

Improving Nurse-Physician Communication:
Analyzing Ethical Codes to Promote Solutions

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Collaboration among the healthcare team has been widely identified as a major factor in improving patient outcomes (Engel & Pretice, 2013; Melia, 2001; Olenick et al., 2010; Pullen, 2008; Thomas et al., 2003). Unhindered communication serves to promote interprofessional collaboration. Identifying potential sources of problematic communication between nurses and physicians can assist in developing strategies to facilitate collaboration within an interprofessional team. Nurses and physicians have independent professional associations that produce and disseminate ethical codes to which their professional conduct is bound. Comparing these two ethical codes will provide a position from which to understand the foundational perspective of each relative profession, and can illuminate areas of potential communication difficulties between the two professions. Determining inherent sources of friction in interprofessional communication can help focus appropriate interventions to facilitate collaboration and improve patient outcome.

The American Medical Association (AMA) Code of Medical Ethics (2002) and the American Nurses Association (ANA) Code of Ethics for Nurses (2015) are long-standing ethical guidelines established and regularly updated by each profession. Both the AMA and the ANA Codes consist of nine points with corresponding declarations of explanation: the AMA Code has nine Principles with associated Opinions, and the ANA Code has nine Provisions with its own Interpretive Statements. In addition to emphasizing advocacy for patient autonomy, beneficence, and justice, both Codes establish a strong basis for professional autonomy (Byrd & Winkelstein, 2014, p. 255). Several other commonalities exist in the two codes, ranging from advocating for human rights and dignity, to implementing and expanding evidence-based research and practices. Revisions in each code have removed gender-specific references pertaining to members of both professions.

Perhaps the most stereotypic aspect of authority and power-differential within nurse-physician communications is that of gender. The U.S. society has come a long way from when sexist attitudes constrained career opportunities, as exemplified in Henry Pratt, M.D.'s 1965 description of the perfect nurse: "She must feel like a girl, act like a lady, think like a man, and work like a dog" (Pratt, 1965, p. 767). Stereotypes of gender roles, specifically male doctors and female nurses, are tenacious; while dwindling, their effects are still present in the healthcare profession. The ongoing evolution of gender stereotypes and associated power disparities still reverberate in nurse-physician communication, and opposition to these stereotypes is reflected in the ANA Code.

While the first unofficial ethical code, the Nightingale Pledge, refers to physicians as male, it was not until the 1976 revision of the ANA Code was gender-neutral language used throughout. (Gretter, 1893; Davis et al., 2008, p. xvi). The nursing profession has consistently encouraged professional equality and autonomy, and the social movements of the late 1960's likely catalyzed revisions to the Code. For example, Fowler acknowledges that "the 1968 [ANA] Code was the first version that did not explicitly mention the physician; "members of other health professions" are mentioned, but the physician is not singled out" (Davis et al., 2008, p. xv). Fowler is referring to Provision 2.3, specifically "The relationship between nursing and other healthcare professionals also needs to be clearly articulated, represented, and preserved" (ANA, 2015a, p. 6). While omitting the word "physician" may be motivated by a desire to be inclusive of all multidisciplinary professionals, it limits mention of the nurse's responsibility to assist physicians in caring for patients by proxy. More clarity in regard to nursing responsibility is provided in Provision 4.1 of the ANA Code, titled "Acceptance and Accountability of Responsibility." This Provision elaborates upon responsibilities of the nurse to provided "care as

ordered by an authorized healthcare provider,” and exclusively expands guidance of responsibility in cooperation with advanced practice registered nurses (APRNs) regarding their prescriptive authority and issuing of orders (ANA, 2015a, p. 15). This juxtaposition of the ANA Code thoroughly describing nursing responsibilities with APRNs, while providing no specific guidance to collaboration with physicians, appears to reflect the desire to strengthen professional autonomy while avoiding any potential support to lingering hierarchal stereotypes. Avoiding this topic of hierarchal stereotypes by exclusion may indirectly allow nonequable communication to continue. Burkhardt and Nathaniel (2014) indicate avoidance is the method most commonly used by nurses in their first-line of conflict management (p. 460). Occasional discord in communication is inevitable, and providing ethical guidelines that strengthen positive collaboration can promote patient care. The nature of patients’ dependence upon interprofessional collaboration illuminates a vacancy within the ANA Code to provide directives specific to nurse-physician interaction. Regardless of the intent, by omitting directives pertaining to this common interprofessional dynamic, the ANA Code suggests an emphasis on professional autonomy to the exclusion of addressing ethical guidelines regarding communications within the structure that much of hospital-centric care currently relies upon.

Meanwhile, revisions to the AMA Code have also reflected, albeit at a slower rate, the evolution of gender-neutrality in the professions of physician and nurse. In 1847 the AMA adopted their initial Code of Ethics, which was a contemporary revision to the Oath of Hippocrates rewritten by philosopher Thomas Percival in 1803 to avoid all reference to pagan deities (Riddick, 2003, p. 6). Interestingly, no gender-specific mention was included in this first Oath, although in considering this era, the profession of physicians was most likely entirely male. Riddick (2003) identifies the most recent gender-oriented change in the language of the

AMA Code when the 1980 Principles “introduced gender neutrality, replacing ‘he’ and ‘his’ with ‘the physician’ and ‘the physician’s’” (p. 6). While gender references were removed, specific guidelines to interprofessional interactions remain. The AMA Code dedicates a portion of Principle 3, “Opinions on Interprofessional Relations,” to the interactions between nurses and physicians (AMA, 2002, p. 102). Opinion 3.02 of the AMA Code identifies patient care as the basis for the interprofessional relationship between physicians and nurses:

The primary bond between the practices of medicine and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to hear the nurse’s concern and explain those orders to the nurse involved. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies, when prompt action is necessary and the physician is not immediately available, a nurse may be justified in acting contrary to the physician’s standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations. (AMA, 2002, p. 105)

The authority of Opinion 3.02 specifically separates nursing care from medical practice, and asserts that nursing duties include carrying out physician’s orders (with a minor but important exception during emergencies). While no references to gender are present, nearly every sentence in Opinion 3.02 is representative of the hierarchal nature in nurse-physician relationships common in the healthcare field. Respectfully balancing the professional autonomy asserted in each ethical Code may be difficult, due to the hierarchal nature of physicians’

authority that the AMA Code has bestowed upon the nursing profession, and the presumed direction of focus away from this hierarchy within the language of the ANA Code. The professional guidelines identified in both Codes are not obviously incongruent, but significant gaps are present which can create obstacles for fluid interaction regarding patient care. The express absence of guidance regarding hierarchal relationships in the ANA Code may reflect the position that nurses have taken to strengthen professional autonomy, but may also be construed as a potential source of friction in communications between the two professions.

In contrast to the ANA Code, the AMA Code contains the outcome of numerous applicable court decisions in the form of Annotations that are imbedded within the Principles and their associated Opinions. These legal decisions delineate legal obligations of physicians by directly referencing court decisions to specific Principles of the AMA Code. These Annotations are relevant since physicians are much more at risk for liability than nurses, as evidenced in a statement by Burkhardt and Nathaniel (2014) that “only about 2 percent of all medical malpractice payments are for professional nurses’ actions” (p. 215). This disproportionate legal liability is reflected by numerous legal references in the AMA Code, compared with none in the ANA Code. While nurses may reduce potential liability by providing competent care and thereby detect potential errors before implementation occurs, the fact remains that physicians are more likely than nurses to be sued. This legal liability does not justify the paternalistic role that physicians have historically held, but nevertheless often perpetuates it. The AMA’s attempt to minimize potential liability for physicians could explain why Opinion 3.02 designates nurse’s duties in such a precise manner: to provide a professionally recognized allocation of responsibility regarding patient care.

Dissimilar foundations of professional autonomy can be a likely source of friction within interprofessional communications. The power differential has long been a studied source of communication difficulties between the two professions. Even with the relatively recent acquisition of advanced skills, nurses are often still subject to subordinate status. Nursing professionals have in the past used their close proximity to patients to advance their desire for patient-oriented decisions from physicians. Manias and Street (2001) identify the two most common methods that nurses use to influence physician decision-making process, the “doctor-nurse game,” and “the game of staging” (p. 137). The motivational basis for both games is derived from the hierarchal influence that physicians have over nurses. The “nurse-doctor game,” originally described by Stein, explains that a nurse’s primary responsibility is to abide to the “cardinal rule...that open disagreement between the players must be avoided at all costs” (as cited in Melia, 2001, p. 708). The doctor-nurse game not only encourages nurses to avoid disagreement, but encourage nurses to perpetuate a dysfunctional working relationship by “offering advice in such a way that both parties can act as if the idea was initiated by doctors” (Melia, 2001, p. 709; Jones, 2003, p. 130). Additionally, Jones (2003) comments that “This [nurse-doctor] model of engagement, while ensuring that the authority of doctors is not challenged and open conflict is avoided, results in poor and inadequate communication” (p. 130). The other most commonly employed game identified by Manias and Street (2001) is called “staging”: the selective offering of information from nurses to physicians to prompt decisions favored by nurses (p. 137). These games of power and communication parallel Chambliss’ view of what he calls the “social organization of ethics” (as cited in Melia, 2001, p. 709). Melia (2001) associates a social organization’s indirect motivation for ethical conduct by explaining “nursing ethics is often more a manifestation of the power struggles between the two occupational groups

with nursing, the less powerful, resorting to moral argument as a means of achieving some control” (p. 709). While perhaps satisfying an immediate desire for nurse-centric physician decisions, both of these games are ultimately detrimental to patient care. Participation in either of these two games not only perpetuates the hierarchal chasm and power differential that undermines collaborative decision-making, it also erodes the ethical component of veracity in the nursing practice.

As evidenced by the contrasting guidelines to interprofessional obligations within the ANA and AMA Codes, physicians and nurses have different expectations in regard to collaboration with their respective counterpart. Thomas et al. (2003) performed a large study of nurses and physicians from six hospitals to measure this inherent difference in attitude between the two professions (with notable gender inequality: physicians were 86% male, nurses 92% female) (p. 957). The nurse and physician staff reported different values in their respective communications: physicians reported more satisfaction with interprofessional collaboration than nurses, who “did not reciprocate the high ratings of collaboration and communication attributed to them by physicians” (Thomas et al., 2003, p. 957). Thomas et al. (2003) identify several contributing factors to this disproportionate satisfaction: “Relative to physicians, nurses reported that it is difficult to speak up, disagreements are not appropriately resolved, more input into decision-making is needed, and nurse input is not well received” (p. 958). These understandably frustrating grievances from nurses could be related to encountering a seemingly immobile power differential intrinsic to an externally established hierarchy reflected in the AMA Code, and a lack of mutual respect perceived by the nurses. Indeed, Engel and Pretice (2013) find that poor communication stems not only from trying to condense patient-specific interactions into an already understaffed and hectic workload, “but most importantly, from professional influences

such as different perspectives about patient outcomes, power struggles among team members, lack of role clarity, lack of understanding about the roles and scopes of practice of other providers, and stereotyping with regard to other professions” (p. 428). While these factors are certainly significant, they may be superficial to the underlying, more fundamental basis that drives decision-making in each profession.

A strong obligation for patient centered care resonates throughout both the AMA and the ANA Codes, but with differing means to an end. To explain, the imperative of physicians is commonly perceived to be focused on curing patients of illness or disease, whereas nurses have patient care as the primary emphasis in their profession (Elder et al., 2003, p. 149). The cure vs. care debate has been widely discussed, and the ANA’s position is demonstrated by their 1991 proposal to amend the national healthcare delivery system: “We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care” (ANA, 2015b, sec. 1991). Davis et al. (2008) identify potential contradictory outcomes of how pursuing cure may actually cause more dis-ease in patients, by explaining “the emphasis on cure in health care that uses the best that science and technology have to offer may do profound physical, psychological, economic, and spiritual violence to those persons who cannot be cured” (p. 109). The nursing profession’s core belief of caring can at times oppose the directive of the physician’s duty to cure, especially during situations regarding heroic or, depending on ones perspective, futile medical intervention. For example, delivering culturally acceptable end-of-life care may be more of a priority for nursing staff than physicians, who are often more invested in cure.

Intensive Care Units (ICU) have commonly served as locations for studies of interprofessional communication, due in part to the nurse-physician ratio and the close proximity between members of the healthcare team. Additionally, ICU patients generally have higher

acuity, which can serve to amplify the nature of interprofessional communications within the unit. Interestingly, the intimate nature of the patient-healthcare staff in these ICU's manifested an unforeseen mutual participation in collaborative interactions, from the unique perspectives of both nurses and physicians. Melia (2001) found that, in the ICU, "proximity to the patient had a part to play in shaping their views rather than, as it is sometimes presumed, a simple rift between medicine and nursing" (p. 707). In regard to withdrawing treatment, Melia (2001) finds that ICU nurses, being closer to patients and families for longer and more continuous than physicians, often come to realize indications that support the withdrawal of treatment sooner than physicians (p. 712). Each profession has its unique ethical philosophy from where these usually mutual, although not always simultaneous, decisions originate. Concern for the patient is the common ground where the perspectives of nurses and physicians meet: one concern that physicians have is providing a cure while considering legal implications, whereas nursing deals more with the interpersonal aspects of patient care. While nurses and physicians have individual sources of motivation that unite in the common goal of providing patient care, the roles of nurse and physician do not have to be antagonistic to fulfill the ethical duties described in their respective Codes. Regarding the professional roles of nurses and physicians, Melia (2001) notes that "When the social context ... is examined, it is clear that there is more shared ground between the two viewpoints than is perhaps commonly supposed" (p. 707-8). Working in close proximity to patients is not the only factor that provides positive collaboration between physicians and nurses.

Pullon (2008) describes collaborative dynamics by identifying how exhibiting competency within a nurse-physician relationship can foster respect, and over time, trust (p. 141). The primary step of every professional member is to understand the professional role of their counterpart. Pullon (2008) cautions that although "The step from respect to

interprofessional trust was not automatic and had to be developed and earned between individuals...” this trust often grew into professional confidence and interdependence within a working relationship (p. 141-2). Establishing a respectful and trusting collaborative relationship may not always be easy, but the subsequent advantages are immense. In researching the benefits of positive collaboration, Thomas et al. (2003) conclude that “good teamwork is associated with better job satisfaction and less time missed from work because of illness. NASA researchers have also found evidence that teamwork can counteract some of the detrimental effects of fatigue on performance” (p. 958). Increased staff health and happiness are not the only benefits of collaborative teamwork: not surprisingly, patient care also improves.

Engel and Pretice (2013) clarify “Interprofessional care is essentially ethical. Its espoused motivation is that it promotes the well-being of the patient or beneficence, which is to do well by the patient” (p. 427). Patient safety, as described by Engel and Pretice (2013), also includes a reduction in medical errors, which consequently reduces the detrimental “economics of error” (p. 429). The importance of interprofessional collaboration is not a newly discovered topic. A myriad benefits of collaborative communication within healthcare teams have been known to the World Health Organization since 1973, when they advocated “support for interprofessional education as a means to achieve collaborative teamwork among health professionals” (as cited in Engel & Pretice, 2013, p. 426). Indeed, nurses and physicians must actively learn how to promote collaboration within the healthcare team to maximize patient care. Olenick et al. (2010) discuss the promotion of interprofessional education (IPE) as a necessary tool for teams of healthcare professionals to realize their collective potential. “In the current health care crisis and workforce shortage in the US, IPE is a particularly timely topic that addresses the problems of fragmentation in health care delivery and separation among health care professionals. IPE

eliminates segmented education between health care professionals, thereby relinquishing hierarchies, misperceptions and miscommunications” (Olenick et al., 2010, p. 82).

As evidenced by intrinsic foundational differences in the respective ethical Codes, nurses and physicians draw from contrasting sources of motivation to provide care for a mutual goal: maximizing patient well-being. Broadening ones perspective to view both care and cure as equal integral components of positive patient outcome can help eliminate outdated hierarchal stereotypes. Delivering competent nursing care will not only benefit the patient by avoiding errors, it promotes interprofessional trust, which indirectly fosters a healthy and safe work environment. On the other hand, physicians can participate in this beneficial process by valuing and incorporating nursing perspectives and perceptions into a mutual patient-centered decision-making process. Focusing awareness within communication can illuminate areas where personal and professional growth can be encouraged, which will consequently strengthen collaboration within the healthcare team. Professional nurses and physicians are often dependent on one another: improving collaboration will provide beneficial workplace interactions, and promote efficient and effective patient care.

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