Dr. Horn before he left the floor, so she hovered outside of the patient's room he was in, and she caught up on her charting while she waited. Her patient was anxious because she had not received the necessary asthma inhalers or medications after surgery. When the doctor finished rounding with the patient, Linda said, "I noticed that none of the medications this patient was on prior to surgery have been restarted." For a moment, he glanced in her direction, and then resumed his charting. Linda wasn't sure what he would do, but much to her relief, she discovered after he left the floor that he had reordered the patient's meds.

Try this

Friendly stranger relationship



If the relationship is friendly stranger:

- People in this category can be quite difficult to reach, so start with daily contact: make eye contact; start with names first
- Don't play the game; engage in conversation
- Look for common educational opportunities—for example, ask to be mentored in a specific area or procedure

Dr. Carlson, I noticed that you are doing more lumbar surgeries from an anterior approach. Can you tell me what prompted that change and give me a brief talk on postop complications for this type of surgery?

Hostile Relationships

Nurses report that negative patient outcomes occur more frequently when they interact with a difficult physician. Most of the scenarios in this book demonstrate negative interactions—and, unfortunately, they are all real-life examples. In reality, only 3%–5% of physician-nurse relationships are hostile, but these difficult relationships exponentially impact daily interactions on the unit.

After a doctor establishes a negative reputation for him- or herself, nurses will go out of their way to avoid him or her. After all, no one wants to feel small, insignificant, or worthless. But the critical common thread in every disturbing nurse-physician interaction is that the patient loses.

Donna began nursing on the surgical floor only two years ago. She was just out of nursing school and still feeling her way around. When the manager asked for volunteers for the hospital's skin committee, she eagerly volunteered and enjoyed her role as a unit resource. The manager would call on her at staff meetings to share new information and report on hospitalwide efforts to decrease pressure ulcers.

One day while Donna was caring for a patient, Dr. Knowlten asked her to help with the wound care. Donna held the patient's leg while the doctor poured half a bottle of peroxide directly into the wound, causing the patient a great deal of pain.

After Dr. Knowlten and Donna left the room, Donna asked to speak to the doctor. She told him about recent studies that

showed hydrogen peroxide inhibited healthy cell development and about the latest recommendations. He replied, "Show me the data."

Donna was excited. Here was her chance to contribute to a practice change that would benefit all of Dr. Knowlten's patients. She spent more than two hours pulling up research and gathering all the pertinent information.

The next day, she proudly handed her work to Dr. Knowlten. But he didn't even look at it. He plopped the papers on the counter and said, "Donna, can you help me?" Then he walked into the same patient's room and proceeded to pour an entire bottle of peroxide into the wound again.

For the next four years, Donna never made another suggestion to Dr. Knowlten. Finally, on the day she quit, she told her manager about the situation and about the fact that every time she saw that doctor, she just turned her head and looked the other way. She shared how painful it was to even look at him because it reminded her of that day, when she had truly gotten her hopes up. She had thought that she had an opportunity to improve patient care and was unprepared for the doctor's arrogant and humiliating response. Donna felt like she had been set up, and the feeling of betrayal was not easily forgotten.

There are many stories like this one, and they all share a common denominator: the hostile physician. For the particular doctor referenced above, either internal or external factors might cause him to become agitated. Sometimes the way a nurse presented a suggestion would set him off, or the weight of his personal problems would cause him to erupt.

Either way, this once-disruptive physician now has better relationships with the remaining nurses—some better than others, of course. Some speculate that his softening came with age—perhaps time has given him a greater understanding of the nurse’s role and a greater appreciation for their work. But let’s not forget that with age comes experience, and some experiences serve as the ultimate eye-openers.

The nurses were at the main station when Dr. Knowlten arrived on the floor. He asked gruffly, “Have you gotten my patient out of bed yet?” It was 10:00 a.m.

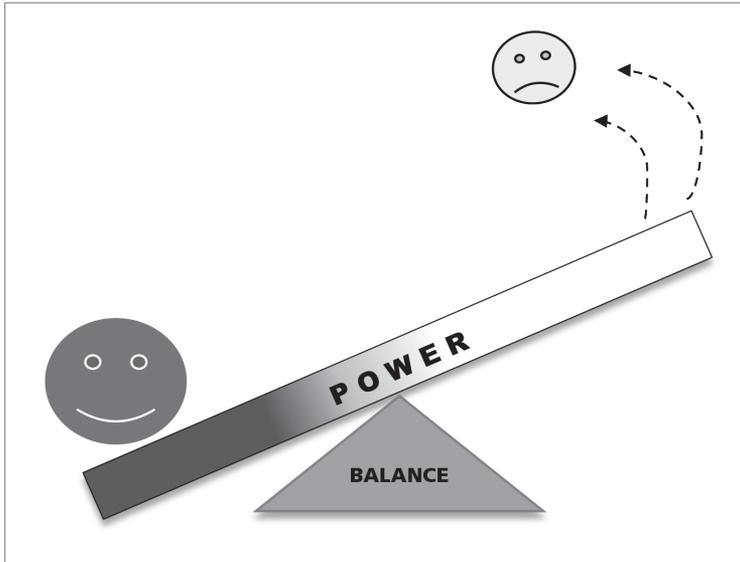
“No,” the nurse responded. “Your patient is very heavy, and I thought it better to wait for physical therapy to help in a half hour.”

“Nonsense. You girls are just lazy,” he said as he stomped off to see his patient.

Several minutes later, the doctor yelled frantically from the patient’s room. “Help! Help!” They all rushed in to the room to find Dr. Knowlten pinned to the bed, under his heavy patient.

Try this

Hostile relationship



If the relationship is hostile:

- Never tolerate the behavior.
- When faced with the behavior, say, “May I speak to you for a moment in private?”
- Explain the unacceptable behavior and state its effect.
- Always take your issues directly to the physician first.
- If that doesn’t work, report it to your manager and copy the medical director.

Dr. Carter, may I speak to you for a moment in private? I noticed you rolled your eyes when I asked you for clarification on your verbal orders—and my peers noticed as well. I am not sure that you were aware that you were doing this, or the impact. Rolling your eyes will inhibit nurses from seeking clarification when they are confused or in doubt.

TEAM-BUILDING HANDBOOK

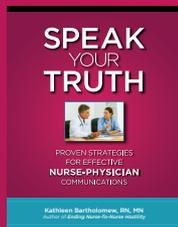
IMPROVING NURSE-PHYSICIAN COMMUNICATIONS

Kathleen Bartholomew, RN, MN

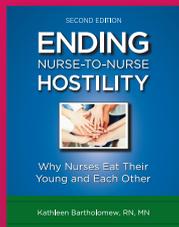
Kathleen Bartholomew's *Team-Building Handbook: Improving Nurse-Physician Communications* delivers effective strategies for creating a high-functioning workplace through dialogues that are clear and respectful. This easy-to-read handbook provides thoughtful scenarios, exercises, and scripts designed to raise the effectiveness of nurse-physician interactions, to the benefit of all.

Sold in packs of 10, *Team-Building Handbook: Improving Nurse-Physician Communications* is the perfect tool for staff training, orientation and in-services, or self-study.

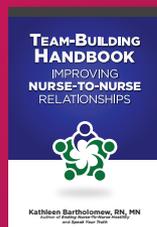
Other books by Kathleen Bartholomew:



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