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A qualitative study of the meaning of the nurse-physician relationship from the perspective of intensive care unit nurses in a university medical center.

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A QUALITATIVE STUDY OF THE MEANING OF THE
NURSE-PHYSICIAN RELATIONSHIP FROM THE PERSPECTIVE
OF INTENSIVE CARE UNIT NURSES
IN A UNIVERSITY MEDICAL CENTER

A Dissertation Presented
by
KAREN R. PERET

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of
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School of Education
A QUALITATIVE STUDY OF THE MEANING OF THE NURSE-PHYSICIAN RELATIONSHIP FROM THE PERSPECTIVE OF INTENSIVE CARE UNIT NURSES IN A UNIVERSITY MEDICAL CENTER

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Donald Carew, Chair
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DEDICATION

This is dedicated to those who are most important to its production.

To my husband, Jim, for his ever present willingness to provide moral and computer support and the time to do this study; and

To my children, Heather, James, Kaitlin and Matthew, for the motivation they provided through their pride in me and through my desire to improve their futures; and

To my mother, Doris Lasher, for her ever present vision of me as always achieving whatever I attempt to accomplish.

Without this support, motivation and faith, this study would still be a dream.
I am grateful to many individuals for their assistance, support and encouragement. I would like to thank the nurses who participated in the study for the earnestness with which they searched for their deep thoughts and feelings. I am truly appreciative of the support and warmth provided by my committee, Don Carew, Norma Jean Anderson and Ginny Chandler. Finally, for their encouragement, support and assistance in a variety of ways, I am so very grateful to Barbara Stachowiak, Carol Beaulieu, Jean Boucher, Carrie Smith, Ray Matusiewicz, Travis Tatum and Doug Johnson. Thank you all for hanging in there with me.
ABSTRACT

A QUALITATIVE STUDY OF THE MEANING OF THE NURSE-PHYSICIAN RELATIONSHIP FROM THE PERSPECTIVE OF INTENSIVE CARE UNIT NURSES IN A UNIVERSITY MEDICAL CENTER

MAY 1993

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The traditional hierarchical relationship between nurses and physicians negatively influences nurse's job satisfaction, stress, empowerment, retention and productivity and the outcomes of health care services to patients. While a major goal of professional nursing is to establish a more collaborative relationship through changes in nurses' relationship behaviors with physicians, findings in regard to these behaviors are mixed. Because nurses' intergroup behavior with physicians is influenced by their formulations of the meaning of that relationship, it is important to understand the nature and content of those formulations.

The purpose of this study was to explore the meaning of the nurse-physician relationship from the perspective of practicing nurses in order to see the world of nurse-physician relationships as nurses do. This process called for a long
qualitative interview approach which allowed the nurse to speak for herself and allowed the researcher to develop an understanding of the categories and logic through which the nurse sees the nurse-physician relationship by means of thematic analysis of the interview data.

The study found that nurses viewed the nurse-physician relationship as a team. Through collegial interaction, physicians showed respect for nurses' knowledge by seeking, listening to and acting upon nurses' recommendations. Nurses believed that they contributed important information to medical decision-making through their knowledge of individual patients, their clinical experience and their scientific training, without which, the medical decision would be incomplete. The findings suggest a new paradigm for the nature of the nurse-physician relationship: nurse participation in medical decision making based on nurses' knowledge. The findings further suggest the applicability of intergroup relations theory as a frame of reference for understanding and improving nurse-physician relations.
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CHAPTER 1

INTRODUCTION

Take the example of a student who breaks a window in the school cafeteria. The principle might define the situation as a behavior problem; the counselor sees it as a family problem; the janitor sees it as a work problem; the school nurse as a health problem; the student who broke the window does not see it as a problem at all (Taylor and Bogdan, 1984, p. 10).

Introduction and Statement of the Problem

Nurse-physician relationships have been extensively considered in the literature during the last thirty years. The relationship has frequently been described as conflictual (Hamburg, 1981; Grissum and Spengler, 1976; Huntington and Shores, 1983 Kalish and Kalish, 1977; Katzman and Roberts, 1988; Keddy, Gillis, Jacobs, Burton and Rogers, 1986; Morgan and McCann, 1983; Sheard, 1980; Speigel, Smolen and Jonas, 1985). Efforts at understanding this often conflictual relationship have generally been based on the meanings of behavior or attitudes developed by the researcher through the use of observation, questionnaire, structured interview and analysis of historical records. The meaning of the relationship from the perspective of everyday actors is not well represented in the literature. The purpose of this study is to explore the meaning of the nurse-physician relationship from the perspective of practicing nurses.
How do practicing nurses see their relationship with physicians? Do practicing nurses interpret this relationship as conflictual? What are the important categories by which they organize their experience? What are the relationships among these categories? On what assumptions are these based? The numbers and roles of highly educated nurses have dramatically expanded since the close of World War II resulting in many nurses demanding increased autonomy and increased recognition as an equal partner in the delivery of health care. Government and consumer concern regarding the effectiveness of health care services, recurring nursing shortages and increases in health care costs have placed heavy demands on health care managers to more fully understand the relationship between nurses and physicians. One way to improve this understanding is to provide an opportunity for nurses to speak for themselves.

National efforts to improve the relationship between nurses and physicians began in the 1960's with three national conferences jointly sponsored by the American Medical Association and the American Nurse's Association (Bates, 1971; Hodes and Van Crombrugghe, 1990). From these conferences grew the National Joint Practice Commission in 1972, an organization jointly sponsored by the American Medical Association and the American Nurse's Association (Morgan and McCann, 1983). The National Joint Practice
Commission summarized their view of the ideal relationship between physicians and nurses with the statement that "In view of their growing interdependence, it becomes increasingly evident that successful or effective delivery of health care cannot be achieved through unilateral determination of functions by either medicine or nursing" (Turnbull, 1982, p. 25).

However, nurses during that time were reporting to the National Joint Practice Commission that they were discontent and experienced burnout as a result of a lack of professional respect from physicians and a lack of real decision making power in patient management (Devereux, 1981a). Many nurses were leaving the professional completely as a result of these conditions. The Commission as a response, developed a demonstration project at four sites to show that supports to communication, competency, accountability and trust would improve collaborative relationships between nurses and physicians and would improve patient care (Devereux, 1981b). While results showed greater subjective satisfaction among physicians, nurses and patients, it was not clear what role the halo effect played in accomplishing these results. Reports from the field continued to show that issues between nurses and physicians were not being resolved (Morgan and McCann, 1983). The National Joint Practice Commission was dissolved in 1981.
In 1980, due to an increasing shortage of nurses in the nation, the National Commission on Nursing was established to examine nurse related problems and issues. The Commission found that nurse's more sophisticated role in health care was not always accepted by physicians. Nurses continued to report frustration stemming from physician's lack of recognition of nurse's contemporary roles in patient care (Hojat and Herman, 1985). The Commission called for reformed relationships among health professionals as part of its nationwide agenda for action to prevent future nursing shortages (National Commission on Nursing, 1983).

However, nurses continue to report frustration in their relationships with physicians. In a 1991 1,000 reader survey conducted by the editors of Nursing91, fifty-seven (57) percent of the respondents report that they are dissatisfied with their relationships with physicians. The most frequent reason for their dissatisfaction is lack of respect by physicians for nursing expertise. Other reasons include rude and arrogant behavior, lack of collaboration, physician's inability or unwillingness to communicate with patients as well as nurses. When asked to characterize their relationships with physicians, seventy-two (72) percent believe that physicians do not consider nurses to be their partners; fifty-seven (57) percent respond that they are subordinate to physicians, not collegial.
Several other investigators have found similar results. Katzman (1989) found that nurses were dissatisfied with the amount of influence they have in health policy making, in patient care decisions and in community health plan programs as opposed to the amount of authority physicians have in these areas. While nurses were not satisfied with an image of being an assistant to the physician, physicians in the same study did not want to change that image at all. In studies of nurse's job satisfaction and sense of autonomy during a physician strike in Israel, Carmel, Shoham-Yakubovich, Zwanger and Zaltcman (1988) and Shoham-Yakubovich, Carmel, Zwanger and Zaltcman (1989) found that job satisfaction and perceived autonomy increased during the strike.

Mechanic and Aiken (1982) report that nurses are increasingly dissatisfied with their relationships with physicians:

Nurses still lack the authority to make many simple decisions necessary for the safety and comfort of patients and have been expected to defer to medical authority even in situations in which they possess greater experience. The undervaluation of their knowledge and experience is a major source of dissatisfaction and frustration with their current roles (Mechanic and Aiken, 1982, p.747).

Nurse-physician relationships have been found to be primary factors in studies of nurse stressors. Leatt and Schneck (1985) studied 24 hospitals in Alberta, Canada. They found that the highest subunit stress scores for the
1,265 nurses studied were related to inadequate communication from the physician and unavailability of the physician. Spoth and Konewko (1987) found that lack of respect or consideration from physician's was the Intensive Care Unit nurse's highest stressor. Eliadi (1990) found that conflict with physicians was the third highest work related stressor for the nurses in her sample and furthermore, that stress from conflict with physicians was positively correlated to nurse's dissatisfaction with physician relationships.

In a national readership survey by Nursing Management, Cox (1991a) found that verbal abuse by physicians accounted for 24.3% of nursing turnover in the more than 1,100 nurses surveyed. Verbal abuse by physicians also affected nurse's moral, job satisfaction, productivity, error rate and attitudes toward unions. Ninety-seven (97) percent of the respondents in this study reported experiences of verbal abuse from physicians (Cox, 1991b).

Chandler (1992) found that nurse-physician relationships contributed to nurses' feelings of empowerment and powerlessness. In her qualitative study of the source and process of empowerment, she asked fifty-six general and specialty staff nurses from medical centers and community hospitals to describe situations where they felt empowered and powerless. Twenty-three percent of the participants reported feeling empowered when physicians "asked for the
nurses' opinions, considered their input, collaborated in making patient care decisions and verbally acknowledged the nurses' input" (Chandler, 1992, p. 7). Fifty-two percent of the participants reported feelings of powerlessness when physicians ignored the nurse when collaboration should have occurred to benefit the patient or when physicians listened to the nurse but then either didn't respond to her input or responded by verbally abusing the nurse. Relationships with physicians ranked second, after relationships with patients, in empowering situations; nurse-physician relationships ranked first in this sample in situations contributing to nurses' feelings of powerlessness.

The effects of nurse-physician relationships extend beyond the issues of nurse dissatisfaction, stress, powerlessness, turnover and diminished productivity. Three investigations have found serious implications for patient care as well. Hofling, Brontzman, Dalrymple, Graves and Peirce (1966) conducted an experimental study in which twenty-two (22) nurses were given an incorrect medical order over the telephone by an unknown caller alleging to be a physician. Twenty-one (21) of the twenty-two (22) nurses were prepared to give an excessive dose of an unknown drug but were stopped prior to actual administration by a confederate. None of the nurses questioned the caller or refused to administer the medication although eleven (11) of the nurses recognized that the dose was excessive. The
majority of the nurses made reference during the debriefing to the displeasure of the alleged physician if the nurse were to resist his instructions.

In a subsequent review of this research, Dalrymple, Peirce, Brontzman, Graves and Hofling (1968) submit two possible rationales for the nurse's behavior. The first was that possibly the nurses were so confident of physicians that the nurses failed to be critical of their judgments. Secondly, they posited that nurses may be uncertain of their role in relation to a physician so are therefore submissive. The study served to point out to the health care field that the traditional relationship between nurses and physicians could be dangerous for patients.

Feiger and Schmidt (1979) found that collegiality in information sharing and decision-making among four teams of physicians and nurses was positively correlated to the success of patient outcomes in a nursing home. Although they experienced some difficulty in the discriminatory ability of their measurement tools, Feiger and Schmidt were the first investigators to point out that patterns of verbal interaction between physicians and nurses were related to health outcomes for patients in general.

Recently, Knaus, Draper, Wagner and Zimmerman (1986) conducted a study comparing treatment methods and patient outcomes in thirteen Intensive Care Units in major acute care hospitals. They found that effectiveness of care,
measured by differences between actual versus predicted death rates, were related more to the interaction and coordination of each hospital's intensive care unit staff than to the unit's administrative structure, the amount of specialized treatment used or to the hospital's teaching status. The interaction and coordination patterns of staff in those Intensive Care Units with the lower death rates were characterized by independent decision-making by nurses, independent responsibilities of nurses within clinical protocols, excellent communication between nurses and physicians, respect between physicians and nurses and a comprehensive nursing education support system. The interaction and coordination patterns of staff in those Intensive Care Units with the higher death rates were characterized by poor communication between physicians and nurses, communication that was difficult and incomplete due to personality differences, no routine discussions of patient treatment between physicians and nurses, no coordination of staff capabilities with clinical demands, frequent disagreements between physicians and nurses and an atmosphere of distrust. While clearly finding that the involvement and interaction of critical care physicians and nurses can directly influence patient outcomes from intensive care, the study found that physician and nurse interaction was even more important in terms of client
outcomes than were the types of advanced technological
treatments that were used, the administrative structure of
the unit or the hospital's teaching status.

The findings from these studies demonstrate the
significance of strengthening our understanding of the
relationships between nurses and physicians. The
relationship influences not only nurse's job satisfaction,
stress, empowerment, retention and productivity but also the
outcomes of patient care. Because of this broad impact,
nurse leaders (Lovell, 1981; McGuire, 1980; Mechanic and
Aiken, 1982; Whitman, 1982), physician leaders (Bates, 1975;
Stein, 1967) and nurse advocates (Gordon, 1991) have
encouraged nurses to break away from the traditional
physician-nurse relationship, to become more vocal, to
become more collegial and to thereby improve patient care.
However, recent studies of nurse behavior in relation to
physicians, while providing valuable insight, show
conflicting results in this regard.

Stein, Watts and Howell (1990) report that nurses have
"unilaterally decided to stop playing the game" (p. 547).
They found that while the traditional physician-nurse
relationship, referred to as the doctor-nurse game (Stein,
1967), was still operating in some areas, many nurses felt
free to confront physicians and to make independent
decisions. Stein et al characterized nurses as hostile
toward physicians and as taking the stance of a stubborn
rebel. They found that nurses perceived themselves as fighting for freedom. Stein et al attribute these characteristics to a move toward nurse autonomy from the physician. They assert that the women's movement, increased nurse education and recurrent nurse shortages were primary factors in nurse's movement away from a deferential stance toward physicians.

Coburn (1988) in his description of the history of nursing in Canada remarked: "The contrast between past and present-day views of nursing toward medicine is startling. In contrast to the old deference, there is now open antagonism and conflict" (p. 451). At the heart of this conflict is Canadian nurse's increased opposition toward medical control and trend toward occupational autonomy. Factors which influenced this trend were feminism, extensive unionization and a shift from hospital schools of nursing to collegiate programs.

Two empirical studies investigated nurses methods of handling disagreements with physicians. Damrosch, Sullivan and Haldeman (1987) found that 280 female nurse graduate students were most likely to use direct, rational behavioral strategies, including the use of data, persuasion and logic, in influencing physicians and nurse superiors, regardless of gender. They point to a change in nursing ethics since the 1960's as major factor in their results. The military metaphor of the nurse as a loyal soldier unquestioningly
obeying her commanding officer physician began to be
displaced by the image of the nurse as a courageous patient
advocate. The change in allegiance from physician to
patient was fostered by the growing feminism and consumerism
of the 60's, resulting in a more collaborative relationship
with the physician.

Prescott and Bowen (1985) found in their descriptive
study that most (53%) of a sample of 1,165 staff and
supervisory nurses used competitive styles of conflict
resolution in disagreements with physicians wherein
assertiveness and uncooperativeness were characteristic.
Descriptions by the participants of interaction situations
had "the character of taking a stand and sticking to it"
(Prescott and Bowen, 1985, p. 131). The next most
frequently used styles were accommodation, characterized as
unassertive and cooperative, and collaboration,
characterized as assertive and cooperative problem-solving
behavior.

Conversely, in their study of (14) nurses in
traditional roles and eleven nurse practitioners, Katzman
and Roberts (1988) found that "primary nurses, head nurses
and nurse practitioners all agonized over calling a
physician" (p. 580) when there was a need to question a
physician's decision. Some of the nurses spoke assertively,
others spoke softly and apologetically. Nurses were found
to tolerate both physician criticism and physician rejection
of the nurse's recommendations. Katzman and Roberts attributed their findings to gender role socialization wherein nurses are socialized into female roles of subservience, passivity and powerlessness and physicians into male roles of dominance, aggressiveness and authoritarianism. They characterized the interaction patterns between nurses and physicians as resembling husband-wife interaction:

Nurses are responsible for meeting the needs of all members of the hospital family. Nurses are subordinate, yet responsible for every aspect of housewifery, especially during evening and night shifts. The physician's role seems much like a pampered father, who briefly visits home, then leaves for work. The nurse, like the mother, remains to care for the patients 24 hours a day. While the physician sees the patient briefly and handles "important" questions, the nurse spends more time with the patient and handles the "less important," more frequently asked questions (p. 582).

McLain (1988) found concealed discord between nurse practitioners and their physician partners in primary care practices. She found these nurses unwilling to communicate important issues regarding inappropriate norms and background assumptions to their physician partners. She found differences in gender and class were central factors preventing conditions conducive to communicative competence, as the interactive structure was not free from hierarchical constraint.

Wroblewski (1987) reported that the traditional pattern of physician dominance and nurse deference still predominates. Nurses were found to use a variety of
indirect strategies in dealing with disagreement with physicians including questioning, finding a different physician and ignoring the physician's directions as an attempt to protect the patient. Wroblewski found no instances where a nurse approached a physician with such statements as "I would recommend" or "I would suggest." Instead, nurses made requests of physicians using phrases as "I was wondering if" or "Would you like to?" She suggested that this pattern of behavior may be based on gender or hierarchical differences between physicians and nurses.

Tellis-Nayak and Tellis-Nayak (1984) in a study of four large voluntary hospitals found that nurses resorted to circumlocution and indirect cues when a physician erred in diagnosis or prescription in order to prevent loss of status for the physician. They argue that the function of this type of discourse is to express and consolidate the unequal authority relations between physicians and nurses, a type of verbal and non-verbal conduct into which both physicians and nurses are socialized and institutionally coerced. They found that nurses in the study would not consider reporting physicians for professional, legal or ethical transgressions. Although there were few male or black nurses in the study, Tellis-Nayak and Tellis-Nayak found that physician demeanor became less arrogant with male
nurses and more distant with black nurses. Issues of gender and race were therefore thought to complicate the understanding of the nurse-physician relationship:

The gender and racial component of interactional behavior in the wider culture carries over into and colors the professional dialogue in the hospital setting: it diminishes the hierarchical gap in the case of males, and widens it in the case of blacks and females (p. 1068).

In a series of articles, Weiss (1983; 1985) and Weiss and Remen (1986) describe a 20-month study of discussion groups composed of physicians, nurses and consumers. The purpose of the discussion groups was to identify areas of independent and common clinical practice between nurses and physicians. What is significant about the results is that the nurse participants in the study groups included all levels of nursing educational preparation from diploma education to advanced graduate work and all levels in the nursing hierarchy from staff nurses to nurse administrators, educators and clinical specialists. Weiss and Remen (1986) found that nurses did not make an active and unique contribution to the interaction. They served primarily as clarifiers or facilitators to discussion between physicians and consumers. Out of 1,585 interactions analyzed, only 342 actually involved nurses. The nurses in the study treated the physicians as adversaries. Weiss and Remen found little indication that the nurses felt personal responsibility for changing the nature of the physician-nurse relationship.
They also uniformly requested (either explicitly or implicitly) that physicians remedy the situation by becoming less assertive and less influential. Nurses seemed not to recognize the option to themselves to become professionally more assertive and more influential (p. 86).

The results of these studies conflict in terms of their descriptions of nurse behavior in interaction with physicians. On the one hand, contemporary nurses have been found to be assertive, even aggressively hostile with physicians, while pursuing an autonomous and collaborative practice, while on the other hand, nurses with widely disparate educational backgrounds and organizational positions have been found to be silent, deferrent with physicians while seemingly accepting the tenets of the traditional relationship.

While the research to date provides rich insight into some of the issues that influence the nurse-physician relationship, sexism, classism, hierarchical authority structures and ethics, it has not addressed these conflicting results. Why do some nurses act assertively and others not? Do some nurses still see themselves as the physician's handmaiden and others see themselves as a patient advocate? Or is it that nurses all see themselves as patient advocates but use different strategies to enact their patient advocacy? Our understanding of nurse-physician relationships, although rich, is incomplete.
Some of these questions may be better understood by giving nurses the opportunity to speak for themselves, to articulate the meaning of their behavior as seen through their own eyes. This is the point made by Taylor and Bogdan (1984) when they note that one example of behavior can be understood in many different ways. Rarely have researchers granted nurses this opportunity. The process of listening to nurses give voice to their own understandings of the meaning of their experiences with physicians may provide the possibility of deepening our understanding of conflicting research findings. Seeing the world as nurses do, through the process of the long ethnographic interview, may show themes or patterns of thoughts and logic that have previously been unexplored by investigators (McCracken, 1988).

Qualitative data may be useful to nurse and hospital administrators who are interested in building support systems to facilitate nurse's contributions to patient care and to reduce the costliness of nurse turnover, burnout, reduced productivity and dissatisfaction. This type of study may provide important information to health care policy makers who are concerned about restructuring the nation's health care system to improve its efficiency and effectiveness. Finally, this study may be of interest to feminist researchers who are concerned with releasing women's full potential.
The traditional nurse-physician relationship has been found to impact on the outcomes of patient care and on nurse's job satisfaction, stress, productivity and turnover. The better we understand how nurses understand and experience their relationships with physicians, the better the health care industry can develop solutions to these problems.

**Statement of Purpose**

The purpose of this study is to explore the meaning of the nurse-physician relationship from the perspective of practicing nurses in intensive care units. The study seeks to respond to the issue raised by Taylor and Bogdan (1984) by attempting to understand how nurses themselves see and understand their relationships with physicians. Little of this type of information is available in the current literature.

In order to see the world of nurse-physician relationships as nurses do, qualitative methods are required. The long ethnographic interview developed by McCracken (1988) is the methodology used in this research. The long interview allows the researcher "into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world...to see the content and pattern of daily experience...and to see the world as they do themselves" (McCracken, 1988, p. 9). This methodology
allows the nurse to speak for herself, to give voice to the meaning of the nurse-physician relationship as she understands it herself.

**Theoretical Framework**

The theoretical framework that guided the design of this study is that of intergroup relations, developed by Clayton Alderfer (1977a, 1977b, 1981, 1982, 1987), who drew heavily in his theoretical formulation on the work of Muzafer Sherif (1966) and Michael Billig (1976). Particularly important for the purposes of this study are the intergroup relations concepts regarding the causes of conflict, the characteristics of intergroup relations, and the assumptions regarding human behavior.

Intergroup relations theory is an important tool in the study of the relations between nurses and physicians because it clarifies the nature of the problems involved and sharpens the focus on the areas of inquiry that are most salient. Sherif (1966) determined that the underlying causes of intergroup conflict are found in the nature of the functional relations between the groups, rather than in the individual natures of the group's members. Functional in this sense means that what members of each group do "makes some difference to the others, at least in the sphere of activities in question" (Sherif and Sherif, 1969, p. 224). He found that the necessary and sufficient condition that
accounts for the rise of intergroup conflict is a competitive functional relationship for mutually exclusive goals. Competition for goals can include "real or imagined threats to the integrity of the groups as a whole, economic interests, a political advantage, prestige or a number of others" (Sherif and Sherif, 1979, p. 10). In Sherif's view, intergroup conflict behavior is a manifestation of functional or instrumental group motivation toward the achievement of a goal that is somehow threatened or blocked by another group.

It was Sherif's view, that the underlying causes of intergroup conflict are to be found in the nature of the functional relations, that led the present study to focus on the relationship itself between nurses and physicians, as opposed to looking at socialization patterns or communication patterns for further understanding of physician-nurse conflict.

The concept that intergroup conflict is a result of relations between the group represented by nurses and the group represented by physicians is significant in that previous studies of the nurse-physician relationships have assumed that the nature of the relationship is based on individual factors, such as the personality structure of the individuals involved (Hodes and Van Crombrugghe, 1990; Murphy, 1983; Stein, 1967). Other studies have assumed that the nature of the relationship is based on societal level
factors such as sexism, classism, oppression (Bates, 1980; McLain, 1988; Lovell, 1981). The first approach drains nurse-physician conflict of all political and historical meaning. Reducing large scale social processes to individualistic or interpersonal processes distorts and precludes a critical social analysis. Coser (1956), Sherif (1966), Billig (1976) and Louw-Potgieter (1988) criticized much of the social science research on intergroup conflict on these grounds. In fact, Sherif (Sherif, Harvey, White, Hood and Sherif, 1961) designed his early experiments in intergroup conflict to expressly disprove the idea that intergroup conflict was caused by aggressive or authoritarian personalities. Coser (1956) believed that social psychologists who follow this reductionist approach are making a politically conservative statement in support of the existing social order of power and privilege.

On the other hand, researchers who take the societal level approach to understanding nurse-physician relations via processes of sexism, classism or oppression are forced to overlook issues between the groups that may not be necessarily reflected in a clear way in generalized social forces. A societal level focus may miss properties of the nurse-physician relationship which may be unique to that relationship, even though it is embedded in the social system (Alderfer, 1987). In other words, it is necessary to examine the specific properties of the functional relations.
between the groups in which physicians and nurses are members, as well as how societal forces and individual forces may influence them, in order to understand how those functional relations are viewed by physicians and nurses. Intergroup conflict theory recognizes that all three levels of analysis contribute important information regarding an intergroup relationship, but focuses primarily on the properties of the functional relationship between the groups.

The perspectives of nurses and physicians regarding the nature of the functional relationship between them, that is, as competitive or cooperative for example, influence the attitudes, beliefs and behaviors of nurses and physicians in several ways. Sherif, Harvey, White, Hood and Sherif (1961) first noted what has been referred to as the syndrome of escalating conflict (Daft, 1983). This syndrome depicts the behavioral, attitudinal and belief dynamics which stem from a functional relationship of competition between groups (Figure 1).

The perception of a functional relationship as competitive influences the views of group members, referred to as the in-group, toward the activities and presumed underlying motivations of the other group, which is referred to as the out-group. The activities and motivations of the out-group, in a competitive functional relationship, are seen to be intentionally blocking the goal
SOURCES OF COMPETITION
- Goal incompatibility
- Competition for scarce resources
- Power & Status Differences
- Group Beliefs, Values & Norms

Figure 1: Dynamics of Competitive Intergroup Relationship
accomplishment of the in-group. Out-group activities in terms of the relationship to the in-group are seen as a series of hurts or frustrations to the accomplishment of in-group goals. Goals, as noted earlier, can include the integrity of the group, economic interests of the group, a political advantage or prestige. The perceived hurts lead to dismay, frustration, hostility and aggressive deeds. Intergroup conflict, then, according to this theoretical formulation, consists not only of aggressive behavior, but also includes the negative character of the feelings and beliefs associated with the out-group.

The perceived hurts, over time, form part of the in-group's history. Past experiences of hurts are, however, distorted by time and tainted with subjectivity through the processes of selective perception, the assimilation effect and the contrast effect (Sherif, 1966; Blake and Mouton, 1984). Each side of the conflict, therefore, has its own 'facts' and 'truths'. Tradition, precedent and practices that support distrust of the out-group are based on these images and stereotypes that were formed by actors no longer present in the system. Negative out-group perspectives promote in-group cohesiveness, group pride and identification in order to defeat the out-group. As groups become more cohesive, they often come to place loyalty above logic. This, in turn, fosters distortions in judgement and perception and the development of attitudes and behaviors
that distinguish "us" from "them'. The in-group members become more and more to be seen as the "good guys'; out-group members become more and more to be seen as the "bad guys' or the "enemy' (Sherif, 1966; Blake and Mouton, 1984). Referred to as intergroup differentiation, these distortions in perception favor the in-group and diminish stereotypes of the abilities, accomplishments and intentions of the out-group as they invariably are formed from the in-group's point of view, interests and goals. This constitutes the basis for ethnocentrism, the tendency to appraise other people and events using the values of one's own group as the standard (Sherif, 1966; Sumner, 1906).

As we-they distortions strengthen, the in-group will attempt to decrease communication with out-group members, which, in turn, leads to increased hostility and suspicion and increased frequency with which in-group members are obligated to act on partial information, inferences or assumptions about the out-group (Sherif, Harvey, White, Hood and Sherif, 1961; Blake and Mouton, 1984). The group representative or leader is responsible for the group's well being and is not freed from the loyalty versus logic dilemma: the in-group representative may want to concur with an out-group representative in intergroup negotiations, but may feel pressured to attack and challenge the out-group in order to justify the trust and confidence placed in the representative by the group (Blake and Mouton, 1984).
Actual intergroup behavior of in- and out-group members is influenced by an interaction between the past history of agreements or disagreements between the groups they represent, pre-conceptions and stereotypic interpretations of the out-group's behavior and the relative power and status of each group in relation to the larger society (Sherif, Harvey, White, Hood and Sherif, 1961; Blake and Mouton, 1984; Alderfer, 1987). It is considered to be a manifestation of intergroup emotion and stereotypically distorted cognitions developed through a history of selective perception of perceived hurts and frustrations. The conflictual quality of the relationship between two groups can therefore be determined through an analysis of the stereotypes and emotions through which members of the in-group view members of the out-group (Sherif, Harvey, White, Hood and Sherif, 1961).

Actual intergroup behavior viewed through these lenses is likely to be seen as additional evidence of hurtful intent on the part of the out-group, with clarification of the out-group's actual intent difficult to determine due to decreased communication. Loser effects in an intergroup conflict situation include increased tension and intragroup conflict within the losing group, increased self-criticism by members who had previously supported the group's position, increased disorganization and a search for new leadership (Sherif, 1966). Members of the losing group may
internalize the out-group's image of themselves as inferior and weak. Winning groups experience a glow of victory and are unable to appreciate why the losing group should be disturbed by their loss (Sherif, 1966; Blake and Mouton, 1984).

The importance of soliciting the nurse's perspective on the relationship between nurses and physicians is made critical by the foregoing and by Alderfer's formulation of the characteristics of intergroup relations. Alderfer (1977a) identifies two types of groups in organizations: identity groups and organizational groups. Identity groups are an individual's social, racial, gender and religious reference groups and result in such distinctions as male and female, black and white, Christian and Jew. Organizational groups are the result of the division of labor and result in such distinctions as nurse and physician, labor and management. Alderfer contends that there is an interactive effect between social identity with departmental identity in diagnosing intergroup conflicts in organizations. He asserts that identity group memberships do not stop at the door of the company.

Alderfer sees practically every interpersonal encounter as an intergroup event. As each person is a member of a multitude of groups, there are bound to be some different group affiliations between two individuals. According to Alderfer, the dynamics caused by the interrelation of both
identity group and organizational group make intergroup conflict in organizations inevitable as behavior among group members is affected to a great extent by the external relations of the group as a whole (Alderfer, 1977b; Alderfer, Tucker, Morgan and Drasgow, 1983).

One of the reasons for this phenomenon is what Alderfer refers to as one of the five characteristics of intergroup relations: cognitive formations.

Cognitive formations, including "distortions" - As a function of group boundaries, power differences, and affective patterns, groups tend to develop their own language (or elements of language, including social categories), condition their member's perceptions of objective and subjective phenomena, and transmit sets of propositions - including theories and ideologies - to explain the nature of experiences encountered by members and to influence relations with other groups (Alderfer, 1987).

According to this framework, an individual's cognitive structure, that is, ideas, ideologies, stereotypes of members of an out-group and the structure of the relationships between them, are partially dependent upon the groups to which the individual belongs. According to Sherif (1969), being part of a group influences this cognitive structure which is part of the central processing of internal and external factors which result in how an individual determines the meaning or the experience of the event. Therefore, group membership influences the meanings and understandings held by an individual. It is therefore likely that members of different groups will see events in
very different ways, such as the janitor seeing the broken window as a work problem and the principal seeing it as a disciplinary problem (Taylor and Bogdan, 1984). Nurse researchers and practicing nurses may see the nurse-physician relationship in very different ways because of the nature of their different group memberships, ie. membership in a group of nursing scholars versus membership in a group of practicing nurses. According to this theory, two aspects of cognitive formations are particularly significant in this study: nurse perception of subjective or objective conditions in relation to physicians and their explicit or implicit explanations for the conditions that they experience (Alderfer, Tucker, Morgan and Drasgow, 1983).

Sherif (1969) proposed that a person behaves in ways that are congruent with their experience of the situation. If practicing nurses experience the nurse-physician relationship differently than researchers do, they are likely to behave differently also. Therefore, to gain deeper understanding of practicing nurses' behavior, it is necessary, according to this formulation, to deepen our understanding of practicing nurses' experience and meaning of the nurse-physician relationship.

Four studies conducted in the 1980's confirm the importance of intergroup perceptions in understanding behavior. Brown and Williams (1984) explored the relationship between group identification and intergroup
differentiation among work groups in a bakery using semi-structured interviews. They tested two of the major variables on which Social Identity Theory is based, that is, the nature of social identification, and its relationship to group behavior. Social Identity Theory defines social identification as the strength of a member's identification with an in-group. Intergroup differentiation represents the we/they group differences in stereotypes and affect.

Brown and Williams included the perception of intergroup conflict between the groups as a control variable. The surprising finding in the study was that the perception of intergroup conflict, which was the control condition, predicted out-group differentiation, that is, differences in stereotypes and affect, more than strength of identification with the in-group. In other words, the perception on the part of in-group members that conflict existed with an out-group was enough to spark the development of those negative attitudes and stereotypes that characterize intergroup conflict. Actual, or objective competition for mutually exclusive goals was not necessary as had been thought by Sherif (1966); what was necessary was only the subjective perception that the conflict existed.

Two years later, Brown, Condor, Mathews and Wade (1986) conducted a similar study of factory departments in a paper mill. Once again, perception of intergroup conflict was the most reliable indicator of intergroup differentiation.
Brown et al (1986) discuss the interesting finding that the perception of the conflict didn't necessarily reflect the reality of the situation. Certain groups did not perceive a conflict that was evident to the researchers. Most notably, conflict between the workers and management existed, both in the Marxian sense and in specific actions taken by management shortly before the study was conducted. These conflicts were not present in the consciousness of most of the workers and did not result in conflict behavior.

Struch and Schwartz (1989) used the perception of conflict as a predictor of aggression in a study designed to test the relationship between in-group bias and an intent to aggress. Subjects for the study were members of five different religious sects in Israel. Results demonstrated that perceived conflict of interest more strongly predicted intergroup aggression than did value dissimilarity or in-group favoritism.

Taylor, Wong-Rieger, McKirnan and Bercusson (1983) studied the perceptions and coping strategies of English-speaking residents of Quebec. This group had formerly held a dominant position over the French-speaking population. Recent social changes resulted in their loss of dominance. Taylor et al used this situation to test an assumption of Realistic Conflict Theory (Sherif, 1966), namely that individuals belonging to a group perceive threats to that group in terms of their group membership and react
collectively as a result of that perception. They found that the English-speaking resident interpreted threats from and by French-speaking residents as an interpersonal event rather than an intergroup event, even when the threat was directed at the person based on his/her membership in the English-speaking linguistic group. Individuals also used individually based coping mechanisms to meet these threats. The responses to intergroup conflict noted in this study were the result, therefore, of the misinterpretation of the source and target of the threat, in this case, a personalization of the threat.

These studies provide some evidence to support the belief that the way a person understands an event or a relationship has impact on their behavior. In these cases, the belief that conflict existed with another group prompted the group members to act in conflictful ways. Their belief that conflict did not exist prompted them to act in cooperative ways. Their belief that a threat was targeted to them as an individual rather than as a group member prompted them to use individual coping techniques. While this study is not involved with examining connections between an individual's interpretation and definition of the situation and their behavior, one of its basic theoretical assumptions is that such a connection does exist (Sherif, 1966; Alderfer, 1987; McCracken, 1988; Taylor and Bogdan, 1984, p. 10).
This assumption is the theoretical rationale for focusing on nurses' perspective of the nurse-physician relationship in framing the problem statement for this research. The traditional hierarchical relationship between nurses and physicians negatively influences nurse's job satisfaction, stress, empowerment, retention and productivity and the outcomes of health care services to patients. While a major goal of professional nursing is to establish a more collaborative relationship through changes in nurses' relationship behaviors with physicians, findings in regard to these behaviors are mixed. Because, according to intergroup relations theory, nurses' intergroup behavior with physicians is influenced by their formulations of the meaning of the nurse-physician relationship, it is important to understand the nature and content of those formulations. The formulations are conceptually and theoretically based on the perceptions of intergroup history, in- and out-group stereotypes and the character of the feelings associated with the nurse-physician relationship.

In summary, this section has presented the theoretical rationale for several elements in the design of this study. First, the selection of the relationship between nurses and physicians as the primary focus for this investigation was supported by Sherif's (1966) proposition that the causes of intergroup conflict can be found in the nature of the functional relations between groups. Secondly, the use of a
group as primary level of analysis was supported by a critique of the narrowness of individual and societal levels of analyses and by Alderfer's conceptualization of cognitive formations. Thirdly, the qualitative focus on understanding the nurse's experience and meaning of the nurse-physician relationship was supported by Alderfer's conceptualization of cognitive formations. Finally, the assumed links between meaning and behavior were supported by Sherif's conceptualization of human cognitive functioning and by four studies relating intergroup perceptions to behavior.

**Significance of the Study**

This study is significant for four reasons. First, very few of the studies on nurses relationships with physicians have sought out the nurse's perspective on the meaning of her experience and behaviors, how the nurse herself understands her world. Through qualitative research, "the qualitative researcher obtains first-hand knowledge of social life unfiltered through concepts, operational definitions, and rating scales" (Taylor and Bogdan, 1984, p. 7). Such knowledge will assist "in gaining access to the conceptual world in which our subjects live so that we can, in some extended sense of the term, converse with them" (Geertz, 1973, cited in Sanday, 1983). This knowledge may expand our insight into how the nurse sees her world and into how nurses' relationships with physicians may
be improved. This study may therefore be of interest to those health administrators, national policy makers, physicians and nurses who are concerned with these issues.

Secondly, discrepancies exist in descriptions of nurses' behavior in relationship to physicians. Qualitative research may "resolve whatever incongruities a researcher has managed to uncover in a given domain" (Van Maanen, 1983, p. 253). The process of listening to nurses give voice to their own understandings of the meaning of their experiences with physicians provides the possibility of deepening our understanding of conflicting research findings. Seeing the world as nurses do, through the process of the long ethnographic interview, shows themes or patterns of thoughts and logic that have previously been unexplored by investigators (McCracken, 1988). These themes and patterns provide new insight and perspective to heretofore conflicting findings.

Thirdly, this study could have significance for organizational development practitioners and management theorists. Benne and Bennis (1959) and Wise, Rubin and Beckard (1974) found that the hierarchical and status relationships between physicians and nurses interfere with effective team functioning. Kinston (1983) found that political conflicts between physicians and nurses interfere with research efforts in hospital organizational design. Weisbord (1976) found difficulty in applying organizational
development techniques in hospitals due to a poor fit between the organizational development team-focused values and the independence-oriented values of health care professionals. Goren and Ottaway (1985) concurred with Weisbord (1976) through their finding that physicians and nurses colluded in an illusion about the relationship in such a way that only slight, but not fundamental change in the nurse-physician relationship, benefited each party: neither group wants to be shaken up by a fundamentally new experience. Such collusion hindered the effectiveness of the organization development change effort. Expanding the understanding of nurses' perspectives in regard to the nurse-physician relationship may provide a focus of interest to organizational development practitioners and theorists which may prove helpful in terms of developing team-building strategies and interventions to change the independence orientation of health care professionals and to influence the fear of fundamental change in the nurse-physician relationship.

Fourth, this study could have great significance for those nurses who volunteer to participate in it. "The qualitative interview gives the respondent the opportunity to engage in an unusual form of sociality" (McCracken, 1988, p. 27). It provides respondents the opportunity to be the center of another's attention, to engage in self-scrutiny, and to gain greater insight into their own understanding and
meaning of their experience. Such insight may assist in making their own thoughts and actions more effective (Sims and Gioia, 1986). "The more aware we are of our basic paradigms, maps, or assumptions, and the extent to which we have been influenced by our experience, the more we can take responsibility for those paradigms, examine them, test them against reality, listen to others and be open to their perceptions (Covey, 1989, p. 29). It is my hope that the nurses who choose to participate in this study were able to recover their beliefs and actions from the taken-for-granted state of basic assumption (McCracken, 1988), and gained greater insight into their own worlds.

In summary, many researchers have been studying the often conflictful relationship between nurses and physicians for several years. The traditional relationship has been associated with nurse dissatisfaction, stress, powerlessness, turnover, diminished productivity and less effective patient care outcomes. A deeper understanding of nurses' perspectives on their relationships with physicians may enhance the effectiveness of methods designed to improve those relations. In addition, a greater understanding of their own meaning-making may help the nurses participating in the study to identify other options in their relationships with physicians.
Definition of Terms

Practicing nurses - Registered Nurses who are licensed to practice by the Board of Registration in Nursing and who are employed by the health care facility in direct service provision roles.

Meaning - or experience is the central process of interpreting factors that are internal and external to the individual. Meaning-making or interpreting is a process which integrates emotional states, attitudes, self image and identifications with external situations. This process is patterned and produces perceiving, judging, remembering and conceptual categories for evaluation in habitual ways. In other words, the individual does not see the external reality as with the objective eye of a camera; the individual selectively perceives and sees through the interpretive lenses of past experience, motives, feelings, self-image, identifications, etc.

Nurse-Physician Relationship - the functional relationship between nurses and physicians. Functional in this sense means that what members of each group do "makes some difference to the others, at least in the sphere of activities in question" (Sherif and Sherif, 1969, p. 224).

Nurse-Physician Behavior - refers to the actions, thoughts and feelings of nurses and physicians when they interact collectively or individually with members of the other group in terms of their group membership.
Group - "is a collection of individuals (1) who have significantly interdependent relations with each other, (2) who perceive themselves as a group, reliably distinguishing members from nonmembers, (3) whose group identity is recognized by nonmembers, (4) who, as group members acting alone or in concert, have significantly interdependent relations with other groups, and (5) whose roles in the group are therefore a function of expectations from themselves, from other group members and from non-group members" (Alderfer, 1977a).

Limitations of the Study

This study is intended to explore the meaning of the nurse-physician relationship from the perspective of the practicing nurse in an intensive care unit. The setting chosen for the study will be a University Medical Center. Nurses practicing in this setting may have different experiences from those in rural or small urban health care facilities. In addition, nurses practicing in a university medical center may more often have a college background where socialization practices differ from traditional hospital-based training programs (Coburn, 1988). These differences may influence the perspectives of the nurses who participate in the study. Therefore, the results must be understood within that context.
In quantitative studies, issues of generalizability include the randomness of the sample in the study. In qualitative studies, the issue is not one of generalizability, but one of depth. "The purpose of the qualitative interview is not to discover how many, and what kinds of, people share a certain characteristic. It is to gain access to the cultural categories and assumptions according to which one culture construes the world. How many and what kinds of people hold these categories and assumptions is not, in fact, the issue" (McCracken, 1988, p. 17). For the purposes of this study, therefore, the non-randomness of the participants who were primarily self-selected is not a major issue.

More of an issue is the role of the investigator in a qualitative study. In qualitative research, the investigator serves as a type of instrument in data collection and analysis. "The investigator cannot fulfill qualitative research objectives without using a broad range of his or her own experience, imagination, and intellect in ways that are various and unpredictable" (McCracken, 1988, p. 18). It is this factor that makes my background as a North American, as a nurse, as a nurse manager, as an organizational development doctoral student and as an investigator important. Each of these group identifications affects my intergroup relations with the participants and thereby "shapes one's cognitive formations" (Alderfer,
Researchers are as subject to intergroup dynamics as are other individuals. Drawing on my understanding of how I myself see and experience the world allows me to supplement and interpret the data that is generated in the long interview. However, this intimate acquaintance with the nursing culture can create sometimes as much bias as there is insight. The long interview is "deliberately designed to take advantage of the opportunity for insight and minimize the dangers of familiarity" (McCracken, 1988, p. 12).

First, the process of preparation for the long interview requires that the investigator inventory and examine the incidents, associations and assumptions that are involved with the topic in mind. "The object of this step is to give the investigator a more detailed and systematic appreciation of his or her personal experience with the topic of interest" (McCracken, 1988, p. 32). Much of this work was accomplished during the process of developing the proposal for this study. Secondly, by adhering to the qualitative principles of substantiation and confirmation, themes and patterns seen in the interview data were multiply confirmed before they were admissible as evidence. Finally, the analysis of the interview data created a "paper trail" which was offered to the participants as a protector of reliability.
CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

The purpose of the review of the literature is to review explanations of the relationships between historical and contextual, individual, group and societal factors and the nurse-physician relationship. A second purpose is to develop thematic categories of the mechanisms through which the various factors come to influence the relationship. These thematic categories assisted in the development of the focus areas for the qualitative interviews and assisted in the later analysis of the data. Additionally, they help to clarify the nature of the relationships between the variables that have been theorized or discovered through empirical study. An understanding of the relationships between the categories and the variables provides additional insight into how an investigator comes to see the nurse-physician relationship as a particular sort of problem or issue.

The review of the literature on nurses relationships with physicians is divided into five sections. The first section will examine the history and context of the nurse-physician relationships. The second through fourth sections examines individual, group and societal issues which have
been thought to cause conflict in the relationship between nurses and physicians. The fifth section presents a discussion and analysis of the literature.

**Historical and Contextual Factors**

This section of the review focuses on three general time periods in the history of the nurse-physician relationship: early twentieth century, post-World War II and the present. Emphasis is placed on structural factors which contributed to the traditional nurse-physician relationship and on societal changes that have since contributed to a change in that relationship.

**Early 1900's**

During the early part of this century, nurses received their basic training in schools of nursing that were sponsored by hospitals (Ashley, 1977; Melosh, 1982; Peplau, 1966; Keddy, Gillis, Jacobs, Burton and Rogers, 1986). Physicians served primary roles as the teachers of nursing students, both in classroom sessions and in the clinical arena. Nursing students spent little time in classroom education, however, because a primary focus in the early days was on the job training. Nurses learned by doing and spent many long hours at the bedside, learning their skills through apprentice-like activity (Ashley, 1977). Once their early service and training period were complete, physicians
administered the final examinations in many hospitals (Keddy et al, 1986). Those graduate nurses who had formed good relationships with their physician teachers were later hired into private duty relationships by families at the physician's recommendation. As hospitals did not generally offer paid employment to their graduates because most of the nursing care was provided by students, graduate nurses were greatly dependent on the physician's approval and recommendations for hire.

Physicians of the time were concerned that nurses not learn too much regarding scientific theory:

1. Every attempt at initiative on the part of nurses...should be reproved by the physician and by the hospital administration. 2. The programs of nursing schools and the manuals employed should be limited strictly to the indispensable matters of instruction for those in their position, without going extensively into purely medical matters which give them a false notion as to their duties and lead them to substitute themselves for the physician. 3. The professional instruction of...nurses should be entrusted exclusively to the physician, who only can judge what is necessary for them to know...

These maxims should certainly be borne in mind by the physician who has dealings with the nurse, as a matter of simple justice to her that she not be encouraged to take steps that are not in her province (Journal of the American Medical Association, 1906 in Ashley, 1977, p. 78)

The predominant theory at that time was that nurses were born, not made. The prerequisites that physicians admired in nurses were a warm heart and a caring manner: "Heart qualities are better than the most elaborate training and skill" (Ashley, 1977, p. 83). The worthiness of the
nurse was evaluated as a measure of her helpfulness to the physician and the proficiency and efficiency with which the nurse fulfilled the physicians orders (Ashley, 1977; Keddy et al, 1986). Nurses were not seen as significant or independent contributors to the control and direction of patient care, but as extensions of the physician's will and expertise.

This idea that nurses were extensions of physicians was formalized as part of state nurse practice acts. During the time when American women were fighting for women's suffrage, nursing leaders sought to obtain legal recognition for nurses. While both movements occurred during the same historical time period, they were not related (Ashley, 1977; Whitman, 1982). Nursing leaders were not seeking equal rights for nurses but instead were concerned about securing public recognition of the training received by graduate nurses. They felt, and most state legislatures agreed, that trained nurses should be the only persons allowed to provide nursing services for a fee. The legislation that was written however stipulated that nursing practice occurred only under the supervision of a physician and thus legally bound nursing to subordinacy under physicians (Ashley, 1977). In light of this philosophy, physicians served on nursing registration boards (Keddy et al, 1986; Whitman, 1982).
For women at that time however, nursing represented upward mobility, training and a chance for paid employment in a time when women had very limited occupational choices (Melosh, 1982). Many nursing students came from low class and immigrant families whose basic value system included a strong emphasis on obedience to authority (Peplau, 1966). Therefore, early nurses found no difficulty in accepting the educational, licensure, regulatory and employment constraints imposed by nursing's dependence on medicine. They learned strict obedience to the physician (Ashley, 1977; Keddy et al, 1986; Winslow, 1984), as is exemplified from the following excerpt from an early nursing journal:

Nurses moving quietly,  
Voices hushed in awe, All things silent waiting,  
Obedient to the law,  
That we have heard so often,  
But I'll repeat once more:  
'All things must be in order  
When Doctor's on the floor'  

Books on nursing ethics also stressed the theme of obedience: "Implicit, unquestioning obedience is one of the first lessons a probationer must learn, for this is a quality that will be expected from her in her professional capacity for all future times" (Robb, 1901, cited in Winslow, 1984, p. 34).

Hard physical work, strict discipline and the shocks of hospital life bonded students together and initiated them
into a common occupational identity with a strong moral and religious focus (Melosh, 1982). Their concept of nursing was that character and dedication were the real measures of a good nurse, mere skills were not enough. Their emphasis was on altruism, service, womanly devotion and dedication to the sick under the tutelage of the physician (Melosh, 1982).

Nursing leaders, however, wanted educational reform. They observed that many hospital training schools exploited nursing students for their free or very underpaid labor rather than educating them (Ashley, 1977). They believed that nursing required a strong foundation in scientific principles and sought stricter educational standards that were weighted toward academic education based in colleges rather than in ward experience (Ashley, 1977; Melosh, 1982).

The movement of the nursing leader's toward an educational process that emphasized scientific training, in colleges that were beyond the economic means of most lower class and immigrant families, conflicted with those nurses who upheld apprenticeship training as part of nursing's craft tradition (Melosh, 1982; Whitman, 1982). A rift began to form between nursing leaders and practicing nurses. The perspective of the practicing nurses was supported by physicians and hospital administrators, many of whom were physicians themselves, who continued to emphasize the womanly prerequisites for nursing and the values of service and dedication (Ashley, 1977). Although collegiate programs
for basic training of nurses began to appear during the late 20's and early 30's, the primary method of nurse training continued to be the hospital school of nursing. The rift between nursing leaders and college prepared nurses on one hand and those whose training occurred in hospital schools on the other, continues to the present day and many consider nursing leaders to be out of touch with the needs and values of the practicing nurse (Coburn, 1988; Melosh, 1982; Roberts, 1983).

Nurses reliance on physicians for employment was shattered during the Great Depression of 1929 and the 1930's (Peplau, 1966). When physicians could no longer secure private duty employment for nurses, many nurses beseeched hospitals to let them work simply for room and board. Many hospitals began residency training programs for medical students during that time. The medical resident replaced the nurse as the physician's primary helper and erstwhile trainee (Peplau, 1966). The strong positive bonds between physician and nurse evolved into a hostile dependence and complicated status structure as physicians seemed more interested in the more knowledgable male medical students who would carry on the medical tradition.

Post World War II

During World War II, the formation of the Cadet Nurse Corps by the federal government increased the
standardization of nurse’s training (Melosh, 1982). More schools of nursing began to hire graduate nurses as instructors (Peplau, 1966). At the end of the war, the G.I. Bill provided an opportunity for more nurses to study full-time in baccalaureate and graduate level nursing programs for the first time (Benne and Bennis, 1959; Makadon and Gibbons, 1985; Peplau, 1966). Governmental and private foundation funds began to be available for graduate programs in nursing. Nurse educators and clinicians grew better prepared through these programs and replaced physicians as the primary teachers of nursing, even in hospital schools of nursing (Aiken, 1983; Peplau, 1966).

Nursing leaders began to succeed in professionalizing nursing education to a level never before experienced. There was increased support for newly forming nursing research. University programs in nursing formed alliances with the social and behavioral sciences which began to expand the conception of the nursing role to more than physical and biological science in their responsibilities for patient care (Benne and Bennis, 1959).

For medicine, the years following World War II were just as exciting. There was increased emphasis on medical research. Physicians took advantage of large increases in federal funding to build a vast research and technological empire (Makadon and Gibbons, 1985). Fewer physicians took up clinical practice as research became the principal avenue
to a successful career in academic medicine. The passage of Medicare and Medicaid legislation offered increased access to medical care and created new demands on the health care system. The vacuum caused by the diminishing numbers of physicians in clinical practice and the increased demand for care opened the doors for new opportunities for nurses and other health professionals (Makadon and Gibbons, 1985). As technology increased, nurses took on responsibilities for practices that a few short years before were the sole perogative of physicians (Mechanic and Aiken, 1982).

These educational and technological changes had little impact at that time on the relationship between nurses and physicians. The courts were equivocal regarding the issue of the nurses as an extension of the physician, and intermittently reinforced the concept of blind obedience to the physician. In 1929, in Manila, Lorenza Somera was found guilty of manslaughter for failing to question the order of a physician who had ordered cocaine for a tonsillectomy patient instead of procaine (Winslow, 1984). However, in 1942, in the Gold vs. Essex case in England, the court ruled:

> It is part of the nurses duty, as servants of the hospital, to attend the surgeons and physicians and carry out their orders. If the surgeon gives a direction to the nurse which she carries out, she is not guilty of negligence even if the direction is improper (Gold v Essex CC, 1942 cited in Dimond, 1987).
The American Nurse's Association, formed in the early part of the century, published a model definition of nursing practice that "specifically disclaimed any independent role for nurses in diagnosing or treatment" (Whitman, 1982). The Association also endorsed the concept of nurse's allegiance to the physician. In 1950, the Code of Ethics published by the Association, stated: "The nurse's obligation is to carry out the physician's orders and to protect his reputation" (McKinley, 1976 cited in Mathews, 1983, p. 1376). Loyalty to the physician was seen as an indirect steppingstone to the ultimate protection of the patient: by protecting the physicians reputation, the nurse was protecting the patient's confidence in the health care effort (Winslow, 1984). Trust in the physician and in his prescribed regime would powerfully assist the patient's recovery. Nurse's loyalty to physicians was guaranteed by the moral power of this reasoning (Winslow, 1984) and by the reinforcement of the judicial system.

During the 60's and 70's, that began to change. Consumerism began to strengthen (Winslow, 1984). People were more educated and more sophisticated regarding medical matters (Baldwin, Welches, Walker and Eliastam, 1987; Elpern, Rodts, DeWald and West, 1983; Mechanic, 1985). They came to believe that health came from a combination of environmental quality and healthy life style rather than from physician's medical technology. Skepticism regarding
authority in general characterized the American culture as a whole. Patients became more assertive about their own rights to control medical care (Mechanic, 1985).

During this time period, the information explosion occurred (Hite, 1977). Biomedical science increased exponentially (Baldwin, Welches, Walker and Eliastam, 1987; Michelson, 1988). The complexity of care increased (Mcgee, 1989). Medicine became increasingly specialized into fragmented medical care with episodic visits by various specialists and made crisis care the physician's treatment of choice (Elpern, Rodts, DeWald and West, 1983; Gamble, 1989). The physician's scope of work grew enormously due to these biomedical advances and to the medicalization of everyday problems. Physicians were required to "remain technically expert and maintain a humane attitude and broad view of patient's problems and needs including psychosocial and behavioral" (Mechanic and Aiken, 1982). The belief that physicians were omnipotent and knowledgable began increasingly to be seen as artificial and quaint (Stein, Watts and Howell, 1990).

The information explosion, more so than any other factor, is responsible for eroding the traditional "Doctor" role where doctors are the repository of all knowledge, the shamans of our culture (Hite, 1977, p. 15).

Medicine sustained a stunning loss of public confidence (Starr, 1982; Stein, Watts and Howell, 1990). The number of malpractice claims tripled between 1975 and 1983 (Mechanic,
The image of the physician as kindly, caring and reassuring began to be more often embodied by a nurse (Gamble, 1989).

Two-thirds of the public now believe that people are beginning to lose faith in doctors...The public believes that doctors do not care about people as they used to, that they don't spend enough time with their patients, and that they are more motivated by money and prestige than a desire to help people (Mechanic, 1985).

Also during this time period, the women's movement began to grow (Winslow, 1984). Women's conceptions of themselves and their work and their expectations for opportunities, incentives and rewards began to change (Mechanic and Aiken, 1982). Nursing is a women's profession, where more than 96% of nurses are female (Katzman and Roberts, 1988). Although nurses did not formally align with the women's movement (Simmons and Rosenthal, 1981; Whitman, 1982), and the early women's movement did not formally embrace the traditional women's profession of nursing (Gordon, 1991b; Muff, 1982), the movement did help nurses raise questions about the relationship between nurses and physicians and the linkage between gender roles and their professional roles (Simmons and Rosenthal, 1981). The awakening social consciousness of female health care workers raised a desire to redefine attitudes toward their tradition roles in the health care system (Hite, 1977).
Contradictory forces within nursing had reached the boiling point; on the one hand, nurses were increasingly educated in academe, where scholarship, autonomy, and decision making were the chief characteristics of their educational fare. On the other hand, their practice in the world of work was directed and inhibited by physician control and institutional (usually nurse-controlled) dicta (Mauksch, 1981, p. 36).

A new, more independent role for the nurse was developed: the nurse practitioner (Mauksch, 1981). Originally developed by two physicians as a way to expand physician activity in communities, the nurse practitioner role required additional education beyond the basic preparation of nurses. The role was expanded relatively quickly into acute hospital settings and would later gain legal rights to perform certain medical practices that had previously been the exclusive domain of the physician. The majority of nurses however, remained in the traditional role of direct service deliverer. Although they were left with the continuing responsibility for patients, "their authority to act in the absence of the physician (was) not formally modified" (Mechanic and Aiken, 1982).

In 1970, the American Nurses Association amended its Code of Ethics. The new code stated: "The nurse's primary responsibility is to those people who require nursing care" (Mathews, 1983, p. 1376). Boards of Nursing Registration around the country were slow to support this fundamental change in nursing philosophy. In 1976, the Board of Nurse Examiners in Idaho revoked Joline Tuma's license to practice
nursing on the grounds that she had unethically interfered with the physician-patient relationship (Winslow, 1984). Ms. Tuma had conceded to her patient's request for information on alternative treatments for her cancer, when the patient's physician was convinced that the only acceptable treatment was chemotherapy. The decision was reversed three years later by the Idaho Supreme Court. Ms. Tuma articulated the issues involved in a letter to Nursing Outlook:

Does the nurse have the right to assist the patient toward full and informed consent? Litigation against nurses already shows us we have the responsibility when we do not properly inform the patient. But do we have the authority to go along with this responsibility as the patient's advocate? (Tuma, 1977 cited in Winslow, 1984).

The Present

The social structure that had strongly supported nurses' blind obedience to physician's orders was beginning to crumble. The 80's and 90's saw further erosion of the structure that supported the traditional relationship between nurses and physicians. The gender composition of medicine is in the process of changing. While males constitute 88% of American physicians (Katzman and Roberts, 1988), greater numbers of women are entering medical schools: thirty-eight percent of American freshmen medical students are female compared to nine percent 20 years ago (Stein, Watts and Howell, 1990). In 1970, women received
8.4% of the medical degrees that were awarded that year; in 1979, they received 23% (Gordon, 1991a). It has been optimistically predicted that the changing gender composition of medicine may eventually change relations between nurses and physicians in the future (Stein, Watts and Howell, 1990).

An oversupply of between 20,000 to 70,000 physicians brought increased competition for patients among physicians and between physicians and nurse practitioners (Gamble, 1989; Lancaster, 1986; Makadon and Gibbons, 1985; Ginzberg, 1981) and new organizational forms of practice: health maintenance organizations, preferred provider organizations, surgicenters and shopping center medicine (Mechanic, 1985). More young physicians sought employment in such organizations rather than set up an economically risky private practice. New federal cost consciousness led to new forms of reimbursement that offered both for-profit and non-profit health care facilities incentive to monitor medical decisions and constrain wasteful practices (Mechanic, 1985; Michelson, 1988). According to sociologist Paul Starr (1982), the growth of the for-profit health sector poses the greatest threat to physician autonomy for these organizations will have the size, the resources and the motivation to monitor the decision-making of physicians. If
physicians are unable to reduce escalating health care costs, they can be replaced by others among the ample supply of physicians.

Nurses took on major roles in federally mandated cost containment and medical quality assurance programs and in malpractice investigations (Gamble, 1989; Mechanic, 1985). Medical decisions that were once the sole prerogative of the independent physician were closely scrutinized by nurses in these positions and threatened physician authority in clinical decision-making (Mechanic, 1985; Michelson, 1988; Stein, Watts and Howell, 1990). "Now that courts hold hospitals accountable for the quality of medical practice within their walls, nurses have become hospitals' first line of defense in observing what is or is not being done for the patient's good" (Gamble, 1989, p. 43).

Continued technologic advances and changes in patterns of medical practice have changed the nature of hospital care. Patient lengths of stay in hospitals decreased by twenty percent since 1970; the use of intensive care unit beds increased seventy-four percent between 1972 and 1980; physicians decreased their work week from 65 hours a week in 1945 to less than 50 in 1980 (Mechanic and Aiken, 1982). As a result, patients did not belong just to the physician anymore (Magee, 1989). Physicians became much more dependent on other health care professionals and more emphasis was placed on effective teamwork, with each
professional discipline contributing their own expertise to the patient care effort rather than reliance simply on the physician (Barry, Frengley, Lepore, Mundinger and Ott, 1986; Mechanic, 1985).

Nurses took on the role of assuring "that patients receive an appropriate level of care at all times" (Gamble, 1989, p. 42). A recent survey of hospital administrators found that nursing care was considered to be a more significant factor in providing quality care than the clinical skills of the medical staff (Gamble, 1989). Increasingly, nursing students received their basic educational preparation in colleges and universities where physicians had less influence on their training. Nursing students were taught that they were equal partners to the physician in the delivery of health care and that their primary role was patient advocacy (Baldwin, Welches, Walker and Eliastam, 1987; Hite, 1977; Stein, Watts and Howell, 1990; Winslow, 1984).

However, most courts are still unclear about the relative independence of nurses from physicians. "Courts are beginning to recognize an affirmative duty of nurses to act to protect patients from physician conduct or orders that are not in accordance with normal medical practice...and have found nurses liable for failure to do so" (Murphy, 1987, p. 15). Moreover, courts have ruled that nurses have a duty to inform hospital authorities if physicians fail to
act on a patient's untoward condition. Yet, most court decisions suggest that nursing's body of knowledge is not unique but is a subset of medical knowledge and state nurse practice regulations do not allow practicing nurses the right to diagnose and treat medical conditions. Courts are still reluctant to find nurses guilty when they are following doctor's orders (Murphy, 1987).

In sum, there have been many societal changes during the past approximately hundred years that have had strong impact on the legal, ethical, technological, educational, attitudinal and service delivery structure of the traditional relationship between nurses and physicians. The next section of this review will examine the literature on individual factors in the nurse-physician relationship.

**Individual Factors**

This section of the review of the literature will examine individual factors that have been thought to influence the nature of the relationship between nurses and physicians. Each sub-section will focus on a description of the factor, the author's view of how the factor influences the relationship and the methods used to reach their conclusions.

The individual level of analysis is one which places its emphasis on the scientific study of the experience and behavior of the individual (Sherif and Sherif, 1969).
Studies of psychology almost always take the individual or interpersonal relationship as its unit of analysis. It assumes that human behavior can be explained by an individual's personal or unconscious feelings, traits, instincts, motivations, biology, personality, beliefs or interpersonal skills in relation to another individual (Billig, 1976). It assumes that a group is "no different from simply a linear sum of individual members" (Alderfer, 1987, p. 195) and that group behavior can be understood by the application of individual personality theories to group phenomenon (Billig, 1976).

While intergroup relations theory takes the group as its primary level of analysis, as will be explained in the following section, it does conceptualize any exchange between people as being subject to individual as well as societal forces. Therefore, it is important to understand how individual forces may influence the nature of the nurse-physician relationship. The types of mechanisms through which individual forces influence the nurse-physician relationship that will be reviewed in this section include psychological, developmental and emotional processes, issues of individual nurse competence and conflicting interpersonal forces.
Psychological

One of the earliest studies of the nurse-physician relationship was conducted by a psychiatrist (Stein, 1967). His observations were conducted in psychiatric facilities and, as a psychiatrist, he focused on the impact of various external stimuli on the development of individual attitudes. Stein conceptualized the relationship between nurses and physicians as a game, wherein the nurse must take the initiative for making significant recommendations to the physician regarding patient care but must do so in a passive manner so that her recommendations seem to be initiated by the physician.

The cardinal rule of the game is that open disagreement between the players must be avoided at all costs. Thus, the nurse must communicate her recommendations without appearing to be making a recommendation statement. The physician, in requesting a recommendation from a nurse, must do so without appearing to be asking for it. Utilization of this technique keeps anyone from committing themselves to a position before a sub rosa agreement on that position has already been established. In that way open disagreement is avoided. The greater the significance of the recommendation, the more subtly the game must be played" (p. 699).

Stein believed this interaction pattern supported and protected a physician dominance/nurse deference quality in the relationship between them that was based on the underlying attitudes of the players. Stein explained that
these attitudes were developed and shaped as a result of certain experiences in basic medical and nursing school training.

For young medical students, the dominance attitude is based on the development of a phobia involving an overdetermined fear of making a mistake. Medical students are taught that they bear total responsibility for making decisions about patient care. The medical student feels this responsibility in a very personal way: if a patient dies, he feels guilty. Any mistake the medical student might make inflicts a large narcissistic wound and reminds him of his vulnerability. Stein notes that "the classic way in which phobias are managed is to avoid the source of the fear" (p. 701). Since making mistakes is impossible to avoid, the young medical student uses a substitute maneuver to defend his basic personality structure: "he develops the belief that he is omnipotent and omniscient, and therefore incapable of making mistakes" (p. 701). Accepting advice from nurses assists the physician in giving his patients the best possible care but accepting that advice is highly threatening to the physician's sense of omniscience which guards his phobia. The solution to this paradox is to make the nurse's recommendations appear to be initiated by the physician.

For the nursing student, according to Stein, the deference attitude is based on the development of a fear of
independent action. The nursing student is taught that physicians have infinitely more knowledge than nurses and that they deserve the utmost respect. Their fear of independent action is inculcated through rigidity and firm control of the student's activities in nursing school, where deviance from rigidly outlined paths results in disciplinary action. Giving recommendations to physicians allows the nurse to fulfill her responsibility for patient care but, paradoxically, to make those recommendations in a direct manner would be to question the physician's medical knowledge. Since the physician has more medical knowledge than the nurse, the nurse fears that the physician may ridicule her recommendation. The solution to this paradox is to communicate the recommendation in an indirect way without appearing to have initiated it.

Stein believes that these attitudes persist in nurse-physician relationships because they provide a great sense of security and psychic comfort to the participants. However, he believes that this interaction pattern is a transactional neurosis which inhibits open communication between physicians and nurses.

Nurses in a study conducted by Keddy, Gillis, Jacobs Burton and Rogers (1986) confirmed that they feared humiliation by physicians. Keddy et al interviewed 34 nurses who had worked or been trained in Canada during the 1920's and 1930's. The respondents reported that their fear
of humiliation developed as a result of the feelings of inferiority they formed as students and led to docile and submissive behaviors. These feelings of inferiority were further reinforced by the superior status positions, as teachers and employers, held by physicians in the early part of the century. Like Stein (1967), Keddy et al were concerned about nurse deference to physicians and its implications for ineffective communication.

Wise, Rubin and Beckard (1974) looked at the issue of nurse deference as arising from the preexisting personality structures of nurses before they entered nursing school. They hypothesized that the hospital training school selection process tended to attract people with submissive personalities. "The last kind of nurse wanted on a hospital ward is a problem solver" (p. 538). Once in the program, the submissive tendencies of the nursing student were further conditioned by the authoritarian structure. Nurses learned to take orders not to take charge. Wise, Rubin and Beckard were interested in helping physicians and nurses adapt to different organizational patterns by learning better group membership and leadership skills.

Kalish and Kalish (1977) looked at the issue of physician dominance as arising from the preexisting personality structures of physicians before they entered medical school. They hypothesized that the opportunity to function independently was a reason for the choice of
medicine as a career. Those making that choice were therefore seen as having a high degree of individualism and a desire for independence. Once in the program, individualism and the desire for independence were further conditioned and strengthened by the emphasis on the physician's total control of the health care situation. Fear of committing an error in light of this total control leads young physicians to become anxious. They "gradually take on feelings of omnipotence in preparation for the world in which he will be confronted with heavy and awesome responsibilities" (p. 52).

Kalish and Kalish (1977) also hypothesize preexisting personality structures to explain nurse deference behavior. They note a "natural inclination toward physician dominance" (p. 52), accounted for in part by the lower socioeconomic class from which more nursing students than medical students originate. The natural inclination is reinforced by nursing school training which systematically culls out overly questioning and rebellious students as troublemakers. Fear of physician criticism is unknowingly passed on to students by nursing instructors who "have been unable to analyze the effects of their own earlier education" (p. 52), which is reinforced by the greater level of education physicians receive.

Baldwin, Welches, Walker and Eliastam (1987) investigated the role that nurse's self-esteem plays in
relationships with physicians. They defined the relationship between nurses and physicians as a troubled partnership that was characterized by conflict, distance and distrust. They hypothesized that this conflict may be a manifestation of low acceptance of one another. Their theoretical framework emphasized a positive relationship between self-esteem, self-acceptance and acceptance of others in interpersonal relationships. They administered a series of structured questionnaires to 422 nurses in a university hospital to determine if nurses' self-esteem influenced their views of and their willingness to collaborate with physicians. They found that nurses with high self esteem expressed more positive views of other nurses. Although weakly correlated, nurses with high self-esteem did express more positive views of physicians and more willingness to collaborate with physicians. They found that the demographic variables of age and gender were related to nurse's self-esteem, but did not give an indication of the nature of that relationship. Position, work area and education variables were not related to the nurse's self-esteem. Therefore, the results supported their hypothesis that a nurse's self-esteem was related to her acceptance of physicians and her willingness to collaborate with physicians.
Developmental

Murphy (1983a, 1983b) views the early training experiences of physicians and nurses from a developmental perspective. His analytic framework is Erik Berne's Transactional Analysis System (1961 as cited in Murphy, 1983a), which classifies communication behavior between two interacting individuals into adult, parent and child categories. Communication from the parent and child categories is heavily emotion laden and more focused on information-giving while communication from the adult category is less emotional and more focused on information-acquiring. Their hypothesis is that "in a society like ours, where information itself is power, behavior which fosters the acquisition and sharing of information tends to be far more important and productive in professional relationships" (1983a, p. 22).

Murphy hypothesized that medical students are probably intellectually gifted people whose high needs for intellectual achievement and social recognition caused them to select medicine as a career. This selection resulted in medical students focusing exclusively on academic achievement both prior to and while attending medical school. While in medical school, the student's educational and social experiences are carefully controlled and emphasize "extreme reliance on his own resourcefulness and knowledge" (p. 23). This control limits the gratification
of normal developmental Child needs and puts "special emphasis on competition, authoritative decision-making and expectations for immediate response" (1983a, p. 22). Deprived of normal maturational experiences, the medical student's interpersonal agenda is imbalanced. He develops the tendency to react to pressure in more emotional Parent/Child ways. As the medical student receives no formal training in interpersonal relationships, many physicians do not grow out of this tendency to which their early training and experiences have conditioned them. Physicians behave in competitive ways in relationships with nurses in which the physician focuses on getting the job done at all costs, lacks concern for other's feelings and needs and "tends not to recognize the role of meaningful cooperation" (1983b, p. 46).

Nurses, on the other hand, while also focused on a need for academic achievement, are focused on it to a lesser extent than medical students. Their training exposes them much earlier to the complex relationships of the hospital operational structure and emphasis is placed on functioning collaboratively rather than independently. Because their training does not deprive them of normal maturational experiences, nurses develop an Adult personality earlier than physicians (Murphy, 1983a). When confronted with physician's behaving competitively, nurses may respond in one of two ways. "Sometimes this form of communication
elicts fears or anxiety which could lead the receiver either to withdraw and become an avoider, or to agree too easily and become an accommodator" (1983b, p. 47). Conversely, this behavior can be extremely irritating and can goad the receiver to responding with similar competitive behavior. Murphy's analysis therefore explains physician dominance behavior, nurse deference behavior and nurse conflict behavior in terms of emotional responses based on differing levels of maturity.

Hodes and Van Crombrugghe (1990) used Murphy's (1983a, 1983b) framework to analyze levels of blame for potential conflict situations between physicians and nurses, levels of understanding of the hospital chain of command and the roles of various nurse administrators and views of the level of independent judgement nurses should be allowed to use in different age groups of physicians and nurses. They interviewed 10 physicians and 10 nurses in a medium-sized for profit hospital for their reactions to a fictitious incident. They found that competence was a moderating factor for both nurses and physicians in their beliefs that nurses should be able to take more responsibility than they currently have in making independent clinical judgments. "All interviewees predicated their answers on the understanding that the physician and the nurse must know each other well in order to nurture a high level of confidence" (p. 74). Although they did not report their
findings in terms of age group, they did find that nurses understood hospital hierarchy and the roles of nurse administrators better than physicians. Their findings with regard to blame were not statistically significant. They argued that lack of individual physician familiarity with individual nurses and with the hospital hierarchical structure interferes with the physician-nurse relationship.

Competence

Prescott and Bowen (1985) provide some insight into the mechanism through which the issue of competence influences the nurse-physician relationship and a different sort of explanation for physician behavior in nurse-physician relationships than what has thus far been reviewed in this section. They characterize the nurse-physician relationship as "an enduring pattern of physician dominance and nurse deference, with increasing conflict between the two groups" (p. 127). Using a semi-structured interview format, Prescott and Bowen asked 264 nurses and 180 physicians in metropolitan hospitals to describe the nature of the nurse-physician relationship, an example of a situation where there was nurse-physician disagreement and a description of how that disagreement was handled. Although they cite many societal and group level reasons for the increasing conflict, which will be discussed in later sections, the nurses and physicians in their sample described the
important elements in their relationship in terms of individual characteristics. In their qualitative analysis of the relationship descriptions, they found that nurses emphasized a physician's trust in the nurse's judgment and physicians who viewed the nurse as a resource and who involve nurses in decision-making as major factors that characterized a good relationship. Physician's views of the elements of a good relationship were different from nurses. Physicians emphasized how the nurse communicates with the physician, a willingness to help and competence of the nurse as factors. Physicians reported frustration with what they characterized as a wide variability in nurse's clinical judgment. The variability of competence in this area made familiarity with the individual nurse an important factor in good relationships. However, similar assessments of physician competence did not figure into nurse's descriptions of relationships with physicians:

Except for new housestaff who must prove themselves trustworthy, nurses seem to assume physician competence unless proved otherwise. In contrast, physicians' concern for nurse competence is basic to their discussions of both relationships and disagreements, suggesting that nurse competence is not assumed. Instead, it appears that nurses' knowledge and judgment are suspect until proved otherwise by experience. Unfortunately, for the competent nurse, this proving oneself to physicians is a lengthy and time-consuming process that repeats with each new physician (p. 131).
Prescott and Bowen linked the physician's concern for nurse competence with variability in the amount of independence and responsibility physicians allow nurses to assume. The critical variable then in influencing the physician's behavior to be dominant or more collegial is the nurse's competence rather than any underlying psychological, maturational or emotional issue. They conclude then that the nurse-physician relationship in general is influenced by the physician's lack of confidence in individual nurse's competence, while the reverse is not the case. They did not view the physician's lack of confidence in nurses as a gender issue, but instead as a result of the variability in educational preparation for nurses between hospital and university schools of nursing and of the lack of a stable nursing work force.

Wroblewski (1987) found that nurses thought competence was a conditional factor in the success of their attempts to influence physicians. Wroblewski's interest was in gaining insight into the patterns of interaction between nurses and physicians, which she viewed as characterized by physician dominance and nurse deference. She conducted semi-structured interviews of eleven nurses in acute care hospitals. Participants were asked to describe specified situations with physicians, the respondent's subsequent feelings, the strategies they used in the interaction and the outcomes. Content analysis of the interview data found
several other individual nurse characteristics in addition to competence that the nurses considered to be important to success in influencing a physician to achieve desired patient outcomes: job position, the nature of the unit worked, years of experience, gender, the shift worked and the amount of education. The critical variable, however, was found to be the nurse's competence: nurses felt that their major source of influence with the physician was their individual competence.

Lack of familiarity and understanding one another's competencies was seen by Weiss (1982, 1985) and Kalish and Kalish (1977) as a major factor in nurse's and physician's resistance to collaboration.

Traditionally, medical and nursing students have not studied together, nor have their curriculums provided them with information about the contributions of the other. Consequently they work their entire professional careers side by side without really understanding what the other is about. This fact has prompted the statement that physician-nurse communication is most characteristic of the parallel play of toddlers" (Kalish and Kalish, 1977, p. 54).

Using this theory that nurse and physician behavior was based on the lack of familiarity with one another's competence, Weiss (1982, 1985) conducted a twenty month study of discussion groups composed of nurses, physicians and consumers in San Francisco. The research interest was to see if the extended discussion, conducted in a less-role prescribed context, would increase the participant's confidence in their own ability to influence health, their
receptivity to shared responsibility in health care and their use of a more collaborative behavioral style. Weiss noted five characteristics of a collaborative relationship: Each individual's skills are appreciated; each participates at maximal skill level; each can influence the other; each is continually open to role negotiation and redefinition and each has a unique area despite role overlap (Weiss, 1983).

Her findings were that the discussions resulted in a decrease in the participant's beliefs regarding the value of shared responsibility, a decline in nurses' use of a collaborative style and nurses' inability to articulate nurse competencies that were unique and independent from the physician's. They tended to see their own professional expertise as mere bias. She noted that "physicians dramatically influenced the direction of group discussion by their articulate, aggressive and instrumental actions" (1985, p. 57). The discussion groups therefore did not accomplish the hoped for outcome.

Bates and Kern (1967) found that competence and good communication between physicians and nurses were believed to be important factors that led to good or bad teamwork between physicians and nurses. However, there were some differences found between nurses and physicians in terms of other behaviors that were thought important. Nurses rated the physician's cooperativeness and adherence to hospital policy as important behaviors. Physicians emphasized a
nurse's willingness to help them and willingness to deviate from hospital policy as helpful behaviors. Bates and Kern's data was based on a critical incident survey of 115 registered nurses and 90 physicians. The participants in the study were asked to describe examples of behaviors that nurses and physicians considered as either impeding or improving their work. The investigators in this study conceptualized the relationship between physicians and nurses as one of conflict, tension, friction and hostility. They believed that the conflict was based in the physician's frustration with bureaucratic and cumbersome hospital methods, physician insensitivity to nurse's needs and the nurse's entrapment between the conflicting external demands of the physician and the hospital. While their explanation of the basic conflict focused on the inherent properties of the system of organizing health care delivery to which physicians and nurses are differently allegiant, Bates and Kern considered that changes in the behavior of individual practitioners would help to improve the relationship. Important elements of that behavior were competence and communication.

Conflicting Intrapersonal Forces

Rushing (1962) also considered that nurses were caught in a trap, but the trap was comprised of conflicting internal demands. Rushing, also a psychiatrist, interviewed
sixteen psychiatric nurses who worked on an inpatient unit of a teaching psychiatric institution. His interest was in determining the functions that deferential behavior performed for psychiatric nurses in their relationship to their supervising physician. He theorized that the performance of the psychiatric nurse role involved two moral principles. First, nurses had a moral obligation to help the patient recover from illness. Secondly, nurses had a responsibility to carry out the physician's orders. He asked the nurses in his study what they did when these moral principles were in conflict. He found three types of response: the nurse would try to influence the physician by going to the physician's superior; the nurse would record observations in the client's record that pointed out aspects of the patient's behavior or status that would suggest that some other treatment plan was indicated; or, would ask questions indicating they didn't understand the physician's order to tactfully encourage the physician to reconsider. He considered that these responses were deferential and were "explicit manifestations of the internalization of the physician-nurse authority relationship which implies that the physician possesses superior knowledge and competence to that of the nurse" (p. 144). However, he also viewed these responses as power strategies, in that the behavior was designed to influence the behavior of another. It was deferential because it was oriented to the institutionalized
normative authority of the physician, but it originated with the nurse thinking that she was better informed than the physician about some aspect of patient care. The nurses felt that if they acted in other than a deferential way to the physician, it would ruin their relationship with that physician and thereby threaten the physician's willingness to help with patients: the physician would not listen to the nurse's input and wouldn't share his own information and greater knowledge about the patient with her. Therefore, Rushing concluded that the nurse's dependence upon the physician for information and her concern about the potential harmful impact on the patient if she were to engage in more direct behavior holds her hostage to deferential behavior.

Cunningham and Wilcox (1985) came to a similar conclusion in their study of inappropriate order situations. Their research interest was to show that the inappropriate order situation was part of a larger class of problematic, interpersonally sensitive situations and to explore the positive functions of indirectness. They defined indirectness as not mentioning desired action and requesting information due to lack of understanding. They noted that deferential behavior carried a negative connotation in terms of prevailing American ideology regarding openness and up front behavior but that deference served a pragmatic function in problematic, interpersonally sensitive
situations. Following Rushing (1962), Cunningham and Wilcox viewed the inappropriate order situation as an interpersonally sensitive one for the nurse due to the conflicting principles of patient welfare and physician authority. Using Bavelas' communication framework (Bavelas, 1983 cited in Cunningham and Wilcox, 1983), they describe the normative response to this type of bind:

An avoidance-avoidance conflict, in which two unappealing choices repel the individual, who will leave the field if possible—in this case, communicationally, by evasive or indirect communication (p. 3).

Furthermore, they view nurse's indirect communications with physicians in this type of situation as face-work to prevent the occurrence of embarrassment, humiliation, conflict or offensiveness while the traditional and accepted role relationship between physician and nurse are reversed.

Cunningham and Wilcox administered questionnaires to 233 nurses to examine the effect on nurse's behavior when varying the amount of potential harm to the patient if the order is carried out. They found that nurses were more likely to use direct communication behaviors when the harm to patients was low but indirect behaviors when the harm to patients was high. In effect, the serious harm to patients tightens the bind of deference. However, in later attempts to influence the physician, nurse's behavior became more forceful and direct. Therefore, the initially indirect influence attempt did not preclude more direct behaviors.
The nurses in the study reported a real concern for relational risk with the physician: they supported their behavioral strategies "by mention of tact, diplomacy, non-offensiveness and the need to give the physician an out" (p. 19). However, their comments supported the functionality of indirectness to open lines of communication for further discussions in exploration of the issues, giving them and the physician the opportunity to learn something from each other. With a direct statement, the opportunity is diminished, as the solution is handed to the physician to be accepted or rejected (p. 19).

Cunningham and Wilcox conclude that indirectness is reasonable and workable and may function as a key to unlocking a sequence of behaviors which eventually loosen and unravel the bind.

Bates (1975) continued the theme of conflicting intrapersonal forces as the cause of conflicts between physicians and nurse practitioners. She believed that nurses were experiencing an identity crisis in which they were attempting to resolve the conflict between their previous role as assistant to the physician and their more current role as a care provider on their own merit. Physicians were experiencing a similar identity crisis in which their former self-identity as the independent, natural boss of the health care team with complete and exclusive responsibility for patient care. These crises make it difficult to interact. The nurse practitioner has
difficulty establishing new relationships with patients. The physician has difficulty sharing decision-making and his patient relationships. Bates notes that issues of trust, jealousy and conflict are inevitable until the identity crises are resolved.

Wise, Rubin and Beckard (1974) and Kalish and Kalish (1977) also note that physician's training to be a solo practitioner causes conflicts with nurses. "Good practice dictates that he look himself at blood smears, at roentgenograms [X-Rays]" (Wise et al, 1974, p. 538). Physicians in the past had to be independent for in private practices they were "all things to all persons" (Kalish and Kalish, 1977, p. 52). However, with the advances and complexities of modern technology and with the changing practice patterns of medical organization, the physician is no longer an island unto himself and is highly dependent not only on other physicians but also on other health care workers, including nurses. Yet it appears that many physicians are not fully aware of the ramifications of this major shift in health care delivery." (Kalish and Kalish, 1977, p. 52).

Kalish and Kalish (1977) and Wise et al (1974) conclude that this lack of awareness of their dependence on others ill prepares physicians to function well in the collaborative relationships which are necessary in contemporary team settings.

In summary, explanations of issues in the nurse-physician relationship at the individual level of analysis
focus on the internal properties of individuals as they naturally exist or as the individual processes and reacts to external events. The themes of individual mechanisms that have been reviewed in this section include psychological, developmental and emotional processes, issues of individual nurse competence and conflicting intrapersonal forces. The next section will review explanations of issues in the nurse-physician relationship from the group level of analysis.

**Group Factors**

This section of the review of the literature will examine group factors that have been thought to influence the nature of the relationship between nurses and physicians. Each subsection will focus on a description of the factor, the author's view of how the factor influences the relationship and the methods used to reach their conclusions.

The group level of analysis is one which places its emphasis on the study of the properties of groups that influence and sometimes transcend the experience and behavior of the individual (Alderfer, 1987). The behavior of an individual can be analyzed from a group level of analysis if that behavior is viewed in terms of the person's group memberships. Studies of ideology and culture are examples of theoretical frameworks which almost always take
the group as its unit of analysis. A group level of analysis assumes that "groups have organizations and values quite apart from the peculiarities of particular individuals and that these properties mold the behavior of individuals" (Sherif and Sherif, 1969, p. 19). Furthermore, it assumes that

the group is different from simply a linear sum of individual members; that groups share collectively unconscious assumptions about members' relations to the group's leadership and to one another and that words spoken and actions taken by group members represent the whole group or subgroup of the whole group (Alderfer, 1987, p. 195).

These unconscious assumptions, also referred to as cognitive formations (Alderfer, 1987) or ideologies (Billig, 1976), are not simply extensions or linear accumulations of the assumptions of individual members. They develop from the beliefs of individuals through a process of subjectification. Through subjectification "the objectified forms of human activity then determine the subjective consciousness of the actors, and shape their outlook upon the world" (Billig, 1976, p. 247). Ideologies are therefore collective subjective beliefs that arise from the objective situation and the practical activity of the group. It is important to understand both the objective, practical realities and also how the subjective beliefs arise from them. However, the practical realities include the objective power relations of the situation and the activity
the group is involved in. These objective power relations also influence the group's ideology: "The ruling group will have the power and resources to shape the ideology of the subordinate group" (Billig, 1976, p. 262). Therefore, the group's ideology may represent a false consciousness, where the influence of the dominant group has shaped the ideology of the subordinate group in such a way as to conceal or misrepresent the objective conditions of society. This section of the review of the literature will begin the exploration of the ways in which power relations between nurses and physicians have influenced nursing and medical ideology. It will focus on the power relations that are the specific properties of nursing and medicine as groups. More of this examination will continue in the next section on societal forces, where the general properties of larger groups in American society, to which medicine and nursing belong, will be examined.

Intergroup relations theory takes the group as its primary level of analysis essentially because it deals with relations among groups and recognizes that groups have properties that are different from the properties of individuals (Alderfer, 1987). Explanations of the nurse-physician relationship that focus on the group as level of analysis provide different descriptions and insights than those that focus on individual factors. Therefore, it is important to understand how group forces may influence the
nature of the nurse-physician relationship. The mechanisms through which group forces influence the nurse-physician relationship will be reviewed in this section by grouping them into three major themes: professional cultural frameworks for interpreting the meaning of words and events, ideologies regarding relationships between physicians, nurses and patients and competition as a subjective and objective condition of the relationship.

Frameworks of Interpretation

Pellegrino and Dake (1966) focused on nurse-physician communication as a manifestation of the relationship. They introduced the idea that faulty communication between nurses and physicians was the result of "two different cultures confronting each other, each having the same goal in mind but speaking different languages and emphasizing different things" (p. 78). They point out that each culture interprets the meaning of the word "cooperation" in a different way and that this difference in interpretation is an obstacle to effective communication. Nurses interpret the word cooperation to mean that she is being asked to participate as an equal colleague in planning and delivering patient care. She expects to be informed about the patient's disease and about physicians' actions in advance so that she can educate appropriately. "Her major urge, it
appears, is to get out of the dependency role, to make a more positive, broader and better contribution" (p. 78).

Physicians, however, interpret the word cooperation to mean the prompt and efficient following of orders by the nurse. He expects assistance in getting observations and scientific information about patients and support from the nurse in the presence of the patient, but is "fearful of the nurse's or anyone else's giving too much education and information to the patient" (p. 78). Thus the nurse interprets cooperation as an invitation to collegiality and an opportunity to increase her own and the patient's knowledge and the physician interprets it as an offer of assistance and as a means to reduce the nurse's and the patient's knowledge. Pellegrino and Dake conclude that the conflicting interpretations can be remedied if each professional group would recognize its bias and listen more carefully to the meaning expressed by the other.

Peeples and Francis (1968) were concerned about social patterns which obstruct effective working relationships between nurses and physicians. They criticized the concept of rugged individualism, the belief that "individuals are totally in control of their behavior and are not or should not be influenced by the groups of which they are members or to which they seek an affinity" (p. 28). They believed that this concept leads people to assume that any conflict which arises between nurses and physicians should be blamed on the
individuals involved and dealt with accordingly. The concept of rugged individualism blurs the vision of those who hope to understand and improve relations between them. Understanding the social patterns that underlie these intergroup conflicts will help people to recognize that the conflict originates in the cultural structure rather than in individual personalities. Peeples and Francis identified several cultural factors that lead to ineffective teamwork between physicians and nurses. Two reflect specific properties of nursing and medicine as a group; those that reflect general patterns in American society will be discussed in the societal section of this review.

The first factor is the pattern of different goals, training, technology and attitudes between nursing and medicine related to their differences as professions. These differences lead to different orientations and perceptions. Conflict occurs when members of each group overlook these differences and expect members of the other group to share their own orientation and perspective. In addition, members of different subgroups within nursing and medicine develop specialized orientations and perspectives such as between surgery and psychiatry, and between nursing education and nursing service.

The second pattern is the rate of technological change in the society. Conflict is caused over the division of labor between nurses and physicians when the rate of
technological change exceeds the ability of each professional group to establish consensus on its technological boundaries. Related to the concept of rapid technological change is the maintenance of an integrated sense of occupational identity. "To get and keep optimum loyalty and commitment to an occupation, the occupation must reduce ideological ambivalence; i.e. it must establish and maintain an undergirding of consensus on such things as the goals of the occupation and the methods of orienting novices to the occupation" (p. 33). Furthermore, the consensus is necessary for adjacent occupations to understand it. Peeples and Francis conclude that the profession of nursing has failed to project a clear image of the competence of contemporary nurses and has not clearly articulated nursing's independent functions.

Bates (1971) discussed the idea that the different roles and educational programs which nursing and medicine have, lead each profession "to observe the patient from different vantage points and perceive respondingly different problems" (p. 130). The primary role of medicine is diagnosis and treatment. This results in a biological, disease and cure oriented focus on the patient. The primary role of nursing is the care process, consisting of helping, comforting and guiding. This results in a more psychosocial, person and family centered focus. This difference in focus leads to differences in how each
profession uses words and to differences in perception of the same process (Lynaugh and Bates, 1973). Medicine uses such terms as diagnosis, treatment, symptom and disease. Nursing uses the terms patient problem, help, discomfort and patient concern to refer to the corresponding phenomenon for which they are responsible. When the nurse uses the term patient concern, the physician may not realize the nurse is referring to a disease. Lynaugh and Bates suggest that members of the two professions become bilingual to avoid the risks of bias, misunderstanding and error.

In 1975, Linn conducted a survey on the care-cure orientations of physicians and nurses. He noted that traditional medical education has emphasized the biological sciences and the expansion of the student's scientific abilities. The social sciences have had low status in medical education and expanding the humanistic abilities of medical students was not prioritized. Nursing education has emphasized the promotion of patient comfort and emotional well-being. However, Linn noted the development of a cure orientation in nursing that emphasized the technical responsibilities of nursing in treating the patient's condition. He administered questionnaires to 189 medical students and faculty members and 162 nursing students and faculty members. Linn found that faculty members were the most extreme in their orientations: medical faculty were the most cure-oriented and nursing faculty were the most care
oriented. However, at least two-thirds of the respondents in each category indicated the importance of the care orientation. Linn concludes that both sets of goals were deemed important by the majority of professionals and students surveyed.

In 1986, Davis pointed out that interdisciplinary collaborative practice between nurses and physicians had "ideological implications for the scientific knowledge base, the professional role skill and relationships of the collaborators" (p. 206). She argued that the beliefs that medicine was cure-focused and nursing was care-focused and that each represented uniquely different skills were outmoded. Nurses and physicians in collaborative practice take on part of the role and orientation of the other resulting in a type of professional role diffusion. Davis underscores the need for negotiating skills and an understanding of the political implications of role diffusion because of the impact of collaborative practice on nursing and medical ideology.

Sheard (1980) believed that conflict between nurses and physicians was related to different conceptions, self-defininitions, methods and inner logic that arose from the different ways in which nursing and medicine structures their work. Like Peeples and Francis (1968), Sheard argued that
members of each occupational group naively expect the other group to look upon work as they perceive it. Because each group fails to appreciate the unique gestalt of the other's work, its members make demands upon the other group which clash with the self-definition of the other group. Individuals from the group which feels oppressed often will try to block disruptive, disagreeable, or inappropriate demands with delaying tactics, subterfuge and bargaining, and, thus, conflict will prevail (p. 14).

Sheard identified differences between physicians and nurses in terms of their conceptions of time (entire course of illness vs hourly or strictly schedule), resources (abundance vs scarcity), unit of analysis (individual patient vs specific task), work assignment (case vs bed), rewards (fee vs hourly wage) and by sense of mastery (strong vs weak). He argued that re-organizing nursing in the same manner as medicine would increase the ability of the two groups to understand one another.

Mathews (1983) was concerned with the transmission of information about illness to patients. She believed that communication between nurses and physicians was problematic because of "differences in ideology between the professions about what ought to be communicated to patients about their illness and who is ratified to give such information" (p. 1371). The medical ideological orientation is focused on giving information in a piecemeal fashion, based on the physician's assessment of the individual and his or her probable reaction to the information. A correlate to that orientation is to withhold negative information to create a
hopeful climate based on the uncertainty of medical practice. The nursing ideological orientation is that patients have a right to all information in order to make decisions about treatment options, make adjustments to life and to reduce anxiety. In addition, the traditional medical view of communication of medical information as the physician's exclusive domain, is becoming diffused as a result of external regulation of medical practice and the contemporary re-conceptualization of the nurse's role in relation to the patient. Mathews notes that these differing ideologies reflect different orientations toward patient care and have been a source of tension between nursing and medicine. "Closure of these gaps has implications for optimizing clinical goals: the more congruent the social reality between members of a culture, the greater the probability that interests and goals will be successfully negotiated" (p. 1377).

Clark and Lenburg (1980) identified six roles that nurses assume in the practice of their profession as the basic structure of nursing culture. As part of an action research project, Clark and Lenburg asked thirty-one nurses from four general hospitals in a northeastern metropolitan area to complete a critical incident questionnaire. Respondents were asked to describe instances were they were able or unable to apply their nursing knowledge and skills fully. The researchers developed a taxonomy of six roles
from the incidents provided by the respondents. The two most frequently reported roles were the nurse as an agent of control, in which the nurse protects the interests of the organization and the medical staff, and the nurse as patient advocate, in which the nurse protects the interests of the patient. The four other roles they identified include the monitor of the patient's condition, the monitor of physician behavior, informer/advisor and overseer of tests and treatment. The role of the monitor of physician behavior was the most difficult for the nurses in the sample to perform. This role and the role of agent of control engendered the most interpersonal conflict. This conflict was found to interfere most with the nurse's ability to use her skills and knowledge. Although Clark and Lenburg conceptualized the conflict engendered when nurses act out their control and physician-monitoring roles as interpersonal, and therefore fit the parameters of the last section of this review, they contributed a beginning structure to the study of nursing culture, which is a group level phenomenon.

Singleton (1981) measured and compared the meanings that a group of physicians and a group of nurses attributed to six types of methods of influence used by physicians with patients. She administered semantic differential questionnaires to 50 black physicians and 50 black nurses in a public hospital in Los Angeles. The methods of influence
included reward, reference, coercion, information, legitimacy and expertise. Singleton developed situations which she thought exemplified a physician's use of each of these methods of influence. The meaning of each method was measured along the continuum of good/bad, fair/unfair, strong/weak, masculine/ feminine, active/passive and rash/cautious. She did not ask the study respondents if they perceived the situation as exemplifying the same method of influence that she conceptualized. Singleton found that mean scores on each method of influence differed significantly for physicians and nurses and concluded that the methods had very different meanings for each professional group. Where responses showed the same direction of meaning for both nurses and physicians, the nurses responses were generally more intense than the physicians. Reward was perceived as slightly cautious by physicians and by nurses as slightly rash. Physicians saw coercion as moderately strong and slightly fair; nurses saw it as slightly weak and moderately unfair. Legitimacy was perceived as slightly strong by physicians and as slightly weak by nurses. Physicians saw expertise as slightly strong; nurses saw it as slightly weak. However, because Singleton did not check the perceptions of the participants regarding whether their interpretation of the meaning of the method of influence matched hers, it is unclear whether the respondents were differing in terms of their evaluation of
the method per se or an interpretation of the situation as exemplifying a different method of influence than that conceptualized by Singleton. Singleton concluded that these differences in meaning regarding methods of influence should pose no conflict between physicians and nurses because although the meanings were significantly different, they were not extremely so. However, the conclusion must be regarded with some skepticism due to the methodological flaws.

Wilcox, Fritz, Russel and Wilcox (1983) studied conflict between physicians and nurses as an organizational communication problem rather than a problem in interpersonal communication. They hypothesized that the structure and function of the hospital organization may have a powerful impact on how conflict is perceived and resolved by the nursing staff. In their introduction, they provide some insight into the meaning competence has for medical staff members. They note that

Staff members perceive that speed or efficiency of intervention is a defining characteristic of professional competence. Medical intervention is often rushed to the alleviation of human suffering. Thus, speed is justified on humanitarian grounds. In the heat of the rush, certain forms of rude and hostile discourse are justified. It is permissible to shout, demand attention, or to abuse coworkers because the rush of duties forces staff members to dispense with the niceties of polite discourse (p. 4).

Wilcox et al theorized that conflict would result from a perceived incongruence between the norm of how incoming
information is perceived by the staff or the order giver and how that information is then processed by the staff. They used a critical incident method to gather data from 144 nurses in three metropolitan hospitals regarding the types of staff conflict they anticipated during the next week. Categories of conflict were developed using a content analysis approach.

Twenty-two percent of the respondents described conflict situations with physicians. Demanding answers from the nurse about a patient or a procedure was seen by the respondents as testing the nurse's competence. "The nurses complained about the speed of these demands and the fact that the physicians often demanded data to which the nurses did not have immediate access...hesitancy served as evidence of their lack of competence in the eyes of the physician" (p. 14). Unfortunately, Wilcox et al did not provide any further insight into the meaning of competence from the perspective of the nurse. However, differences in the meaning of this concept resulted in nurse perceptions of conflict in this study.

Ideologies

Devine (1978) explored how nurses' perceptions of themselves were influenced by physicians' perceptions of the
nurses' job and by the social structure of the hospital. She theorized that nurses and physicians would have different modes of perceiving reality:

The derivation of our meaning, whether they be true or false, plays an indispensable role, namely, it socializes events for a group. We belong to a group not only because we profess to belong to it, nor finally because we give it our loyalty and allegiance, but primarily because we see the world and certain things in the world the way it does (Mannheim, 1936 cited in Devine, 1978, p. 288).

Devine hypothesized that a conflict exists between the ideology of nursing professionalism, which emphasized occupational autonomy from the physician, and nurses' position within the hospital hierarchy, which obliges them to work with a lower status under the direction of a physician. She notes that "perceptions are formed not only from how the social system is understood or interpreted, but also as it objectively exists" (p. 289). The objective power relations between physicians and nurses in hierarchical hospital situations therefore conflict with nursing ideology. Devine argued that "Physicians are quite clear about their professional status, but it is to their advantage and a means of protection of self-interest to at least pay lip service to the idea that nurses are also professionals and an 'equal' member of the health team" (p. 288).

Devine administered semi-structured questionnaires to 22 nurses and 11 physicians on two units of a pediatric
hospital in Nova Scotia. There was a difference in the structures of the two wards in the study. On one of the wards, the structure included interns and clinical clerks; on the other ward, the structure included only physicians and nurses. She concluded that the stratification system between physicians and nurses was a major source of conflict between them.

Devine found that nurses' expectations for an independent role aligned with the ideology of nursing professionalism; physicians' behavior conformed to the medical ideology of physician control and nurse subordinacy. The interns and medical clerks interacted in a different manner with the nursing staff than did the physicians:

An example of this was the frequent exchange of conversations between staff nurses and interns. The nurses were less intimidated by interns and felt freer to ask them questions concerning patients. Interns, in return, would ask advice of the nurses in situations which caused them uncertainty because of lack of experience or expertise (p. 291).

The amount of satisfaction nurses had with their relationships to physicians, the amount of conflict they experienced with physicians and the amount of understanding that existed between nurses and physicians was related to the amount of direct or indirect contact the nurses had with physicians. Devine theorized that the interns and medical clerks functioned as a buffer or a mediating function between the physicians and nurses resulting in a reduction
of the clear-cut dichotomy between nurses and physicians. However, although Devine identified differences in the nature of the interactions between nurses with interns and nurses with physicians, she believed that the results were due to the quantitative amount of interaction between the group members, not the qualitative nature of the interaction. She believed that the dichotomy between nursing ideology and the reality of lower status with physician supervision was reduced by the greater amount of social interaction between the nurses and the interns than that found between the nurses and the physicians. However, a close review of Devine's data shows that the interns and medical clerks were not acting in conformity with the medical ideology of physician control and nurse subordinacy, but more in conformity with the nursing ideology of nurse autonomy and interdependence. The findings could therefore be reinterpreted to mean that conflict, misunderstanding and nurse dissatisfaction with nurse-physician relationships was related to ideological differences between the two professions regarding their functional relationship, that is, the question of whether nurses are subordinate to or equal to but different from physicians. Devine did point out that nurses' perceptions of their relationships with physicians were influenced by the different perceptions held
by interns and physicians, but articulated the results in terms of ward structure rather than ideology, although ideology was her original theoretical framework.

Kalish and Kalish (1977) theorized that the medical ideology of the relationship between physicians and nurses was a generalization of the physician-patient relationship. The physician-patient relationship, in turn, is based on what Kalish (1975) described as aesculapian authority. This authority derives first from the authority of the physician as a expert, "as is true of all people who have the knowledge and skills essential for rendering a needed service valued by society" (Kalish, 1975, p. 23). Secondly, the aesculapian authority of the physician derives from the moral base of the Hippocratic Oath: physicians are allowed the right to control patients because it is believed that physicians are guided by the ethical principle of putting the patient's interest above his own. Thirdly, as a result of tradition centuries old, aesculapian authority stems from the idea that

the physician has license to control by reason of God-given grace. People believe - in a vague and almost unconscious way - that the physician has special connection with the world of the unknown, philosophically and spiritually (p. 23).

People submit to medical control due to their fear of death and their conviction that the physician has more than
simply technological and knowledge-based expertise. Kalish suggested that the physician's authority somewhat resembles that of the tribal medicine man.

Kalish reviewed the logic and beliefs of the ideology that accounts for physicians' use of this level of authority. She notes that proponents of aesculapian authority believe that without this type of medical control, the patient would not accept the treatment that they need because of fear and ignorance of appropriate medical interventions. Therefore, the physician restricts the information that a patient may receive to prevent fear and misinformed choices, which further reinforces the nature of aesculapian authority. Medical use of aesculapian authority stems from the well-intentioned belief that the patient's welfare is at stake.

This ideology of the physician's relationship to patients "spills over into the physician's relationship with coworkers" (Kalish and Kalish, 1977, p. 52). The physician sees himself as the expert whose ethical responsibility is to insure the welfare of the patient. The nurse serves as assistant to the physician, but it is the physician who maintains the primary relationship with the patient. Nurses who subscribe to this ideology see themselves as a physician helper rather than a patient advocate (Kalish, 1975).

Winslow (1984) notes that early paradigms of nursing emphasized nursings' loyalty and subordinacy to the
Physician. The metaphor used by nursing during the early part of this century was that of the military: nursing as a battle against disease.

It is associated with virtues such as loyalty and norms such as obedience to those of 'higher rank' and the maintenance of confidence in authority figures (p. 32).

Winslow saw the power of metaphors as deriving from their ability to focus attention on certain aspects of reality while concealing others. Metaphors create expectations and make some behaviors appear to be more natural than others. The early military metaphor of nursing focused attention on the nurse's relationship with the physician; her role in terms of patients was to encourage obedience to the physician's orders and to maintain the patient's confidence in the physician.

As a result of legal decisions regarding nurse's responsibilities toward patients, the rise of consumerism, feminism and the human rights movement, the metaphor nursing used to define itself changed. Winslow frames this new metaphor as advocacy: nursing as courageous advocate for the patient's rights. Components of this role are derived from the legal rights of the patient: "the right to adequate information about proposed medical procedures, the right to refuse or accept any or all such procedures, the right to full information about prognosis and diagnosis, the right to leave the hospital, and so forth" (p. 36). The central,
moral significance of this metaphor is the power to shape action to protect and enhance the personal autonomy of the patient. This emphasis on the autonomy of the patient represents a major difference between nursing advocacy ideology and medical ideology, where the patient is seen as too fearful and ill-informed to be able to make appropriate decisions regarding medical treatment procedures.

The implications for the nurse-physician relationship that derive from the metaphor of the relationship between the nurse and the patient make the second central difference between nursing ideology and medical ideology. Lindeman (1989) points out that since the 1940's nursing has existed to serve the needs of patients. As one aspect of the concept of professionalism, nursing defined its practice in terms of social needs for nursing care rather than in terms of its relationship to another professional discipline. "To the extent that expectations of medicine...are consistent with the patient's or societal needs, nurses will fulfill them. When the nurse senses conflict or differences in priorities, the nurse's primary duty is to the patient" (p. 70). Lindeman is clear that nurses must advocate for the patient if medicines' expectations are inconsistent with the patient's needs. The nurse is therefore duty-bound within this ideological framework to enter into conflict with the
physician if it serves the patient's best interests, as determined by the autonomous patient and the courageous nurse.

Benne and Bennis (1959) argued that it was the growth of the conception of nursing as a profession that was the basis for conflict with physicians. The growth of the conception of professionalization was brought about by the efforts of nursing leadership in the previous twenty-five years, since the close of World War II, to expand university connected schools of nursing, to increase graduate programs for nurses and to form and support nursing research. Through these educational socialization processes "nurses learn to be and to see themselves as autonomous professionals sharing with substantial equality in appropriate judgements regarding treatment processes" (p. 381). Conflict is raised when physicians still expect nurses to function as an obedient extension of their own professional judgment. Benne and Bennis did not frame this issue as an individual identity crisis within the nurse, but as a conflict in professional ideologies. They conclude that "growth only takes place in a profession through the creative resolution of conflicts of this sort and only when the fact of confusion and conflict is accepted. Denial leads to adjustments other than growth" (p. 382).
Competition

Friedson (1970) combined the concepts of nurses' relationships with physicians and their relationships with patients:

One of the variables mediating interoccupational relations in the health services seems to be functional autonomy - the degree to which work can be carried out independently of organizational or medical supervision and the degree to which it can be sustained by attracting its own clientele independently of organizational referral or referral by other occupations, including physicians. On the whole, the more autonomous the profession, and the greater the overlap of its work with that of physicians, the greater is the potential for conflict, legal or otherwise (p. 53).

He thereby introduced the idea that competition between nurses and physicians can be framed in three ways: independence from medical supervision, independent clientele and an overlap of functions. These three issues have not only been the subject of ideological differences between nursing and medicine but have also been a factor in the objective conditions of the delivery of health services.

Bates (1971) noted that technological advances in medical science had enlarged the overlap of medical and nursing roles because tasks which were instrumental to the diagnosis and treatment of patients' illnesses were delegated from physicians to nurses. This expansion of the role of the nurse was seen as an invasion into the diagnostic and therapeutic domain of medicine. "Many individual physicians and much of organized medicine have
mobilized their forces to fight back. Where the turf is occupied by paying patients, however, medicine has put up its most vigorous fight, as if defending its oil fields (Bates, 1975, p. 703).

Kalish and Kalish (1977) note that the large problem of overlapping functions and responsibilities between medicine and nursing was a source of conflict between the two groups. The describe a change in the position of the American Academy of Pediatrics regarding the independent functions of pediatric nurse practitioners as a result of fear of competition. While originally in favor of an independent role for pediatric nurse practitioners whose training and certification would be controlled by the nursing profession, the Academy later withdrew its support and developed its own certification exam.

Lancaster (1986) discussed the implications of the increasing physician surplus expected during the 1990's. He predicted that physicians would be competing with nurse practitioners and midwives for the jobs that had recently been delegated to them in rural and inner city areas. Due to increasing federal control of health care costs, he predicted that:

Turf issues abound in an era of retrenchment. As competition for the health care dollar increases, we will see more intensive efforts by physicians to limit the practice of nurse practitioners and midwives and more vigorous efforts to block the 'enlightened' nurse practice acts and third party reimbursement for nursing services (p. 34).
Baggs and Schmitt (1988) conducted a review of the literature in regard to concepts related to nurse-physician collaboration. They noted that the meaning of the term collaboration is twofold: working together in a joint intellectual effort and treasonable cooperation with an enemy occupying one's territory. They cite Styles (1984 cited in Baggs and Schmitt, 1988), indicating that physicians are often threatened because they see collaboration with nurses as an invasion of their territory. Those physicians who do collaborate are seen as traitors by other physicians.

Competition then has been seen as one of the factors leading to conflict between nurses and physicians. Competition was seen as a factor both in the differences between nurses' and physicians' ideological beliefs regarding nursing's dependence on or autonomy from physicians and in the objective conditions of their interrelationships.

In summary, explanations of issues in the nurse-physician relationship at the group level of analysis focus on properties of groups as a whole. The themes of the mechanisms that have been reviewed in this section include professional cultural frameworks for interpreting the meaning of words and events which arise out of differences in goals, training, technology, roles and structures of work, ideologies regarding relationships between physicians,
nurses and patients and competition as a subjective and objective condition of the relationship. The next section will review explanations of issues in the nurse-physician relationship from the societal level of analysis.

**Societal Factors**

This section of the review of the literature will examine societal factors that have been thought to influence the nature of the relationship between nurses and physicians. Each sub-section will focus on a description of the factor, the author's view of how the factor influences the relationship and the methods used to reach their conclusions.

The societal level of analysis is one which places its emphasis on the study of the stabilized social forms of experience and behavior of large groups or nations and the processes through which these forms of organization and relationships between groups are maintained or changed (Sherif and Sherif, 1969). Studies in sociology and anthropology take this perspective. Once these groups and institutions come into existence, they pass their values, beliefs and assumptions to new generations. These values, beliefs and assumptions become "stimulus conditions for the new generation, setting certain limits and perspectives for
them and for the very human beings who originated them" (Sherif and Sherif, 1969, p. 19). In this manner, people both create and are created by their societies.

Intergroup relations theory considers that a particular intergroup relationship is influenced by its relation to its environment (Alderfer, 1987). A particular identity group's place in a given social system influences its members' sense of how the group's interests are cared for or abused by the system and its assessments of whether one's own group or another group is in control of distributing scarce resources. Identity groups are broad categories of people distinguished by social class, race, gender, religion and so forth. Membership in identity groups is not independent from membership in organizational or professional groups. Larger system forces involving identity groups influence the perceptions of members in smaller organizational and professional groups (Alderfer and Smith, 1982). The individual may or may not notice the influence of these larger societal forces or patterns on their perceptions, values, beliefs or assumptions because some patterns of culture are beyond the immediate apprehension of individuals. They only understand their own small part (Malinowski, 1931 cited in Singer, 1968). It therefore becomes important to understand how these larger social forces may influence the nurse-physician relationship. The themes of the mechanisms that will be reviewed in this
section include opportunities, social comparison, beliefs and ideologies and power that are related to the social issues of gender, class and race.

Opportunities

Kalish and Kalish (1977) pointed to the women's movement as a reason underlying a change in women's acquiescent behavior and their role as subservient to men. "The movement has led to a greater role for women in generating the family income, even for those who are married and have children. Knowing that they will be working,...many nurses are more committed to investing the energy essential to gain improvements" (p. 56). Kalish and Kalish believed that diminished acquiescence was a factor causing increased conflict between nurses and physicians.

Turnbull (1982) noted nurses' irritation and anger with physicians resulted from the historically dependent position of women, the subjection of many nursing activities to physicians' orders and the resistance of physicians to accept nursing judgements as valid. "With evolving health care needs as well as roles in nursing, there is a new, clear desire to achieve a different recognition, status and sense of professional respect" (p. 27).

Stein, Watts and Howell (1990) believed that the move of nursing toward autonomy was an extension of the women's movement, which was augmented by the many nursing shortages,
to result in more opportunity for nurses to define their roles. They referred to changes in educational practices for student nurses as the principle vehicle of the change. With the change in education site from the hospital to the university, the physician's influence over nursing education was reduced. Stein, Watts and Howell argue that university schools of nursing teach nurse students that they are equal to physicians; students learn an aversion to medical authority. This type of socialization into the practice of nursing is very different from that provided in the hospital associated school of nursing in their opinion. As a result of this different socialization, nurses feel free to confront physicians and to make independent clinical practice decisions. Stein et al observed that many nurses take the stance of the stubborn rebel and seem to perceive themselves as fighting for freedom. They contend that "medicine has been one of the main sources of oppression exerted through institutionalized sexual discrimination" (p. 548). They conclude that the doctor-nurse game is stifling, anti-intellectual and has resulted in nurse dissatisfaction and the nursing shortage.

Social Comparison

As early as 1965, Christman (1965) was concerned with identifying factors that contributed to barriers in communication between nurses and physicians. He suggested
that the second class status which resulted from being the physician's handmaiden may cause concealed resentment in nurses which would create a subtle barrier to full communication. Due to the gender compositions of the professions, nursing as primarily female and medicine as primarily male, Christman asserted that "the societal norms for male-female relationship are undoubtedly in effect. Male dominance and assumed male superiority are part of our cultural heritage" (p. 153). Under the influence of gender norms, physicians emphasized the nurses' relationship to his own role, as a subordinate, rather than her relationship to the patient, as a patient support. Due to changes in gender roles however, the "women nurses see much evidence that women are rapidly achieving equal status on practically all facets of the open society" (p. 153). It was this disparity in status between the women in society and the women in nursing that Christman believed was the cause of nursings' rising irritation with medical dominance.

He also noted that differences between the class origins of nurses and physicians influenced the perceptions of members of each class and resulted in differing perspectives, professional ideologies and attitudes. Traditionally, physicians more often come from families with professional and business backgrounds, the upper-middle and upper classes. Nurses more often come from working and lower-middle class families. Christman concluded that the
differences in perspective, beliefs and attitude resulting from these different class backgrounds, if not objectively assessed, pose an additional obstruction to free and open communication between physicians and nurses.

Peeples and Francis (1968) theorized conflict between physicians and nurses as originating in the patterns of cultural structure that underlie the relationship rather than in the personalities of the individuals involved. Following Christman (1965), Peeples and Francis note that people from different social classes have different modes of thought and behavior. Some of the difference between the perspectives and variations in perception of nurses and physicians can be attributed to their middle/working class or higher class backgrounds, respectively. Once again, Peeples and Francis note that "individuals are strongly influenced in both internal values and overt behavior by the groups which they value or to which they aspire to belong. Social class relates also to differences in income and status between nurses and physicians. "Collegiately educated nurses invest between one-third to nearly one-half of the time that the doctors invest while the nurse's return is only approximately one-fifth of what physicians earn" (p. 31). Physicians hold the most esteemed social position in this country while nurses rank considerably lower, in fact lower than many other occupations with similar education and responsibility.
Another pattern described by Peeples and Francis was public attitude and belief regarding the work of physicians and nurses. They theorized that "these attitudes and beliefs function as reference points for behavior toward nurses and thus tend to retard the full acceptance of nursing as a profession" (p. 33). Nursing is perceived as feminine in character, its major contribution as the capacity for being tender and sympathetic and the nature of its work as routine, requiring little competence to perform. Medicine, on the other hand, is perceived as masculine in character, its major contribution as specialized scientific knowledge and skill and the nature of its work as dramatic. Peeples and Francis concluded that the disparity between physicians in terms of social class perspectives, income expectations, social status and public stereotype lie at the root of many conflicts between nurses and physicians, particularly when viewed against the egalitarian values of American society.

Simmons and Rosenthal (1981) cited feminism as a reason for a change in the tone of nursing literature in the early 1970's. "Nursing leaders began to realize that when feminists discussed women's position in terms of powerlessness, dependency and discrimination, they were describing the position of the nurse within the health care system" (p. 371). The functioning of the nurse as a subordinate to the physician began to be discussed in the
nursing literature in terms of its result from discrimination rather than its being a result of nursings' inherent limitations. Nurses' lack of awareness of their dependency and their unwitting acceptance of the existing power structure were argued. Nurses were urged to recognize that their acceptance of an inferior position was related to the general pattern of gender role differentiation in the society at large. Simmons and Rosenthal contended that the women's movement provided a backdrop for this literature which in turn, supported "the development of a group consciousness among nurses and a willingness to exercise power" (p. 371).

However, in their study of 28 nurse practitioners and physician partners in independent practice, they found that at best, the women's movement provided encouragement and a new perspective for some nurses to expand the traditional domain of their practices, but that it did not impact on the basic pattern of thought and action with which nurses defined their roles. The relationships between nurse practitioners and physicians in this study occurred only when the physician was comfortable with the nurse practitioner's competence and were confident that the nurse would not practice beyond her level of expertise. The relationships were found to remain relatively uncomplicated and tension free if the nurse practitioner conformed to what the physician's thought were her limitations. The nurse
practitioner's were found to be accepting of those restrictions in order to secure their jobs. These nurses were not eager to struggle with the physicians to further actualize or expand their role, and believed that they would have to wait for the medical profession to change its point of view before greater independence could be achieved. Several of the respondents criticized their peers who associated with the women's movement arguing that they would cause a rift within the nursing profession "by stepping beyond the boundaries of the law in their eagerness to treat patients and forcing women to give up preferred traditional roles" (p. 374). Simmons and Rosenthal concluded that "the new consciousness of nursing leaders has filtered down to the practicing nurse only to a limited extent" (p. 372).

Fagin and Diers (1983) examined issues that underlie the social perception of the concept of the nurse. Like Winslow (1984), they believed that metaphors influence language, thought and action. They contend that in American society nursing is a metaphor for mothering, class struggle, equality, conscience, intimacy and sex. Maternal types of behavior are seen in American society as essentially mundane when compared to socially competitive settings. As a class, nursing takes the position of the underdog, dominated and controlled by the upper class of physicians with little social distance between nurses and patients. Seeing the negatives as well as the positives that occur in health
care, nurses can be an uncomfortable reminder that all of the physician's attempts to conquer disease might not work. People identify nurses with moments of vulnerability, loss of control and personal touch activities that healthy individuals perform for themselves. Fagin and Diers conclude that while these metaphors make up the psychological milieu in which nurses work, they cause discomfort, awkwardness and a reminder of weakness and they clash with contemporary American ideology.

Beliefs and Ideology

Hite (1977) labelled nursing as an "institutionalized method of symbolizing the male superiority ideology that has been so central to American social thinking" (p. 14). He referred to the image of nursing "as a stable metaphor promoting the myth of male dominance in American culture" (p. 16). He predicted that the American health care system would undergo a phase of irreconcilable conflict between physicians and nurses over attitudes toward the roles of females. Reasons for what he referred to as the new radicalism in nursing were the awakening social consciousness of women health care workers, which led to a desire to redefine attitudes toward traditional roles, and the information explosion, which eroded the concept of the
physician as the repository of all knowledge. He believed that conflict was inevitable because of the human tendency to view conflict as hierarchical:

the tendency of humans to assume that because roles are intertwined, there is an automatic sequence: if one gains, it will be at the expense of the other. The conflict is irrepressible because people have the tendency to view conflict as a zero-sum activity (p. 15).

Ginzberg (1981), an economist, discussed the impact of cost containment on nursing's goals for collegiality in the 1980's. He predicted that decreased federal funding for nursing education would delay the profession's goal of increasing the number of college prepared nurses. However, he noted that nurses with collegiate and higher degrees were experiencing growing hostility, dissatisfaction and alienation in their relations with physicians. The reason for the growing discontent according to Ginzberg was the machismo ethic of medicine. He described the basis of the machismo ethic as an assumption by physicians that they are in positions of authority and privilege by virtue of a right rather than as a result of history and tradition. By virtue of this ethic, physicians "fail to recognize that a revolution has occurred in the role of women, particularly the role of educated women, in society and the economy" (p. 32). He believed that physicians' attitudes toward nurses as subordinates rather than colleagues were based on this machismo ethic and that the movement of the nursing
profession toward collegialty with physicians was a struggle for professional emancipation. Ginzberg therefore theorized that medical and nursing ideologies were at least in part influenced by gender ideology.

Melosh (1982) believed that practicing nurses of the present era are now motivated to challenge the basis of the medical hierarchy that pervaded the nurse-physician relationship. She credits this motivation to feminism and unionism. She believed that while early nursing leaders provided nurses with an ideology of entitlement to authority and a commitment to work, it was the growth of feminism and unionism that redefined the leaders' goals of professional autonomy into worker-defined views of the job that support challenges to physicians.

Whitman (1982) was concerned with the review of historic changes and the identification of changes which need to occur in order for nursing to take charge of its own profession. She noted that the rise in nursing anger regarding the second-class status of the profession, its lack of clout and feelings of powerlessness were the result of a change in women's explorations of their own needs instead of men's and their evaluations of themselves on their own terms. She cited Jean Baker Miller: "It is only because many courageous women have, once more in our time,
said, 'we refuse to be second class,' that we can begin to see all the meanings that second class status has contained" (Miller, 1977 cited in Whitman, 1982, p. 48).

Whitman believed that nurses' socialization as women and nurses, in which nurses were taught to be supportive, helpful, nurturing and followers, made attempts to change the second class status difficult in the past. Nurses who made great strides in improving the status of women were labelled deviant and role-breakers. During the first efforts to gain control over nursing practice through the achievement of state licensure, nursing leaders had to compromise and accept physicians on boards of registration in nursing. Whitman labelled definitions of nursing practice that were written in the 1950's as an example of anticipatory discrimination, whereby nursing leaders, not wanting to risk rebuff, put themselves and their profession in a second class position under medicine. She noted that this was classic minority group behavior, in which "a minority group will cause disfavor to fall upon themselves rather than to allow others to bring it upon them" (p. 49). Presumably, although not specifically articulated by Whitman, gender role socialization as women and the subsequent minority group behavior were significant factors in the development of nursing ideology as boards of registration in nursing and definitions of nursing practice
that are developed by national organizations of nurses
impact on legal definitions of nursing practice and court
decisions regarding violations of that practice.

Morgan and McCann (1983) describe three historic
nursing ideologies: "Nightingalism where the nurse is the
handmaiden of the physician, paternalism where the hospital
plays the role of father...and professional collectivism,
where nurses band together to determine their own working
conditions and the quality of nursing practice" (p. 2).
They argue that western cultural tradition holds women's
roles subservient to mens' and the nurse-physician
relationship as an example of mens' exploitation of women.
They conclude that a collaborative relationship between
nurses and physicians will depend on closing the economic
gap between nurses and physicians. Morgan and McCann
emphasize the need for nurses to take responsibility for
sharing their concerns and their role expectations when
participating in health care decisions regarding patient
care.

Roberts (1983) reasoned that the development of nursing
theory and nurse leaders' beliefs which supported medicine's
control of the health care system were influenced by the
dynamics of oppression. Citing Freire's (1971) model of
oppression, Roberts notes that dominant groups such as
medicine have the ability to identify their own norms and
values as the 'right' ones in the society and have the power
to enforce them. Differences between the dominant group and the subordinate group, such as race, gender and primary task, are emphasized and the differing characteristics of the subordinate group along these dimensions are devalued. Members of the subordinate group tend to "internalize these norms and to believe that to be like the oppressor will lead to power and control" (p. 22). The characteristics of the dominant group become perceived as exemplifying the best that can be obtained. The primary mechanism through which this occurs is the control of education and its limitation to the curricula that support the values of the dominant group. Members of the dominant group reward subordinates who ascribe to the dominant values, even though the subordinates must degrade their own characteristics to do so.

Roberts contended that the development of mechanistic and professional nursing theory echoed the models used by medicine. She argues that the nursing leaders who shaped these theories of nursing had internalized the characterizations of medicine as the best that could be and therefore believed that attaining the characteristics of mechanization and professionalization would provide the same level of power to nursing as held by medicine. She notes however, that these models are not the paths to power and autonomy but are descriptions "of the powerful and the autonomous who have set their characteristics as the highest
values possible" (p. 26). The characteristics of warmth, nurturance and sensitivity belonging to nurses are devalued and seen as negative by the dominant American culture which values intelligence, decisiveness and lack of emotion. Roberts notes that oppression theory cites this devaluation of the characteristics of the subordinate group as the basis for passive-aggressive behavior. As subordinate group members are socialized into devalued roles, they internalize the norms of the dominant culture and come to devalue and feel hatred for themselves. Because of the power of the dominant group, the subordinate group cannot express aggression against them. 

"Although there may be much complaining within the oppressed group, self-hatred and low self-esteem create submissiveness when confronted with the powerful figure" (p. 23). They have little faith in their own ability to manage without the dominant group so they begin to fear change of the status quo. She concludes that the better strategies to use in attaining autonomy from medicine would be first, to demythologize the nature of the medical dominance of nursing through a better understanding of role played by the devaluation of nursing attributes and second, to enhance the cultural priorities that are of interest to the larger group of practicing nurses.

Winslow (1984) did not discuss class or gender influences on the derivation of early nursing ideology but cited feminism as a highly important development in the
later transformation of the nursing paradigm from the military metaphor to the client advocacy metaphor. Along with other forces such as the patient's rights movement, consumerism, and the loss of confidence in medicine, feminism allowed nursing to challenge the distribution of power and expertise through their public statements of ideology. Codes of ethics and definitions of nursing practice subsequently developed by a national nursing organization removed references to the nurse's relationship to the physician and replaced them with statements of nursings' primary obligation to patients.

Campbell-Heider and Pollack (1987) were concerned with barriers to collegial interaction between nurses and physicians, the foremost of which they saw as sex-stereotyping. In their anthropological analysis, they explored themes of ritual, secrecy and the ideology of hierarchy. They contended that ritual, designed to separate men from women, was a mechanism through which men symbolized their occupation of roles that were highly valued in any cultural context. They believed that physicians' interactions with patients in hospitals, characterized as brief, highly structured, and almost ceremonial, exemplified this difference. Nurses' interactions with patients were characterized by long hours in direct intimate contact. "The nurse's closeness to the patient and the physician's
remoteness are pervasive features of the ideology of social relations within hospitals, in which status is proportional to separation from patients" (p. 422).

Secrecy is an issue because the symbolic value of knowledge is negatively correlated to "access to the means of its production and use" (p. 423). Secrecy therefore creates value and justifies systems of rights, obligations and privilege. Medical knowledge preserves its value only through restricting access to its production and use.

Campbell-Heider and Pollock contend that physicians have traditionally opposed college education for nurses and dissemination of knowledge to patients in order to preserve the value of medical knowledge and to symbolize their domination of the highly valued domain of knowledge.

Campbell-Heider and Pollock believed that the authority hierarchy of physicians over nurses, based on gender stereotype, has served to increase physicians' status and power differential over nursing. Maintaining the stereotypic second class status of nursing prevents the reduction the public's perception of medicine as the highest level of expertise in health care. The acknowledgment of competence in nurses could therefore decrease the powerful image of the physician. They cite investigations that support the idea that "males tend to select competent females only when they are in situations that will not tend to challenge their own sense of worth" (p. 423). Therefore,
medicine's continued doubt of the competence of nurses supports medicine's ideology of expertise and dominance. Campbell-Heider and Pollock conclude that medicine and nursing are "two of the most sex stereotyped professional groups in Western cultures" (p. 424).

Webster (1988) found that medical students viewed nurses and nursing through an ethnocentric perspective "characterized by a belief in the inherent superiority of one's own group and culture accompanied by a feeling of contempt for other groups and cultures" (p. 134). She interviewed sixty randomly selected medical students in various institutional settings. The medical students tended to believe that other health professionals would have been physicians if they could have gotten into medical school. Nursing was viewed as a lower level of medicine, which is responsible for what the students referred to as the scut work that they themselves were no longer responsible for after completing the third year in medical school.

Webster argued that educating physicians and medical students regarding the differences between nursing and medicine would be ineffective because "in an ethnocentric culture, it is likely that physicians and medical students value only what they themselves offer patients, ie. diagnosis, prescription and treatment decisions" (p. 134). Nursing activities are seen as less important. She concluded that the view of nursing by medicine was so
ethnocentric that it was antagonistic to the development of real cooperation. She believed that change in the nurse-physician relationship would occur only if there were changes in the status differences between men and women in society.

Cooper (1989) proposed that an ethic of caring based on Gilligan’s theory of moral development (1982 cited in Cooper, 1989) better represented the experience of working-class nurses than the legalistic, rule and principle ethic in biomedicine. She argued that Gilligan’s distinction between the perspective of care and the perspective of justice provided a paradigm for the development of a cooperative relationship between nurses and physicians in moral decision making. These perspectives characterize different ways of organizing experience and the relationships between the self and others. They are not intended to promote disparity between men and women but to highlight that modes of experience can be different from the male perspective that currently dominates much of psychology and nurse-physician relations. By suggesting that the ethics of care and of justice can be used to promote the relationship between nurses and physicians, Cooper implies that the ethic of care underlies the ideology of nursing and that the ethic of justice underlies medical ideology. The perspective of care organizes relationships in terms of attachments within the metaphor of a web; that of justice in
terms of equality under the metaphor of hierarchy. Under an
ethic of care, the concept of autonomy becomes one of
interdependence through choosing to embrace the dependence
humans share, rather than through helplessness. Under an
ethic of justice, autonomy is viewed as self-sufficiency and
detachment. Cooper therefore provided a new perspective on
some of the major differences between nursing ideology and
medical ideology. She proposed a new dimension to the
nursing paradigm outlined by Winslow (1984), that is,
relational caring, and a new model to frame nurse-physician
relationships.

Gordon (1991a) points out that issues of caring,
hierarchy and competence are gender and class issues through
which the gender and class values of society have influenced
the relationship between nurses and physicians. She argues
that caring activities are the manifestation of traditional
female activities in American society and are therefore
devalued by both mainstream American culture and by the
feminist movement. American culture devalues caring
activities because the culture is dominated by the male
marketplace values of success, competition, hierarchical
power and control, autonomy through disconnedtedness and
individual self-actualization.

Men have been taught to capture credit for
accomplishments which are not always theirs
alone, but rather the product of contributions
from many others with whom they work. They
deny the fact of interdependence and conceal,
far more than they reveal, the input of others who help make them who and what they are. Women, on the other hand, tend to recognize and respect collaboration (p. 89).

Hierarchy is therefore the masculine epitomization of an ethic based on individual accomplishment achieved through competition and dominance over others. The masculine concept of professionalism focuses on a distance and an objectivity that considers any sign of emotion or caring for others unprofessional.

Early feminists feared that a focus on caring and collaboration would be used to impose a duty to care on one half of humanity and one half only, that would "pull women back into the home, once again to be confined to domestic slavery of 'subservience' in the caring professions" (Gordon, 1991a, p. 131). They believed that the very entrance of women into the marketplace would eliminate the competitive, individual success-oriented conditions that might compromise their femininity and would create a more egalitarian, democratized management process. However, Gordon contends that the new feminists, in seeking to overcome their male socialized insecurities about their competence outside of the domestic sphere, created a new masculine mystique which assumed that women could find happiness and self-fulfillment by emulating and ultimately internalizing the ideology of the male marketplace. They "denigrated the very skills, values and activities that have been the substance of women's claim to difference" (p. 26).
Consequently, both male marketplace and early feminist ideology view caring activities as based in sentimentality and the need for care as based in neuroticism, weakness and dependence, both of which have a lesser place in the strength and dominance oriented themes they espouse.

Gordon contends that society’s devaluation of caring is seen most clearly in women’s attitudes toward traditional caring work such as social work, teaching and nursing. She argues that these professions have become the negative standard against which feminists measure their progress, that is their distance away from caregiving work and toward traditional male activities, because of the feminist’s grounding in masculine values. Popular culture trivializes nursing or ignores it because of what Gordon refers to as the national obsession with medical heroics. Nursing is viewed as an extension of women’s work inside the home and a manifestation of the dominant, male value system of patriarchal, and in this case, medical ideology. She believes that nursing’s negative image, low pay and lack of autonomy from physicians has contributed to a major crisis in the supply of nurses.

Class is also an important issue in the nurse-physician relationship. In addressing the issue of the increasing number of women in medicine, Gordon notes:

The fact that she is a woman does not mean that a physician will be more collaborative, less authoritarian, or more willing to listen
to and recognize a nurse's expertise than a male doctor. Most nurses insist that it is a physician's training on the job, not sex, that determines how he or she relates to nurses (p. 149).

Gordon describes the concept of lateral feminism whereby a sense of comradeship and concern is felt only with women in similar jobs and titles with the same prospects, and gender is no protection against classism or racism. One of her main arguments is that "in analogous situations, men and women in power tend to act in the same way (p. 180)...It is this difference in class, rather than in gender, that most frequently determines conduct" (p. 181). Because of this, Gordon believes that strategies that rely on women at the top, either in medicine or in nursing leadership positions, to bring about real change for those at the bottom are limited by pressures to conform to gender and class based rules of conduct. Therefore, Gordon's analysis has shown how gender and class values have contributed to the devaluation of nursing and the dominance of medicine over nursing through their influence on medical, nursing and societal ideologies.

Power

Ehrenreich and English (1973) argue that nursing's subservient status to medicine was the result of an active political struggle between upper class males and lower class females for control of the profits, prestige, theory and
practice of health care organizations. They believed that it was a gender struggle in that "the status of women healers has risen and fallen with the status of women" (p. 4). They believed that it was a class struggle in that early women healers were the doctors of the people, while male professionals served the ruling classes. Ehrenreich and English assert that the interests of male professionals have been served by universities, philanthropic foundations and the law and that they owe their victory in the struggle not to their own efforts, but to the intervention of the ruling class that they served.

Through their analysis of historical documents, Ehrenreich and English found that autonomous female healers of the 12th and 13th centuries were suppressed by the Church because their healing allowed peasant's to help themselves and thereby reduced their dependence on the Church. The Church legitimized upper class male healing on the grounds that it was based on formal education; lower class women healers, being barred from institutions of higher education, were condemned as witches who based their healing on evil and magic. The rise of professional medicine in America was associated with the financial contributions of the Rockefeller and Carnegie Foundations to medical education and to the passage of medical licensure laws that restricted medical practice to those who received medical education in schools that were closed to women, poor men and blacks.
Ehrenreich and English pointed out that competition and financial gain were part of the motivation for restricting female healers: "When physicians moved into the lucrative midwifery market and claimed technological superiority because of forceps, women protesters were easily put down as ignorant old wives, clinging to superstitions of the past" (p. 20).

They contended that nursing was part of this political struggle. Once professional medicine had established control of healing activities, they allowed primarily lower class women back into the process in a subordinate role. Early nursing leaders, being from the upper class, stressed the concepts of wifely obedience to the physician, motherly care to the patients and training in moral character in educational programs that were geared to lower class women. Ehrenreich and English concluded that it was at that point that women gave up the fight for equal treatment. "The drive to 'professionalize' nursing is, at best, a flight from the reality of sexism in the system" (p. 41).

In 1975, Hoekelman, a physician, stated that collaboration between nursing and medicine was hampered by sexism, economic disparities, classism and educational differentials. He called the physician dominant-nurse suppressed relationship "a prime example of the male exploiting the female" (p. 1151). He noted that medicine dominates nursing because physicians have more educational
credentials and generally come from higher social levels. Because of the education gap, society's lack of recognition of the value of nursing and sexism, that is, the fact that men usually have higher salaries and more promotions than women, physicians make much higher average salaries than nurses. This exploitation by medicine of nursing, concluded Hoekelman, creates barriers to a constructive nurse-physician relationship.

Hoekelman viewed physicians as victims of a variety of political and economic changes which were threatening their self-image and self-esteem. He saw that resolution of the conflict would be also beneficial to physicians, by removing the burden from them of having to pretend to be omniscient.

Ashley (1977) conducted an extensive historical analysis of the writings of physicians and nursing leaders during the early part of the twentieth century. She contended that early hospital schools of nursing "provided both a structural and functional arrangement whereby the medical profession and male officials in the hospital could claim the right to exercise control over women" (Ashley, 1977, p. 76). This right was derived from Victorian sexist conceptions regarding the nature of women which defined the role of women as a servant to men's needs and convenience. Ashley found that the prime method through which medicine controlled nursing was the continued advocacy by medicine for the apprenticeship method of education. The
apprenticeship model was the prime method through which medicine maintained nursing's lack of freedom and nursing's inequality with and dependence on the presumed superiority of medicine. It was the prime method through which competition and threats to the value of the physician's contribution from educated and skilled nurses could be prevented. Through the vehicle of apprenticeship education, medicine persuaded "the rank and file in nursing to believe in their inferiority" (p. 64) and to accept economic exploitation as legitimate. These attitudes presented insurmountable barriers to nurse-physician communication and convinced nurses, physicians and the public that nurses did not have the capability of advancing to the levels of competence achieved by the primarily male professions.

Lovell (1980) contends that "power is presently being used by the medical profession against the interests of nursing and society" (p. 74). She conducted a historical analysis for the purpose of identifying the deceptive practices and exploitation of women, nurses and society in order to better understand how nursing and society have allowed this situation to flourish. She pointed out that early efforts of the American Medical Association to establish licensure requirements for the practice of medicine were an effort to establish a monopoly. Subsequent efforts by the AMA were on behalf of physicians' economic interests to the detriment of such public health measures as
compulsory inoculations against diphtheria and smallpox. The purposes of codes of physician ethics were attributed to the maximization of profit rather than the patient's best interest through the identification of such themes as exclusive physician ownership of the patient, physician control of information, discouragement of competition and the patient's belief in magic cures. Lovell asserts that the nurse-physician relationship is symbiotic by which medicine dominates and exploits nurses. She contends that the relationship is based on conflicting interests:

medicine is characteristically disease oriented and derives profit from illness, whereas nursing claims it is health oriented. It is in the area of preventive health care that the conflict between nursing and medicine is most evident... Medicine profits from keeping humanity sick or making it sick" (p. 84).

Lovell concludes that medicine is basically a profit oriented business. Society and nursing have been deluded by the myths and lies through which medicine has veiled its true purpose. Seeing through the deception will free nurses and society to create new levels of health.

Along the same theme, Lovell (1981) conducted further historical analysis to show how medicine historically used women to increase profits. Citing Miller's framework of inequality (1976 cited in Lovell, 1981), she pointed out that

the actions and words of dominant groups tend to be destructive to the subordinates. Dominant groups usually define the acceptable roles for the
subordinates. These roles typically provide services that no dominant group member wants to perform. Functions that a dominant group prefers to perform (those most highly valued in any particular culture) are carefully guarded by the dominants and closed to the subordinates (p. 25-26).

She found that medicine defined most of women's bodily functions as essentially pathologic to keep upper class women as perpetual patients and thereby increase their profits. Medical wives provided the support system for male physician's mobility through their financial contributions to the practice and through their behind the scenes performance of auxiliary and supportive labor. The role of the nurse was designed to make the practice of medicine easier and more profitable for physicians. Lovell asserted that the nurse assumed wifely duties in caring for the physician's needs and motherly duties in caring for the patient's needs in the hospital. "The medical business advanced primarily through the efforts of nurses who worked at demeaning tasks for long hours at little pay" (p. 38) yet whose full worth was devalued so nurses would continue to support the medical effort without demanding better. Lovell concluded that wives and nurses served as the domestic servants of men, whose contributions were devalued and exploited through processes of domination.

Tellis-Nayak and Tellis-Nayak conducted an ethnographic study of nurses in four large hospitals in the Midwest. They found that the physician dominance-nurse deference ritual was grounded in an unequal control of desired
resources, an aspect of power and privilege and an avenue for institutional control and social legitimation. They argue that professionalization is a form of power in which the professionalized group is granted the autonomy to control the nature and conditions of work. Medicine, they contend, completely controls health care: "they define the standards of health, diagnose an illness, preside over the medical management of the patient and even set standards for the training, registration and licensing or certification for some of the paramedical specialties" (p. 1064). Nursing, however, does not control its own functions. "A staff nurse with a Ph.D. or D.N.Sc. cannot, in a hospital or other institutional setting, prescribe even an aspirin or give an enema without a physician's order" (p. 1064). They contend that the physician's superior competence, the basis on which medicine has been granted such autonomy from society, cannot easily be established due to studies which have shown that nurses and nurse midwives obtain comparable or better results than physicians at the same diagnostic and treatment activities. Tellis-Nayak and Tellis-Nayak believed that it was historical developments, rather than superior competence, that shaped the unequal authority of medicine and nursing. They found that the physician's use of space, time, language and touch serves to express and reinforce physician dominance over nurses. Tellis-Nayak and Tellis-Nayak therefore differ greatly from the conclusions
drawn by other analysts who see differences between nurses' and physicians' conceptions of time, space and language as arising from the objective differences of the two professions. Tellis-Nayak and Tellis-Nayak see these differences as manifestations of the differences in power of the two professions. They support Gordon's (1991) assertion that power differences bear more heavily on the relationship between nurses and physicians than either gender or racial dimensions, because they found that hierarchical differences occurred between physicians and nurses when gender and racial characteristics were constant. Tellis-Nayak and Tellis-Nayak concluded that the gamesmanship ritual between physicians and nurses was more than a mere reflection of status differences. The ritual behavior supported and reinforced their power differences particularly when the actors were unconscious of its origin and purposes.

In summary, explanations of issues in the nurse-physician relationship at the societal level of analysis focus on properties of the society as a whole. The themes of the mechanisms that have been reviewed in this section include opportunities, social comparison, beliefs and ideologies and power that are related to the social issues of gender, class and race. The next section will present an analysis and discussion of the literature.
Discussion and Analysis of the Literature

The discussion and analysis of the literature will focus on two areas: characteristics of the field of the study of nurse-physician relationships and some tentative conclusions which emerge from the data provided in the literature.

Characteristics of the Field

According to Thomas Kuhn (1970), the acquisition of a paradigm is essential to the development and maturity of a science because the paradigm produces commitment to a set of rules for research and consensus regarding the nature of the problem to be studied. A paradigm is an accepted view of reality or patterned way of seeing, which in scientific endeavor, is related to a specific school of thought that serves as a foundation to a particular kind of scientific achievement (Wilson, Matusiewicz, Peret and Tatum, 1989). A paradigm focuses research attention on a small range of problems. This focus forces scientists to investigate some part of nature in detail and depth that would otherwise be unimaginable. And normal science possesses a built-in mechanism that ensures the relaxation of the restrictions that bound research whenever the paradigm from which they derive ceases to function effectively. At that point scientists begin to behave differently, and the nature of their research problems changes (Kuhn, 1970, p. 24).
Kuhn characterizes groups who have no organizing paradigm as those merely interested in the study of a problem. Groups who do possess a single paradigm he labels as scientific disciplines or professions.

The field of study of the nurse-physician relationship has no single paradigmatic view. It is characterized by differing views of the nature of the problem to be studied, differing views of the factors which influence the problem, differing views of the mechanisms through which the factors exercise their influence and differing methodologies through which to gain more understanding of the phenomenon. Each of these areas of difference will be discussed in turn.

Within the field of the study of nurse-physician relations, there are two broad views of the nature of the problem to be studied. The first sees the relationship between nurses and physicians as what can best be described as the metaphor of a battle zone, an arena of conflict. Examples of this view include Kalish and Kalish (1977), Peeples and Francis (1966), Sheard (1980), Murphy (1983a), Stein, Watts and Howell (1982) and others. They approach the relationship as inherently conflictual and seek to understand how the conflict originated and is maintained. They tend to conceptualize the problem in terms of difficulties in communication between nurses and physicians.
and their predominant view of conflict is that it is detrimental to the relationship and to the provision of effective patient care.

The second broad view of the nature of the problem to be studied can best be described as the metaphor of the demilitarized zone, an area where no conflict is allowed through the application of strict rules of conduct. Examples of this view include Rushing (1962), Hofling, Brontzman, Dalrymple, Graves & Pierce (1966), Stein (1967), Cunningham and Wilcox (1985), Lovell (1980, 1981), Roberts (1983) and others. They approach the relationship as inherently non-conflictual and seek to understand the forces that prevent conflict from occurring. They conceptualize the problem both in terms of communication difficulties and in terms of the hierarchical arrangement of authority between physicians and nurses. Their predominant view of conflict is that it would be beneficial to the nurse-physician relationship and would enhance the effectiveness of patient care.

As can be seen, these views of the nature of the problem to be studied represent polarities: is the problem to be solved one of communication inadequacies between two professions where accurate and timely communication may be a critical factor in the effectiveness of patient care, or is it a deeper problem of the basic hierarchical structure which impacts on the totality of the functional relationship
between the two professions? The first view of the nature of the problem focuses on relatively simple communication inadequacies; the second focuses on much deeper issues which have much broader manifestations than simply communication. The two views also offer opposite solutions to resolve the problem of the nurse-physician relationship as they conceptualize it: the first would resolve conflict, the second would promote it. The implications of these differences are not only that they place the field in Kuhn's category of immature science, but also that it lends confusion to further study of the nurse-physician relationship. Future investigators must either read very broadly to discern the differing views of the nature of the problem to be studied, or select one aspect of the problem, perhaps without an awareness that the other aspect exists. Individuals looking for solutions in the literature are confronted with differing prescriptions for action, either to reduce or to promote conflict, which can lead either to inappropriate action or to no action at all when unable to understand the basis of the conflicting prescriptions. There is a need then for an overarching paradigmatic view of the nature of the problem in the nurse-physician relationship that will reconcile these differences and provide a unified focus for future research and action.

In terms of the differing views of the factors which influence the problem of the nurse-physician relationship,
one is reminded of Taylor and Bogdan's (1984) example of the principle who sees the problem as a behavioral one, the counselor who sees it as a family problem, the nurse who sees it as a health problem, etcetera. Primary contributors to the literature include nursing leaders, physicians, economists, sociologists, lawyers, ethicists and anthropologists. This review of the literature has shown that this variety of investigators classify the important factors in the relationship into such categories as emotion, individual competence, interpretive cultural frameworks, ideology, social issues such as classism and sexism, and the objective structure which leads to hierarchical arrangements and competition. They espouse a variety of theoretical mechanisms through which these factors influence the nurse-physician relationship: psychological, developmental, interpersonal, cognitive categorical, group ideological, ethnocentric and oppressive.

These differences can be seen as a variety of rich inputs into a comprehensive explanation of the nurse-physician relationship. As was reviewed earlier, and articulated clearly by Peeples and Francis (1968), a focus on one level of analysis, individual, group or societal, does not provide a comprehensive understanding of the phenomenon. To focus exclusively on an individual level of analysis, such as the psychological, developmental or interpersonal factors and mechanisms, risks inappropriately
viewing nurse-physician relationships as based on the personality and skill of the individuals involved. To exclude the individual level of analysis from an explanation of nurse-physician relations however, eliminates the possibility of identifying and understanding what occurs when nurses and physicians do relate to one another as individuals. The same issues of inclusion and exclusion apply to group and societal levels of explanation as well. It is important to understand what occurs when physicians and nurses relate to one another as physician and nurse, as well as when they relate as male and female, as upper class and lower class and as superordinate and subordinate. The diversity of the field in terms of its coverage of factors and mechanisms in the nurse-physician relationship, adds depth and breadth to the understanding of that relationship. However, the voice of the practicing nurse is seldom represented among those who articulate and investigate the issues involved in the nurse-physician relationship.

The field differs also in the methodologies through which understanding of the phenomenon is sought. Much of the literature is theoretical in nature and focuses on a deductive analysis of the nurse-physician relationship by comparing certain aspects of the relationship with salient points which are taken from established theoretical perspectives. Examples of this type of work include Stein (1967), where he compares the development of the doctor-
nurse game to defense mechanisms that protect the ego, Murphy (1983a, 1983b), who compares nurse and physician personality development to adult, child and parent ego states, and Roberts (1983), who compares the relationship between nurses and physicians to that between subordinate and dominant groups. Through this process of comparison, different factors are selected and evaluated in terms of their applicability in the nurse-physician relationship and their value in increasing the understanding of the relationship is consensually determined. Kuhn (1970) notes that this is characteristic of a discipline in the early stages of development: "the body of belief...must be externally supplied, perhaps by a current metaphysic, by another science, or by personal and historical accident" (p. 17).

Another type of methodology frequently used is quantitative in nature. A quantitative methodology assumes that reality is objective, that it is external to the individual and that knowledge can be gained by observing and analyzing the regular relationships between various elements in reality (Burrell and Morgan, 1979). Methodological tools for the collection of data in the quantitative tradition include questionnaires, structured interviews, observation and analysis of historical records. The researcher determines what the important variables are, from a review of the literature or from a guiding theoretical framework,
and then interprets the meaning of the data from their own or the theory's perspective. In other words, the meaning of the data comes from a source outside of the data itself.

An example of this method was the study conducted by Katzman and Roberts (1988), wherein they observed the behavior of fourteen nurses in traditional roles and eleven nurse practitioners. They found that some of the nurses spoke assertively and some softly. They were found to tolerate both physician criticism and physician rejection of the nurses' recommendations. Katzman and Roberts attributed their findings to gender role socialization in which nurses are socialized into female roles of subservience, passivity and powerlessness and physicians into male roles of dominance, aggressiveness and authoritarianism. In their theoretical framework, gender role socialization played a pivotal role in male-female behavior. As they chose to conceptualize the nurse-physician relationship as a manifestation of male-female behavior, it followed then that they would interpret the data that was gleaned from their observations, as evidence of gender role socialization. In other words, the interpretation of the results springs from the theoretical framework or lense through which the phenomenon is originally viewed, which is a source external to the data.

While their study, and others like them, offer important descriptive information of the phenomenon in
question, their analytic possibilities are imprisoned by the original theoretical framework. If one believes that human behavior is a product of an individual's interpretation or meaning, then this type of quantitative study only highlights the interpretive frame of reference of the researcher, not the participant. Katzman and Roberts specifically noted in their article that the participants in their study were unaware of the effects of gender role socialization on their behavior. It is unknown how the participant's interpreted the situations they were in, whether gender issues were salient in their interpretations and subsequent behavior, or if there were other factors that were predominant in their interpretations. Therefore, while quantitative methodologies are helpful in adding descriptive knowledge regarding phenomenon and in enlarging the possibilities for explanation, they are less helpful in understanding why nurses and physicians relate as they do: quantitative methodologies do not represent the interpretations of the practicing nurse, nor are they usually conducted by practicing nurses themselves.

Qualitative methodologies were used infrequently by investigators interested in the nurse-physician relationship. A qualitative methodology assumes that reality is subjective, that it is internal to the individual and that knowledge can be gained by understanding the way individuals create, modify and interpret the world in which
they exist (Burrell and Morgan, 1979). Methodological tools for the collection of data in the qualitative tradition include semi- or un-structured interviews, participant observation and the analysis of historical documents. The participant determines what the important variables are and what the meaning of them is. The researcher then interprets the meaning of the data from the participant's perspective with reference to external theoretical frameworks only to substantiate the findings. In other words, the meaning of the data comes from a source internal to the data itself.

An example of this type of methodology was the study by Keddy, Gillis, Jacobs, Burton & Rogers (1986). They interviewed 34 nurses who had worked or been trained in Canada during the 1920's and 1930's. Their interest was in learning more about the experiences of nurses during the early part of the twentieth century. The researchers used a grounded approach to theory development. That is, they asked open questions regarding what experiences influenced the participant's relationships with physicians. The respondents reported that they developed a fear of humiliation as a result of the feelings of inferiority they formed as students which led to docile and submissive behaviors. These feelings of inferiority were further reinforced by the superior status positions, as teachers and employers, held by physicians in the early part of the century. Keddy et al concluded that the structure of early
training and the structure of the health care system at the time influenced nurses' attitudes and behavior toward physicians. Their conclusions emerged from the data; they were not imprisoned by a pre-existing theoretical view. Through this approach, further insight into why nurses and physicians interact as they do can occur. If an imprisonment of perspective or interpretation occurred, it was based on an inherent limitation in the perspectives of the participants themselves, which once again, points to the value of external theoretical perspectives in substantiating the participant's perspectives and in expanding the possibilities for those perspectives through the use of deductive theorizing.

Only nine studies in the literature reviewed in this section, excluding the qualitative analysis of historical documents, utilized qualitative methodologies. Five of them, Rushing (1962), Bates and Kern (1967), Clark and Lenburg (1980), Prescott and Bowen (1985), and Wroblewski (1987), conducted qualitative interviews with practicing nurses but focused on critical incidents in the relationship between physicians and nurses. A focus on critical incidents provides greater understanding of specific instances of nurse-physician conflicts from the perspective of the nurse on an individual level of analysis, but doesn't provide insight into their view of the functional relationship between the two professions. Keddy, Gillis,
Jacobs, Burton & Rogers (1986) conducted qualitative interviews with practicing nurses but stipulated their interest only in experiences which occurred during the early part of the twentieth century. Simmons and Rosenthal (1981) and McClain (1988) conducted qualitative interviews with nurse practitioners. Webster (1988) conducted qualitative interviews with medical students. Therefore, the view of the practicing nurse on the meaning of the functional relationship between nurses and physicians is missing from the literature.

In summary, the field of study of the nurse-physician relationship has two paradigmatic views: the relationship as a battle ground and the relationship as a demilitarized zone. It treats conflict both as a barrier to communication and as a mechanism to redress status differences and present clear information regarding patient care. The field is characterized by differing views of the factors which influence the problem and the mechanisms through which the factors exercise their influence, which leads to a breadth and depth of understanding about the nurse-physician relationship. The field also differs in the methodologies through which it gains more understanding of the phenomenon, providing rich descriptive and theoretical information, but lacking in the area of nurses' interpretive frameworks for the meaning of the nurse-physician relationship. The next
section will focus on a discussion and analysis of the data provided about the nurse-physician relationship in the literature.

**Characteristics of the Data**

While the previous section viewed the literature as a field of study which represents multiple perspectives on the nurse-physician relationship, this section views it as a source of data regarding that relationship. It will focus on a discussion and analysis of the specific issues that were thought to be important in that relationship by investigators who have a variety of academic and theoretical backgrounds. It will also highlight the characteristics of the interrelationships between the issues and factors of most importance.

The literature describes three fundamentally different types of relationship between nurses and physicians. The first can be labelled as the traditional relationship, wherein the physician is superordinate to the nurse on the basis of knowledge, skill and authority. The relationship is characterized by an acceptance of physician dominance within both professional groups and by society (Rushing, 1962; Hofling, Brontzman, Dalrymple, Graves and Pierce, 1966; Keddy, Gillis, Jacobs, Burton and Rogers, 1986). Interaction patterns are typified by physician dominance and
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alike (Weiss, 1983; Prescott and Bowen, 1985; Kalish and Kalish, 1977; Gordon, 1991a); the solo medical practice structure of medical care which frightens young medical students into a phobic response of omnipotence (Stein, 1967; Kalish and Kalish, 1977; Murphy, 1983a); the authoritarian structure of early nursing schools which frightened young nurses into dependence upon the knowledge of the physician (Stein, 1967; Kalish and Kalish, 1977; Wise, Rubin and Beckard, 1974); nurse's concerns that direct communication with the physician would ruin their relationship and decrease the physician's cooperation in meeting patient care needs (Rushing, 1962; Cunningham and Wilcox, 1985); and the daily rituals of contact between physicians, nurses and patients which enact and express the differing levels of power held by each group (Tellis-Nayak and Tellis-Nayak, 1984; Campbell-Heider and Pollack, 1987). Each of the factors in this list supports and promotes a functional relationship of physician dominance and nurse subordinacy and the acceptance of the legitimacy of this relationship by medicine, nursing and society.

The second type of relationship described in the literature can be labelled as the conflictual relationship, wherein the physician is superordinate to the nurse on the basis of authority. The relationship is characterized by an acceptance of physician dominance by medicine and by society but nursing rejects the legitimacy of the physician's
authority in at least one of three ways. Nursing rejects medicine's claim to superior knowledge as an inherently hierarchical concept: nursing's knowledge is not a lesser variety of medical knowledge but is knowledge of a different sort, with a focus on caring and the technology necessary to accomplish the caring task, rather than on medical curing (Benne and Bennis, 1959; Bates, 1975; Clark and Lenburg, 1980; Cooper, 1990; Gordon, 1991a; Gordon, 1991b). Nursing rejects the exclusivity of the medical relationship to patients, asserting that nursing also has a primary relationship to the patient, based on its expertise in the caring function (Hite, 1977; Kalish and Kalish, 1977; Devine, 1978; Feiger and Schmidt, 1983; Winslow, 1984; Makadon and Gibbons, 1985; Murphy, 1987). Nursing rejects the hierarchical authority of medicine, asserting that hierarchical authority is a result of gender and class oppression that characterizes American society (Wise, Rubin and Beckard, 1974; Hoekelman, 1975; Ashley, 1977; Lovell, 1989; Whitman, 1982; McLain, 1988; Stein, Watts and Howell, 1990). Conversely, in the conflictual relationship, medicine and society also reject nursing's claims to legitimacy and autonomy from medicine (Mechanic and Aiken, 1982; Webster, 1988; Gordon, 1991a). Interaction patterns are typified by physician attempts at dominance and either nurses' outright rejection of that dominance through hostile and conflictual responses, or, nurses' outward compliance
with medicine's expectations of deference with hidden, internal reactions of anger, frustration and hostility (Prescott and Bowen, 1985; Wroblewski, 1987; Katzman and Roberts, 1988; Stein, Watts and Howell, 1990; Cox, 1991a).

Individual, group and societal factors which contribute to the rejection of medical dominance by nursing include increased funding for postgraduate nursing education and research which reduced medical control of nursing education (Benne and Bennis, 1959; Peplau, 1966; Makadon and Gibbons, 1985); changes in nursing's ethic from subordinacy to the physician to autonomous patient advocacy (Benne and Bennis, 1959; Devine, 1978; Kalish, 1975; Whitman, 1982; Mathews, 1983; Winslow, 1984); increasing numbers of nurses receiving their basic education in colleges which expanded the conception of nursing beyond the biological focus and beyond dependence on the physician's knowledge (Benne and Bennis, 1959; Kalish and Kalish, 1977); the increasing complexity and fragmentation of medical care, the increasing demand for health care services, the information explosion and increased governmental concern created new roles and opportunities for nurses which increased nursing control of and responsibility for patient care and overlap and competition with medicine (Friedson, 1970; Bates, 1971; Mechanic, 1985; Lancaster, 1986; Murphy, 1987; Michelson, 1988; Gamble, 1989; Stein, Watts and Howell, 1990); the rise of nursing unionism and the change in public regard for
medical authority (Melosh, 1982; Morgan and McCann, 1983; Winslow, 1984; Mechanic, 1935; Coburn, 1988); differing work, education and organizational structures of nursing that lead to orientations and perceptions that differ from those in medicine (Pellegrino and Dake, 1966; Peeples and Francis, 1968; Bates, 1971; Linn, 1975; Sheard, 1980; Mathews, 1983; Clark and Lenburg, 1980; Singleton, 1981; Wilcox, Fritz, Russel and Wilcox, 1983); and the women's movement which broadened nurses' consciousness of their subservience, increased their understanding of their behavior as an oppressed group, sparked nurses' anger at their second class status, and provided models of independence and equality (Christman, 1965; Hite, 1977; Kalish and Kalish, 1977; Ginzberg, 1981; Simmons and Rosenthal, 1981; Turnbull, 1982; Whitman, 1982; Roberts, 1983). Each of the factors in this list supports and promotes the rejection of a functional relationship of physician dominance and nurse subordinacy by nursing and questions the legitimacy of this relationship.

The third type of relationship described in the literature has been labelled as the collegial or collaborative relationship, wherein the physician and nurse are equal in terms of authority, but different in terms of knowledge and expertise. Each professional group accepts the legitimacy of the knowledge and skill which each has in making a unique contribution to the care of the patient.
(Devereux, 1981b; Feiger and Schmidt, 1979; Weiss, 1983; Knaus, Draper, Wagner and Zimmerman, 1986). Interaction patterns are typified by shared leadership and decision-making.

Individual, group and societal factors which contribute to the acceptance of the legitimacy of one another's knowledge, skill and authority include a willingness to collaborate (Baggs and Schmitt, 1988; McClain, 1988; Eliadi, 1990); nurses' trust in their own competence to sharpen their vision of their unique contributions and to increase their willingness to take on additional responsibility (Weiss, 1985); increasing physicians' trust in nurses' competence to increase the amount of independence, responsibility and shared decision-making physicians allow nurses to assume (Bates and Kern, 1967; Prescott and Bowen, 1985; Wroblewski, 1987; Baggs and Schmitt, 1988; Hodes and Van Crombrugghe, 1990); increasing the standardization of nursing's educational preparation to increase the uniformity of nurses' competence (Mechanic and Aiken, 1982); increasing physician understanding of the roles and structure of the hospital to increase their sensitivity to the conflicting demands on nurses (Bates and Kern, 1967; Hodes and Van Crombrugghe, 1990); improving communication to decrease distortion and misinterpretation (Bates and Kern, 1967; Kalish and Kalish, 1977; Sheard, 1980; Cunningham and Wilcox, 1985; McLain, 1988); increasing the emphasis and
articulation of shared superordinate goals between nursing and medicine to provide a vision of their mutual interdependence (Bates, 1970; Thomstad, Cunningham and Kaplan, 1975; Mechanic and Aiken, 1982); and increasing the value society places on nursing and caring activities through improving the public's knowledge about the scope and nature of nursing's contribution (Gordon, 1991b). Each of the factors in this list supports and promotes the acceptance of a functional relationship of equality between nurses and physicians and the acceptance of the legitimacy of this relationship by medicine, nursing and society.

From this analysis of the descriptions of the three different types of relationships between nurses and physicians it is possible to tentatively conclude that there are two key issues in the functional relationship between members of these two professional groups: the acceptance of the legitimacy of the knowledge, skills and authority of the other professional discipline and the primacy of the medical and/or nursing relationship to the patient. These two concepts are related in that independent legitimacy is the basis of the direct relationship to the patient (Friedson, 1970). Figure 2 provides a summary of the types of nurse-physician relationship that emerge under differing conditions of the acceptance of the legitimacy of the other professions' authority in relation to patients and patient care.
It is theoretically possible then to have a nurse-physician relationship wherein the nurse is dominant and the physician deferent. Although not a predominant theme in the literature, some investigators note that this relationship sometimes exists between young medical students or young interns and experienced nurses (Spiegel, Smolen and Jonas, 1985).

There are four key themes in the literature which contribute to nursing's acceptance or rejection of the legitimacy of medicine's authority in relation to patient care: the view of the physician as an authority figure or as
a collaborator, the view of nursing as an extension of medicine or as the autonomous provider of caring technology, the view of the patient as dependent object of medical ministrations or as subject whose independence requires nursing advocacy and the view of conflict as dangerous to the patient and to the nurse or as a necessary strategy to promote patient success. Several factors were found to contribute to similarities and differences in these views among nurses. These include class and gender background, the location of early training in a hospital or a college, the legal, ideological and ethical structure of the medical and nursing professions, the changing societal visions of womens' and patients' rights, roles and contributions and level of education and position in the nursing hierarchy. These factors are believed to influence nurses' views of medicine, nursing, the patient and conflict by investigators of the nurse-physician relationship. These views in turn, are believed to influence nursing's acceptance or rejection of medical authority, which influences nurses' view of the optimal relationship between nurses and physicians. However, as Melosh (1982) and Roberts (1983) point out, and as intergroup relations theory supports, the views of practicing nurses are probably quite different from those of the nursing leaders, the physicians, the economists, the sociologists, the lawyers, the ethicists and the anthropologists who have primarily contributed to this body
of literature. It is to the exploration of what those differences might be that this study now turns.
CHAPTER 3

RESEARCH METHODOLOGY

Introduction

The purposes of this description of research methodology are to review the theoretical assumptions of the qualitative methodological technique chosen for this study and to identify the specific methods through which this technique is utilized in this study. The description of the research methodology will be divided into four sections. The first section will review the philosophical assumptions and rationale for the qualitative approach. The second section will outline the technique of the long interview. The third and fourth sections will describe the setting for the study and the selection of the participants.

Philosophical Assumptions of the Qualitative Approach

This study uses a qualitative research method to explore the meaning of the nurse-physician relationship from the perspective of practicing nurses in order to see the world as nurses do. This approach and research interest are based upon ontological, epistomological, human nature and methodological assumptions which represent a unique way of seeing human behavior, and as such, represent a paradigmatic view referred to as interactionist. (Burrell and Morgan, 162)
The interactionist perspective is a subset of an interpretist paradigm. This section will compare and contrast the interactionist view with its two polar views, labelled functionalist and interpretist, in order to situate the assumptions of this study in their broader philosophical context.

Ontology represents assumptions about the very essence of the phenomenon under study. It asks a question about the nature of the reality we seek to study: is reality external to the individual or is it internal? Is reality imposed on the individual consciousness from without or is it the internal product of the consciousness of the individual? The functionalist position is that the social world exists external to the individual; it "is a real world made up of hard, tangible and relatively immutable structures" (Burrell and Morgan, 1979, p. 4). The interpretist position is that the social world that is external to the individual is composed of nothing more than concepts and labels which provide a structure to that reality. Reality then is internally constructed by individuals and groups through a process of thinking and acting in the world (Berger and Luckman, 1967; Billig, 1976).

Epistemology represents assumptions about the basis for knowledge itself. It asks questions of how one learns about the world, of what forms of knowledge can be acquired and of how truth can be distinguished from falsity. The positivist
position in terms of these questions is that knowledge itself is real and is cumulative, can be transmitted in tangible form, can be acquired through approaches that search for regularities and causal laws and can be used to explain and predict behavior (Burrell and Morgan, 1979). The interpretist position is that knowledge is more subjective and relativistic, is based on experience and insight and can only be understood from the perspective of those involved in the activity to be studied. The interpretist searches for understanding, rather than prediction and control, by occupying the frame of reference of the person in question.

Assumptions about human nature focus on the relationship of humans with their environment. It asks questions regarding the mechanisms through which humans relate to their environment or through which the environment relates to humans. The positivist approach views the environment as deterministic and as essentially shaping human responses. Humanity and its experiences are the products of environment; "humans are conditioned by external circumstances" (Burrell and Morgan, 1979, p. 2). The interpretist views humanity as the holder of free will where humans exert a creative force upon their environment as the controller rather than as the controlled.
Ontological, epistemological and human nature assumptions have direct implications for methodology. If one subscribes to a view of reality which is external, to a view of knowledge as objective and external to the individual and of human nature as essentially determined by the environment, then one is likely to be concerned with identifying and defining the elements of the environment and their regular relationships to humans (Burrell and Morgan, 1979). This quantitative approach attempts to isolate and define categories before the study is undertaken; the determination of the relationships between the categories is the main purpose of the study (McCracken, 1988). If one subscribes to a view of reality which is internal, to a view of knowledge as subjective and of human nature as voluntary free willed and creative, one is likely to be concerned with understanding the ways in which individuals create, interpret and change the world. "This approach questions whether there exists an external reality worthy of study" (Burrell and Morgan, 1979, p. 3). This qualitative approach views the isolation and definition of categories as the goal of the research; it seeks to understand the patterns of interrelationship between many categories rather than sharply measured relationships between a small number of categories (McCracken, 1988).
Burrell and Morgan identify an intermediate position between these two polarities labelled interactionist. This type of ontological and human nature position views reality as a product of the interaction between external reality and individual consciousness. The interactionist views humans as both the recipients of an already formed culture and as the creator of new cultures. It views external reality as the context within which cultural categories and shared meanings occur (Sherif and Sherif, 1969; Billig, 1976; McCracken, 1988).

In addition to the basic division of ontological, epistemological, human nature and methodological assumptions into functionalist and interpretist polarities, Burrell and Morgan further divide these philosophical assumptions into radical and status quo orientations toward the nature of society. The status quo orientation is concerned with the integration, ordering and stability of society through shared values. It attempts to understand why "society tends to hold together rather than fall apart" (Burrell and Morgan, 1979, p. 17). The radical orientation is concerned with identifying the processes through which society becomes integrated, ordered and stable and the processes through which consensus of values comes to be established. They raise the issue that integration, order, stability and consensus may be "the product of the use of some form of coercive force" (Burrell and Morgan, 1979, p. 14). It is
concerned with emancipation from the structures and ideologies which limit and stunt humanity's potential for development.

Functionalist and interpretivist assumptions can therefore be further refined to result in two categories of the objective view: status quo functionalist and radical structuralist; and in two categories of the subjective view: status quo interpretivist and radical humanist. The major concern of the radical humanist is the identification of and release of human consciousness from constraints which existing social ideologies place on human development. The major concern of the radical structuralist is identifying the deep-seated internal contradictions of society and the structure and analysis of power relationships.

In this case, based on the interactionist philosophical assumptions outlined above and the theoretical assumptions of the intergroup relations framework, the basic assumption of this study is that the meaning of the nurse-physician relationship from the perspective of practicing nurses will be different from the perspectives of others. It assumes that reality is a product of the interaction between external reality and individual consciousness. Therefore, it is necessary to see the world as nurses do in order to understand how they create and enact their seeing. It views nurses as both the recipients of an already formed culture and as the creator of new cultures.
Based on these interactionist assumptions, this study uses a qualitative technique which allows the researcher "into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world...to see the content and pattern of daily experience...and to see the world as they do themselves" (McCracken, 1988, p. 9). Furthermore, through the process of the long ethnographic interview the researcher and the participant may develop critical insights regarding domination which may prompt action about social situations developed through the interviews which in turn, may contribute to the potential for change (LeCompte and Goetz, 1982; Kvale, 1983; McCracken, 1988). Therefore, this study fits within the interactionist.radical humanist paradigm as described by Burrell and Morgan (1979).

The Long Ethnographic Interview

The long interview is part of the ethnographic tradition of qualitative research. The essential question in ethnography concerns "what it is to be rather than to see a member of the organization" (Van Maanen, 1983, p. 52). Ethnography is the work of "describing a culture from the 'native's' or insider's view and not from the researcher's or outsider's point of view" (Gladwin, 1989, p. 9). It defines culture in ideational terms, as "a system of standards for perceiving, believing, evaluating and acting"
It is concerned with learning how people "order and make sense of their everyday activities and the ways in which they make them accountable to others, in the sense of being observable and reportable" (Burrell and Morgan, 1979, p. 247). It attempts to clarify the investigated phenomenon and its meaning, rather than presupposing that what is to be investigated is known (Kvale, 1983). Ethnographers attempt to describe systematically the characteristics of variables and phenomena, to generate and refine conceptual categories, to discover and validate associations among phenomena...and commonly avoid assuming a priori constructs or relationships (LeCompte and Goetz, 1982, p. 33).

The purpose of the long ethnographic interview is to describe and understand the meaning of themes in the life-world of the participant and helps situate these themes in a social and cultural context (Kvale, 1983). The long interview allows the researcher to map out the organizing ideas and "determine how these organizing ideas enter into the individual's view of the world" (McCracken, 1988, p. 10). The long ethnographic interview is a four-stage method of inquiry that begins with the review of the literature and ends with the presentation of the analyzed interview data.

There is a controversy among qualitative researchers regarding the value and functionality of conducting a review of the literature regarding the focus area of the research. Some researchers contend that the literature is irrelevant or biases the views of the researcher, such that subjective
naivity is destroyed (Glaser and Strauss, 1967). The alternative view, the one inherent in the long ethnographic interview, is that the literature review creates distance from the topic for the researcher in two ways. First, the literature review creates a set of expectations for the researcher which can be contrasted with the meanings in the data that will be collected. This sharpens the ability of the researcher to be surprised by counterexpectational data, which will be one of the abilities critical to its analysis. Second, the literature review increases the consciousness of the researcher in regard to how the assumptions in the literature force the definition of problems and findings. This critical focus is a kind of qualitative analysis in itself (McCracken, 1988). In this case, assumptions in the literature regarding nurse-physician relations were found both in terms of the nature of the problem to be studied, that is, the nature of the relationship as a battle ground or as a demilitarized zone, and in terms of the nature of the individual, group or societal mechanisms through which internal and external variables influenced the relationship. Therefore, the first step of the long ethnographic interview was accomplished in the extensive section on the review of the literature.

The second step of the long ethnographic interview consists of the review of cultural categories held by the researcher. This step assists the researcher in identifying
the cultural categories which he or she uses to understand the world in order to permit critical distance. It assumes that the researcher's subjectivity "is like a garment that cannot be removed" (Peshkin, 1988, p. 17). Indeed, ethnographic research depends on the subjectivity of the researcher to serve as an instrument in data collection, understanding and analysis through the analytic processes of contrast, surprise, matching, imaginative reconstruction, deviance and incongruity, subjective feeling and conceptual understanding (LeCompte and Goetz, 1982; Eden, 1983; Kvale, 1983; Van Maanen, 1983; McCracken, 1988; Peshkin, 1988; Gladwin, 1989).

However distance from that subjectivity is necessary, in order to guard against allowing the researcher's own ethnocentrism and perceptual biases to invalidate the presentation of the perspectives of the participants (LeCompte and Goetz, 1982). This step was taken in this study through the process of the literature review, in the development of the categories for the mechanisms of interactions between variables and the analysis of the themes in the literature.

The third step of the long ethnographic interview consists of the development of a written tool to give structure to the interview through the construction of a series of grand-tour questions, floating prompts and biographical questions. The grand-tour questions focus the
participants testimony "to move them to talk without overspecifying the substance or perspective of this talk (McCracken, 1988, p. 34). The grand-tour questions lead the participant toward "certain themes in their life-world but avoid leading her in the direction of expressing specific meanings about these themes" (Kvale, 1983, p. 190). Grand-tour questions are developed out of the central themes in the review of the literature and in the researcher's review of her own cultural categories. Such themes in the present study include the participant's conceptions of physicians, medical practice, nursing, the patient, conflict, and the relationships between them (Appendix A).

Prompts include secondary questions to help the participant uncover the deeper meaning of their perspective and their taken-for-granted assumptions. They include depth questions, such as "What do you mean, exactly?" and "What was that like for you?", contrast and similarity questions, such as "What is the difference between categories `a' and `b'?", significance questions, such as "Why does this matter?", special incident questions, such as "What was most striking about the incident?", and category questions, such as how the participant defines key actors, central action, etcetera. (Eden, 1983; McCracken, 1988).

The biographical questions (Appendix B) focus on simple descriptive details of an individual's life. They "cue the
interviewer to the biographical realities that will inform the respondent's subsequent testimony" (McCracken, 1988, p. 34).

The use of the written tool containing grand-tour questions, floating prompts and biographical data increases the efficiency of reaching ethnographic objectives "without committing the researcher to intimate, repeated and prolonged involvement in the life and community of the respondent" (McCracken, 1988, p. 7). This design element of the long ethnographic interview is based on concern for the time scarcity and the privacy of the participants. Therefore, the long ethnographic interview is designed to be conducted in one session.

The interview itself consists of the interviewer adopting a Columbo-like role of playing dumb, in which the interviewer invites the participant to explain his or her reality (Kvale, 1983; McCracken, 1988; Gladwin, 1989). The investigator listens for key terms and for key material that is referenced by the participant but not made explicit, and pursues further testimony around the key terms and material, through the asking of floating prompt questions, to unearth the participant's assumptions, companion terms and the interrelationships of the term.

In order to refine the skills of this researcher, a small pilot study was conducted prior to interviewing the nurses for the study. One nurse who is known to the
researcher was interviewed according to the interview guide. After these pilot interviews, the researcher discussed the process with the participants to determine if the framing of the questions served to suggest bias for the answers. In addition, the results of this pilot were to be used to revise the questions in the interview guide, but proved unnecessary.

The fourth stage of the long ethnographic interview concerns the analysis of the interview data. In approaching the analysis, the investigator has

a sense of what the literature says ought to be there, a sense of how the topic at issue is constituted in his or her own experience, and a glancing sense of what took place in the interview itself. The investigator must be prepared to use all of this material as a guide to what exists there, but he or she must also be prepared to ignore all of this material to see what none of it anticipates (McCracken, 1988, p. 42).

Interviews were recorded on audio tape and transcribed verbatim using a word processor with a wide right margin for notetaking. Each line was be numbered, using the computer program Ethnograph (Seidel, Kjolseth and Seymour, 1988). The five steps in the content analysis process represent a movement from the particular to the general, from individual utterances to the implications of that utterance in other sections of the transcript and to the eventual development of a field of patterns and themes. In the first stage, the numbered lines were examined to identify and mark the
utterances which served as an entranceway into the assumptions and beliefs of the participant, using the conclusions of the academic literature and the culture review as "templates with which to search out the systematic properties of the interview data" (McCracken, 1988, p. 45). Such templates included the nurse's perspective of the nature of the nurse-physician relationship as competitive and conflictual or as cooperative and collaborative, the nurse's understanding of her behavior as assertive, conflictual or deferent, the nurse's view of their role as a physician's handmaiden or as a patient advocate, the nurse's description of strategies used to influence patients and physicians, and the nurse's acceptance or rejection of the authority of the nurse and the physician. While using such a template assists in establishing the reliability of the interview data, through reference to the conclusions in the literature, the researcher must also use herself as instrument to recognize the possibility of meanings that have not been reflected in the literature thus far.

In the second stage of the analysis, the researcher relates the preliminary observations back to the transcript, using them as a type of lense to see whether any relationship or similarity suggests itself in terms of identity, similarity, opposition or contradiction. The specific passages of the transcript which encompass the initial utterances, the observations and the relationships
between the observations were coded, using participants' language as the basis for the codes, for further examination in stage three.

In stage three of the analysis, the observations and the pieces of text from which they sprang were examined to identify a field of patterns and themes. The main transcript was referenced only to confirm or disconfirm developing possibilities. Interview text was reprinted to place all passages together which reflect the same pattern or theme.

The fourth stage of the analysis created an entirely new file that was filled with the most general themes that emerged from the winnowing and sorting of the preliminary themes discovered in stage three. Decisions were made regarding the relationship between the themes, with redundant themes discarded and the best formulations organized hierarchically. All themes were examined to determine if they contradict any of the important themes that have been identified or if they contradict the hierarchy into which the themes had been organized.

The fifth stage of the analysis was the examination of the cultural themes to identify analytic categories in regard to the general properties of thought and action which characterize the sample as a whole.

Additional reliability was accomplished at various points in the process of the content analysis through the
sharing and discussion of the observations, themes and categories with an outside reader. The outside reader is a master's prepared nurse who provided feedback to the researcher on the analysis. Validity of the categories was established through consideration of comparability, translatability, exactness, economy, mutual consistency, external consistency with the literature, unity, power and fertility (LeCompte and Goetz, 1982; McCracken, 1988).

Although the interview process is necessarily conducted with individuals, this type of analysis of cultural categories allows one to have insight into areas of agreement about the knowledge, perception and meaning categories held by members of a group (Eden, 1983; Van Maanen, 1983; McCracken, 1988; Gladwin, 1989). It therefore fits within the group level of analysis necessary for understanding intergroup relations (Alderfer, 1987).

The Research Setting

The health care facility selected for this study will be a medium-sized, 371 bed urban university medical center in the northeastern United States. The composition of practicing nurses in this facility includes 40 percent baccalaureate-prepared nursing staff and 60 percent associate degree and hospital-prepared nursing staff. There
are approximately 150 practicing nurses who provide direct patient care in the six intensive care units in this facility.

Physicians working in the intensive care units include interns, residents and attending physicians. These physicians are in different levels of training post medical school. The attendings have completed their training and are the senior physicians.

Selection of the Participants

Participants for this study were selected from an urban university medical center in the northeastern United States. They were contacted through the use of an open letter (Appendix D) which was distributed to all practicing nurse staff who work in the intensive care units, which asked individuals to contact the researcher if they were interested in participating in the study. Each participant was asked to read and sign a consent form (Appendix C) prior to participating in the interview.

According to McCracken (1988), "eight respondents will be perfectly sufficient" (p. 17). He believes that it is more important to work in more depth and with greater care with a few people than superficially with more of them. The purpose is not to discover how widely certain views are shared, but to explore what those views consist of. This view is shared widely by qualitative researchers, of whom
some have conducted extensive ethnographic work with a sample of one individual (Taylor and Bogdan, 1984).

Inasmuch as the methodology of the study is qualitative and as the purpose of this study is to be exploratory, the selection of the nurse participants did not need to be controlled or random. Eight intensive care unit nurses participated in the study.
CHAPTER 4

THE INTERVIEW RESULTS

Introduction

The purpose of this chapter is to present the major patterns and themes of the data shared during the interviews. The ethnographic analytic scheme emphasizes not only what the participants think, but how they think. Therefore, the second purpose of this chapter is to present interview data which underlies the relationships between the patterns in order to more fully understand the cognitive formations through which the participants view their world. Selected portions of the interview data will be presented in order to "provide a clear and vivid sense of the ethnographic particulars while also showing the general formal properties and theoretical significance of these data" (McCracken, 1988, p. 58). The data will be presented in four sections: the background of the participants, their view of the nurse-physician relationship, their view of objective conditions that they experience and their view of subjective conditions.

Background of the Participants

The eight participants in this study are staff nurses who work in different intensive care units in the same
university medical center. Four participants work in the cardiac intensive care unit (CCU), two work in the pediatric intensive care unit, one works in the trauma intensive care unit and one in the medical intensive care unit (see Table 1). They range in age from 28 years to 41 years. They have been practicing registered nurses from 6 to 17 years and have been working in their present intensive care unit from 5 to 13 years. All but one have previously worked in settings other than the university medical center that is their current employer.

All of the participants have some college education in nursing. Five of the participants currently hold bachelor's degrees in nursing. One of the five has taken several Master's degree level nursing courses. Two of these five previously held associates degrees in nursing, one of whom also previously held a license as a practical nurse. Two of the participants currently hold nursing associate's degrees. One of these has taken several courses toward a nursing bachelor's degree. One participant currently has a diploma in nursing, having transferred to that program after two years education in a bachelor's degree program.

All of the participants are women. Only two have children. Seven of the participants identified themselves as having middle class, white American backgrounds. One participant identified herself as having a middle class Hispanic background. Five of the participants were born and
brought up in New England states. One participant was born on an American Air Force base in Germany, and describes herself as having lived all over the United States. The final participant was born and raised in California.

<table>
<thead>
<tr>
<th>Table 1: Background of Participants</th>
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<tbody>
<tr>
<td><strong>Setting</strong></td>
</tr>
<tr>
<td>Cardiac Intensive Care Unit (4 participants)</td>
</tr>
<tr>
<td>Pediatric Intensive Care Unit (2)</td>
</tr>
<tr>
<td>Trauma Intensive Care Unit (1)</td>
</tr>
<tr>
<td>Medical Intensive Care Unit (1)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Bachelor's Degrees in Nursing (5)</td>
</tr>
<tr>
<td>Associate's Degrees in Nursing (2)</td>
</tr>
<tr>
<td>Diploma in Nursing (1)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>26-30 years (2)</td>
</tr>
<tr>
<td>31-35 years (1)</td>
</tr>
<tr>
<td>36-40 years (4)</td>
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<td>41-45 years (1)</td>
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<td><strong>Gender</strong></td>
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<tr>
<td>Female (8)</td>
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<tr>
<td><strong>Class</strong></td>
</tr>
<tr>
<td>White, American, Middle-class (7)</td>
</tr>
<tr>
<td>Hispanic, American, Middle-class (1)</td>
</tr>
<tr>
<td><strong>Geography</strong></td>
</tr>
<tr>
<td>New England (5)</td>
</tr>
<tr>
<td>Other (2)</td>
</tr>
<tr>
<td><strong>Siblings</strong></td>
</tr>
<tr>
<td>One sibling (3)</td>
</tr>
<tr>
<td>Three to eight siblings (5)</td>
</tr>
</tbody>
</table>

Three of the participants come from small families with only one sibling. Five of the participants are from larger families with from three to eight siblings. All of the participants have immediate family members, that is, parents and siblings, who have technical or college education beyond high school. College education includes a few college courses, associate's degrees, bachelor's degrees, master's degrees and one nearing completion of a doctoral degree.
Occupations of immediate family members included sales, teaching, auto mechanics, police work, small business ownership, mental health administration, nursing, secretarial, manufacturing foreman, domestic engineering and career Air Force.

The Nurse-Physician Relationship

This section of the data presentation focuses on the participant's view of the nurse-physician relationship in their current setting, its major components and major dynamics. It seeks to answer the question: How do practicing nurses see their relationship with physicians?

Team

All of the participants defined the nurse-physician relationship as a team, in which collaboration toward the common goal of patient care was the major element. Several selections will be presented to express the participant's definition of the team relationship and the mechanisms which they see as important to its accomplishment.

Nurse #4: I think that they should work as a team. That's why we're all here. We're all here for the patients. That's the bottom line. What we do here is we work with the team. I think that medicine and nursing, they have their own little things, but I think that we are working as a team.

This selection portrays the nurse's view of the relationship as a team. She focuses on working together
toward a common goal as an essential element of that definition. She sees physicians and nurses as functioning differently but believes that the differences between the functions performed by nursing and medicine as professions do not detract from that primary definition of team. Nurses see these differences are important for teamwork.

Nurse #5: We see things they don't see and they see things we don't see. They're trained differently and we're trained differently. It all has to come together somewhere.

This participant believes that differences in training result in differences in how nurses and physicians view things. She sees team as the coming together, or merging of the two professional differences in perspective. Her group view is shown through her use of "we" and "they" language.

One mechanism in how these two perspectives come together is physician listening. Indeed, physician listening was one of the major elements in nurses' definitions of the relationship as a team.

Nurse #6: ...I find them to be much more, most of them, the majority of them, at least at the attending level, to be most willing to listen to me. To see me as part of a team...I find most of them, at least the pediatric residents to be pretty collegial, collaborative, work together, but there is the occasional, maybe to give them the benefit of the doubt, maybe it's a reflection of their own security coming in here. I don't know. They feel that they can't come across as weak...

In this selection, the nurse sees most physicians in her area as collegial and collaborative. She interprets the physician's willingness to listen as symbolizing that she is
seen as part of a team. Team means working together. She uses this willingness to listen as the definitional element in working together in a collegial and collaborative way. She sees deviance from this norm, in either physician group of residents and attendings, as an occasional occurrence, an expression of a physician's individual insecurity.

Another mechanism that is important to the participants in working together is portrayed in the following example.

Nurse #1: ...They're all wonderful. They're all great. They treat us well, they listen to our idea's. Now, for instance: "Heather, do you have anything to add? Do you have any questions? Do you have any options to the plan? What have you noticed?" Things like that.

This participant sees the physicians, as a group, in a very positive manner because she views physicians as treating nurses well. Her group view is shown in her use of us and they language. She defines being treated well not only by the physician's active listening to the nurse's ideas but also by the physicians actively seeking out the nurses' opinions.

A third mechanism that is important to the participants in working together is described in the following example.

Nurse #4: ...It's nice. I like it here because it's a team. I think the nurse-doctor relationship here is really good because you're like a team and your opinion counts a lot in this CCU [Cardiac Care Unit]. They do respect the nurses in there a lot. Not that we have anymore experience and brains. There's a lot of respect for the nurses in this CCU which is nice...It's nice to come to work and be treated like that. You don't want to go to work and feel like the enemy, and you don't. Granted you're going to have a run in. You can
have a run in with your co-worker too. You're
going to have personality conflicts with
physicians, residents, interns, fellows and
attendings. All and all the majority of them are
real respectful of the nurses here. Hardly any of
them don't treat us that way.

This participant uses the metaphor of team to express
her perception of the nurse-physician relationship. To her,
the important component of her definition of team is the
value placed on the nurse's opinions by the physicians. She
implies that her opinion makes a difference in terms of
decisions that are made. She believes that this component
of the relationship is due to attributes of the physicians,
rather than from any outstanding merit on her part, due to
more experience or intelligence than the physicians have.
She sees this weight placed on her opinion as being based in
intrinsic respect for the nurse, as a nurse, and labels it
as respectful treatment. She experiences this respectful
treatment as being on the same side as the physician, and
not being treated as the enemy. She sees the majority of
physicians as fitting into this pattern of behavior; those
that do not conform to this pattern are viewed as having
personality conflicts. She dismisses personality conflict
as an exclusive or inherent quality of the nurse-physician
relationship by seeing it as an aspect of relationships with
other nurses also.

A fourth mechanism that is important to the
participants in working together with physicians is
illustrated in the following selection.
Nurse #7: I think here at the medical center, I have much more leeway. I feel like I'm more of a participant and I share a lot of information with the families. The doctors, we like a lot. I think the physicians, particularly here in the unit, rely tremendously on the nurses for their input. We have very critically ill patients. The doctors sometimes don't get the machines until later, late in the morning, or they may be involved with a case where they may be taken away again for sometime, so the nurses, my big thing was hooking up labs and all that right away and the doctor will say, "okay, I'll be glad to give this, give that." I think our relationship here is very important. It's a first name basis...It puts us a little more at their level. We're relating better. It's not like they're up here or we're down here. So I kind of like the first name basis.

Interv: What do you think does that? How do you account for that?

Nurse #7: I say that because they rely on us a lot up here. I think if we shared that with some of the other nurses, I think we play an important role in perfecting the patients need and then coming up with strategies to get them better.

This nurse feels that she has more freedom in her relationship with physicians than in other settings in which she has worked, as shown through her having the authority to share information with patients. She feels more of a participant by sharing in the decision-making process regarding the development of the patient's plan of medical care. Her basis for participating is her knowledge of the patient, which the physician may not have. She sees the physician's acceptance of her information and recommendations as confirmation that the physicians rely on the nurses. She interprets this reliance and the participation in the decision-making process as meaning that
nurses are interacting with physicians as equals. The use of first names symbolizes this equality to her in the nurse-physician relationship.

A fifth mechanism that is important to the participants in working together is highlighted in the following selection.

Nurse #4: We question a lot of things. I think that's just the way nursing is nowadays. At least in this medical center it is, I think. Which makes it good. It's like you're a team. You're not a nurse and you're not a doctor. You have your own jobs but you're working together for the benefit of one thing.

For this participant, the act of the nurse questioning the physician is a normal part of nurse functioning in this facility. She believes that nurse questioning influences the nature of the nurse-physician relationship by making it more team-like. For her, team is accomplished by reducing authority distinctions between professional identities, by equalizing them, while merging the job function aspects of the professions in pursuit of the same goal.

In summary, nurses viewed the nurse-physician relationship as a team. Team was defined as members of different professions, working together on an equal basis in order to accomplish the same goal. The major mechanisms nurses viewed as important in accomplishing team were physicians listening, physicians seeking nurse's opinions, physicians placing value on nurse's opinions, nurses participating in decision-making and nurses asking
questions. The nurses see their role on this team, in this relationship, as equals to the physician. Physicians who do not engage in collegial relations are viewed as individual exceptions to the norm. In the next section, the dynamics that nurses view as important to the nurse-physician relationship will be explored.

Respect

For the participants, team means that their knowledge and skill are recognized. This recognition allows them to participate as equals in planning and providing patient care. They most frequently express the recognition of their knowledge through use of the word respect. This section will explore nurse's beliefs regarding their knowledge, physician's knowledge and respect, and the mechanisms through which these issues relate to team functioning and the nurse-physician relationship.

The participants see nurses' knowledge and skills as a central issue in their relationship with physicians.

Interv: You said most of the relations were cordial. Does that mean that some aren't?

Nurse #1: Yes. Certainly sometimes they're not. I think that it's a relationship that's ripe for conflict. Relationship between physicians and nurses. I think because of the, just because of the, just the power structure of the relationship. Over the years, I've always thought that the physicians were in a position of superior power in general to nurses, and I think that it makes conflict, and often I felt that the nurses who were in direct
contact with the patient were in a position of superior knowledge of the patients. So the conflict between power and knowledge has been... Do you know what I mean?

For this participant, a major source of nursing knowledge springs from nurses' extended direct contact with patients. Because of this contact, she believes that nurses possess more knowledge of patients than physicians do. She views physicians as having more power than nurses. She frames the basic nurse-physician relationship as one of conflict between physician power and nurse knowledge. In a more cordial relationship, she sees the inherent conflict as not being an issue. Another nurse expresses the importance of nurse's knowledge in a different manner.

Nurse #4: It's hard for me because I have worked at other hospitals and I just see this place as being much more open than a lot of other hospitals. I don't know, it might have changed after six years. I can remember this doc walking in and the whole floor just kind of stood up. A lot of these were older nurses, and I had just graduated from nursing school, and this doctor walked in, and it was like, it was his unit and you just bowed. I just think nursing is a specialty and not everyone can do it. That we just spend a lot of time with the patients and that we really know the patients better than the docs do. I'm sorry. We're there for eight hours with them.

This participant also sees the source of nurses' knowledge as deriving from extended patient contact and as placing her in a position of superior knowledge of the patient in relation to the physician. She views that knowledge as an important contribution to patient care. Because patient knowledge is so important, she believes
nurses are as important as the physician. In a situation where the physician is viewed as more important than the nurse, this participant believes that it is the nurses' knowledge that is being devalued. In a more open situation, the nurse and the nurses's knowledge are more valued. The mechanism through which that value is recognized by physicians is viewed by the participants as respect.

Nurse #4: ...Most of them are just only a few years out of medical school and they will listen to your opinions. I like that. Three quarters of the time they will ask you, "what do you think or what do you want to do," which makes you feel real good. Like your inputs - "well, what do you want to do." I've had interns ask me, "what do you want to do," because they don't know what to do. Other times, it's just because they want your opinion. You're at the bed side with the patient and they see the patient briefly for ten minutes in the morning and you're there for eight to twelve hours. That respect is shown by, "what do you think, you spend a lot of time with the patient," and I like that.

For this participant, seeking the nurse's input is interpreted as acknowledgment by the physician that she has valuable knowledge derived from her lengthy contact with the patient at the bedside. At times, she sees the new physician's request for opinion as deriving from a lack of knowledge, at others, she sees the request deriving from a desire to know the nurse's opinion. She sees that behavior as respect for her valuable knowledge and evaluates
it positively. Another example of respect for the nurse's knowledge being shown by physicians in this manner relates to more senior physicians.

Nurse #1: They listen to all our ideas. For instance, "Heather, do you have any questions? Do you have any options to the plan? What have you noticed? Things like that. Which when you're in a large group which mine always tends to be, like general surgeons, vascular surgeons, it shows in respect that they actually value your opinion to make the whole group wait and let them listen to you.

Interv: Why do you think that is?
Nurse #1: It's obvious that we have more of a feel for what's going on at the bedside. Although they're in the unit, they're doing other things. They have other patients. They understand that we have a better feel of what's going on. We see them every day.

This participant interprets the physicians' asking for the nurse's opinion and keeping the whole group of senior physicians waiting for her input as recognition of and respect for her superior knowledge of the patient.

The participants also believed that knowledge derived from clinical experience is a central issue in the nurse-physician relationship. In the following selection, the nurse is referring to physicians who are new to her specialty area.

Interv: How do they come across?
Nurse #6: Very collegial. "This is what I'd like to do, what do you think?" By the same token, they're not a bunch of gumbies. They don't say, "what do you think about everything." They are physicians and I respect that. I'm not a physician, I'm a nurse.

Interv: So what does that mean, when you say that I'm not a physician, I'm a nurse, you respect them for being physicians.
Nurse #6: I respect their knowledge base. They have far greater, I think in certain areas, I've been out
of school since 19__. I mean, microbiology
fields, biochemistry, their actual textbook
learning and knowledge, I think, is more than what
mine is. I'm not downing myself. It's just a
fact of life. They having gone on for four more
years. But there is something that I have too
that they don't have. I've been in the clinical
area for seventeen years. It's a big difference
interviewing a two year old colleague's daughter
as a...

This participant distinguishes between text-book
knowledge derived from schooling and knowledge derived from
clinical experience. She sees new physicians as having more
textbook learning than nurses, which she respects. She
views the knowledge gained through the years of experience
in dealing with real clinical situations as more valuable to
that gained through fictitious, practice situations. This
greater experiential knowledge is for her the basis for
making a contribution to the plan of care and balances, or
equalizes the physician's greater textbook knowledge in the
relationship. In a collegial relationship, the physicians
recognize and seek access to the nurse's experiential
knowledge by asking for the nurse's opinion. The
participant believes that the relationship would be
unbalanced by physician weakness if the physicians did not
utilize their own knowledge base, symbolized by physician's
asking nurses about everything.

The following selection portrays another mechanism
through which nurses believe that physicians recognize the
value of the nurse's experiential knowledge.
[Speaking of the chief physician in the unit.] Now he tells a lot of the residents, "go to her she knows about head trauma." "Ask Kaitlin, what do you think."

Interv: So he'll actually refer the residents to you?
Nurse #6: Yes, "go listen to her, and if she calls you and tells you her gut tells you the patient is acting funny," you know, kids aren't like adults, there can be very subtle things that you have to pick up on with children, they would tell them, "if Kaitlin says to you the patient is acting funny, listen to her."

The participant here is saying that this physician respects her expertise to such an extent that he will send junior physicians to her because she has extensive clinical knowledge. Not only is the referral an indicator of respect to her, but it also suggests that use of the word "listen" means taking the nurse's observations seriously. Listening, in this sense, can be interpreted as an injunction against dismissing the nurse's observations as lacking substance. Listening to this participant means recognizing the nurse's experiential knowledge.

Another nurse provides an example of this mechanism of showing respect for the nurse's valuable knowledge through listening.

Nurse #2: ...You know when a doctor has respect for you, that's that doctor say to you, "I'm glad you're taking care of this patient today." It's kind of like he knows that things are going to get done and they know that things are going to get done right. It's kind of like we respect each other. It's like when a doctor comes in that you like, you say, "good, I'm glad you're the one that's on today." You know the things that they're going to pick up with the patient. That they're going to listen to you. Things run much smoother. Like if I have a patient that has a problem, I'll go up to them and say, "his I&O's [intake and output}
measures] are off today" or "I think this patient needs lasix," and the doctor will say, "OK, I'll write the order" instead of fighting with the doctor. If you come up to the doctor and say, "this patient needs lasix," you know this patient, you've been taking care of this patient for weeks, you know how they work, this patient needs lasix. "Oh, no, I don't think so" or "what makes you think that." It's like they flip on you or something.

This participant believes that a respectful physician will trust that the nurse knows what she is talking about, because she has sound knowledge of the patient, and will accept her judgment regarding what the patient needs by acting on it. A physician who has no respect for the nurse's knowledge, in her view, will dismiss that judgment as shown by not taking action or by disagreeing with the nurse. This is referred to in a shorthand way as "listening, or not listening, to the nurse."

In the same vein, not listening connotes to the nurse that the physician does not respect her clinical knowledge and the relationship would be unbalanced by the physician treating the nurse as if she knew nothing.

Nurse #6: ...But if I were to go to a resident for instance and say, "this central line catheter that this child has in is leaking, it should come out," and if they say, "well I have to come see it first or maybe we can fix it," and I know this is not a type of catheter that can be fixed, why don't they listen? Do you know what I'm saying? Certain things that I as a nurse know, I expect them to...

Interv: If they question further something that you are certain of, that's what you take as not respect, or lack of respect or they don't believe you.

Nurse #6: Yes, or if you go out and say the patient has a temperature of 104 and they'll say, "did you
shake the thermometer before you took it?"
"Excuse me but we have nursing aides doing this type of care."

This participant was explaining how she knew if she was respected by the physicians, by way of pointing out a contrasting situation wherein she is not respected. She sees not listening as characterized by the dismissal of her recommendation, the physician not believing her. She interprets the physician's question regarding the thermometer as questioning her knowledge and basic expertise as a critical care nurse, which is offensive to her. Further, this example shows that by not listening to her recommendation, which is based in the nurse's view that she knows what needs to happen, the nurse is unable to influence the physician's actions. Through listening and respect, nurses are able to influence physician's actions.

In the next selection, the participant views knowledge as accruing from additional responsibilities that nurses have assumed and as a requirement for assuming even more responsibility.

Nurse #7: I think nurses play a much more vital role than they did years ago.
Interv: In what way?
Nurse #7: Before we did more technical things, you know, sterilization, etcetera, now we are doing technical things but beyond that there's a lot of other interventions, the way we are, like even the labs and all that. Doctors always in the past used to be responsible for checking the labs and interpreting them, now more and more we're getting labs, we're looking at them. I always ask what this might mean or that might mean, so I'm learning from that. We're playing more of a role, not as a doctor, but because we have to try to get
to their level a little more, we need to be on top of things and we need to know some of these other things.

This participant experiences learning as a result of being involved in more technical interventions than nurses performed in the past. She sees this technical knowledge as a basic requirement for playing a more important role in patient care. With knowledge, she is able to make more of a contribution. She views the physician's role as different from nursing's, because of differences in knowledge.

In the next example, a participant articulates a mechanism through which the nurse's technical knowledge contributes to nursing's greater vital role.

Nurse #8: I think it's just one of those things where they're supposed to give the orders. That's been the structure that I think is pretty outmoded at this point. I think even that word, physician's orders, is kind of a crazy conflict from the past that this keeps carrying on. But I mean, that essentially is the relationship. In reality, if they give orders and you don't think they're going to hurt your patient, it's your obligation to carry them out...I think at one time their expectation was the nurse would carry out just what it is they thought was right for the patient. Now, I think that they do expect that the nurse will have an opinion that's scientifically sound.

For this participant, the provision of a scientifically sound opinion by the nurse to the physician and the evaluation of the physician's order by the nurse in terms of potential harm to the nurse's patient, have made the traditional hierarchical structure between nurses and physicians outmoded. Part of that structure remains, in that if the nurse's evaluation of the harmfulness of the
order is negative, the nurse is still obligated to carry it out. This nurse believes that the former physician expectation of the nurse as an unknowledgable and unthinking extension of the physician's will no longer exists. She views the physician as no longer the sole owner of the physician's order, nor the sole owner of the patient. Nurses have an important role in developing that order and in patient care because of their knowledge.

In the next example, a participant articulates a similar mechanism through which the nurse's greater patient knowledge contributes to nursing's greater vital role.

Interv: And who do you think has control?
Nurse #2: I think we both do. I don't thing it goes one way or the other. I think ultimately the doctor. But you have a lot to say in what's going on. So it's not a hundred percent the doctor. It's not like the old times where the doctor comes in and says, "you do this, this and this," and that's all you did was what the doctor told you to do. You have a lot of give and take here.

Interv: Why is it that the nurses have a role in what's going on with the patients?
Nurse #2: Why is that important? Things run more smoothly when everybody is working together. Some look at the patient as a whole because the doctors might miss something that the nurse can pick up on because we're in the room with the patient for twelve hours and we may pick up on these little things that we could share with the doctors. The doctor wouldn't know that not being in the room.

This participant also sees a difference in part of the current hierarchical nurse-physician relationship, wherein the nurse's greater knowledge of the patient influences the physician's orders. To her, although the physician retains ultimate control, the mechanism of give and take means that
the physician is not totally in control of what happens with the patient. She frames this as working together and sees that things run more smoothly as a result. In her view, the nurse's input contributes information that the physician would not otherwise have had.

The perception of the physician and nurse working together with joint responsibility for patient care is seen as the definition of team in the next example.

Nurse #3: I think that basically we have to keep in mind that the patient is the bottom line. That the nurse and the doctor work together as a team. It's not just the doctor carrying the patient. Some people might say it's not just the nurse carrying the patient. It's the team that needs to work together and in order to do that you need to communicate and you need to have a good understanding of what the other is doing. I think that comes from communication, with the patient also, all three...I think that we're all equally important in the team and even though I have a great deal of respect for the physician and their education, I hope in turn they have a great deal of respect for me. Our end result is to help the patient, but we're functioning differently and equally important.

For this participant, the common goal of patient care between nursing and medicine requires working together as a team. Working together as a team means joint patient responsibility for which good communication is necessary. She views nurses and physicians as equally important members of the team who function differently, whose equal importance is acknowledged through mutual respect for one another's knowledge.
Knowledge, for the next participant, is a key ingredient in the nurse-physician relationship. She is discussing the advice she gives to new nurses coming into the unit.

Nurse #3: I generally tell people that we have a lot of autonomy here and are very well respected in this unit. That, to just do things to maintain their respect as far as - that's usually what I tell them. That we just have a lot of autonomy and are very well respected...We have a lot of knowledge base. We try to keep up with education. We try to carry a professionalism...We tend to have a professional relationship and we've gathered that the autonomy that we have from the relationship, from the professionalism that we have showed over the years. The autonomy comes through that and our knowledge base and that's what I'd be telling our temporary replacement.

For this nurse, the professional relationship she experiences between nurses and physicians is the result of physicians' respect for nurses' professionalism and for the nurses' knowledge base. She believes that the nurse's role is autonomous or equal in the professional relationship as a result of that respect. She advises a temporary replacement to do things to maintain that respect in order to maintain that type of relationship.

In the next selection, autonomy means the expression of knowledge. Again, this participant is explaining the advice she would give to a new nurse.

Nurse #5: What I'd tell people that I have perfected, if they have a question or an afterthought or they disagree, I always tell them to ask them why. They'll be more than happy to sit down and explain it to you. Anything that goes on in here, they're
always, unless it's incredibly busy, they're very good about explaining. Just ask them, they're more than willing to.

Interv: And why is important that this fictitious replacement feel comfortable about asking?
Nurse #5: I think we enjoy a certain amount of autonomy here. Just so that we maintain that, but we still have these people to answer to as well. You have to feel comfortable with the other nurses, with the doctors. They have to feel comfortable with you.

Interv: These people you have to answer to, do you mean nursing administration or do you mean the docs?
Nurse #5: The physicians and the patients even. They should be asking questions too and you better have the answer to them. That's what I tell people that are new coming in or people that have to float up here. Just go ask them and they'll tell you.

Interv: What does autonomy mean to you?
Nurse #5: Feeling comfortable expressing your views. Taking a certain amount of, something that you can do constantly, just things that you learn over the years that just comes second nature. In other words, a skill, or something you see and it needs to be treated and you know it needs to be different but you have to be responsible for what you do or what you decide to do.

Interv: So are you saying that you make independent decisions?
Nurse #5: Being in the room alone and the guys heart rate goes from 80 to 20, you don't wait to watch it come up, you're going to treat it. If nobody is around, you're going to treat it...Everything is so split second in here. When you see it you're going to do it. It might be too late in a minute. The docs are here all the time, but they're not in the room all the time.

The meaning of autonomy, the relationship between nurses and physicians, for this nurse is the expectation that nurses will act independently and competently. Asking questions not only maintains the nurse's position as autonomous or equal, but also insures that the nurse has the information she needs to be able to answer questions and be competent. In order to ask questions, there has to be a
comfortable relationship between the new nurse, the physicians and the other nurses. This participant views autonomy as resulting in the comfortable expression of her opinions and the expression of her experiential knowledge through independent action. In her work area, independent action by the nurse is sometimes lifesaving. Even though physicians are present in the unit, this participant believes that autonomy, her knowledge gained through her clinical experience, her bedside role and the speed with which the patient's condition changes, places her in a position where she feels that she is able to and must take independent action.

The participants believe then that respect for nurse knowledge and the common goal of patient interest influence the nurse-physician relationship. This final selection highlights the nurses' view of the nature of this influence.

Interv: What kind of things do you see as most important when you think about the nurse-physician relationship?
Nurse #8: I think the most important thing is that both parties have genuine knowledge and expertise in their field...Also I think of equal importance is that everyone have the best interest of the patient foremost in their mind.

Interv: And how does that impact on the relationship between docs and nurses?
Nurse #8: Well, I think if that's the case, power dynamics don't become involved in it as much. People can actually rely on each other as resources and colleagues more than getting involved in any power struggles.

For this participant, genuine knowledge and expertise, in conjunction with the common goal of patient interest
reduces the power dynamics that she sees as remaining in the authority structure. She believes that by focusing on the common goal as more important than power struggles, physicians and nurses see each other's knowledge and expertise and rely on each other as resources and colleagues, or as equals.

In summary, the participants see the nurse-physician relationship as collegial because they participate as equals in the planning and provision of care to patients. The nurses want to be involved because they believe the information they have will result in better decisions and better care for patients. To not involve nurses, by asking for, listening to and acting on their knowledge, is jeopardizing patient care, because they believe that alone, the physician does not have adequate patient information, and may not have adequate experience and clinical skill. Respect is important for nurses because for them, it is the recognition of the importance of the knowledge they possess. Through respect, nurses believe that they are invited to participate as equals in the process. Nurses do not see themselves as physicians, but as skilled clinicians who have a lot of knowledge to provide. They see the physician's role as writing the order, and their own role to add input, because of the physician's greater textbook knowledge and schooling. When nurse's input is sought, heard and acted upon, nurses feel equal despite the structural and formal
inequalities of the nurse-physician relationship. The next section will present interview data in regard to how the nurses explain the reasons for this type of relationship.

**Objective Conditions**

This section of the data presentation focuses on the participant's beliefs regarding objective phenomena related to the nurse-physician relationship. It seeks to answer the question: How do the participants perceive and explain objective conditions that they experience? It will be recalled that objective conditions have to do with the reality that is external to the individual, which is "made up of hard, tangible and relatively immutable structures" (Burrell and Morgan, 1979, p. 4.) This presentation will be divided into four sections: setting, learning atmosphere, reliance and personality.

**Setting**

Each of the participants noted that the nurse-physician relationship in their current setting was different from that which they had experienced in other employment settings, including both other hospitals and the general floors in the facility involved in this study. Exploring this contrast not only highlights participant's views of the how the setting influences the nurse-physician relationship through causes, mechanisms and effects, but also provides
additional insight into qualities of the present nurse-physician relationship which are thought to be important by the participants.

All but one nurse noted that the nature and frequency of interaction between nurses and physicians differed between various settings, and that these differences influenced the collaborative nature of the nurse-physician relationship. In this first selection, the participant was discussing what it was like for her to have been thinking about nurse-physician relationships during the interview process.

Nurse #5: You don't think about it until a change comes along. Or somebody with a totally different attitude comes along. That's when you think about it. "Well, where did he come from?" Or you go to work somewhere else. That's when you notice it the most.

Interv: And what do you think you would notice the most?
Nurse #5: The way you're treated. I've worked for agencies before and going into these smaller hospitals where there's only a few attendings. They're the ones who expect you to get off the chair and let them have it.

Interv: And how do you feel about that?
Nurse #5: Get your own chair, I was here first. But I wouldn't have done that before. I think it was just when I started working in the medical center. When I worked in the smaller hospitals I wouldn't. I got off the chair.

Interv: Oh really?
Nurse #5: Definitely. I didn't know there was another world out there. It was totally different.

Interv: In another world you mean a different way of interacting?
Nurse #5: Yes. Of interacting period.

Interv: How do you mean?
Nurse #5: You didn't interact with them. They would come in and, first of all, if they talked to you, you were lucky. If they knew your name you were twice as lucky. That type of thing. It was a lot different.
Interv: So you're saying there was no relationship then?
Nurse #5: No. The only relationship was he came in and if they wanted a pen, you got them a pen. If they wanted a paper, you got them a paper. If they wanted this done then you got it done. That was the relationship. There was no collaboration at all.

In the smaller hospital, there was limited and impersonal interaction between the nursing and medical staff, wherein the physicians seldom knew the nurses' names and interaction centered on trivial servant like issues. She framed this as no interaction at all and was a barrier to a collaborative relationship. She also alludes to a norm in the smaller hospital in which the physician expects extreme courtesy and the nurse is expected to accede to it. She interpreted this as meaning that she was of less importance than the physician, which sparked resentment. This norm seems to have served as a barrier to greater interaction between nurses and physicians. Working in the medical center was a learning experience for her in a different type of nurse-physician relationship. Her present relationship with physicians was so different for her that she labelled it as a different world. Another nurse speaks of the same types of issues.

Nurse #4: It's hard for me because I have worked at other hospitals and I just see this place as being much more open than a lot of other hospitals. I don't know, it might have changed after six years. I can remember this doc walking in and the whole floor just kind of stood up. A lot of these were older nurses, and I had just graduated from nursing school, and this doctor walked in, and it was like, it was his unit and you just bowed. I
just think nursing is a specialty and not everyone can do it. That we just spend a lot of time with the patients and that we really know the patients better than the docs do.

This participant echoes the description of the nurse-physician relationship as different in another hospital. The physician was treated with extreme courtesy, a norm learned by this participant, as a new graduate, from older nurses in the setting. She felt that this norm evidenced a lack of recognition of the importance of her contribution as a nurse, which was an important element in this participant's view of an open, or collegial, relationship. She continues on to articulate the difference in her current setting.

Nurse #4: We question a lot of things. I think that's just the way nursing is nowadays. At least in this medical center it is, I think. Which makes it good. It's like you're a team. You're not a nurse and you're not a doctor. You have your own jobs but you're working together for the benefit of one thing. This is why I like it here as opposed to some of the smaller hospitals I've worked in. It's totally different...One hospital I worked at, the nurses were more like handmaidens. I worked here and I've seen what the doctor and nurse relationship was, and this, not really hand maidens, but, you never question the doctor orders. You would never say why. This is just one hospital. If the doctor said to do it, you just do it as opposed to asking why. The doctor came on the floor and it was like god had come onto the floor.

Questioning, for this participant, symbolizes the difference in the nature of interaction in the small hospital and the present medical center. Questioning to her represents a more equal relationship between nurses and
physicians wherein traditional distance between them is less of a barrier to communication and interaction. Another nurse notes discussion of patient-related issues as an indicator of difference.

Nurse #3: Usually the physicians are very good and receptive around here. If they have a difference of opinion usually they'll sit down and talk to you about why they think this other means of therapy is better and you can talk about it and have a discussion about it. Which is different than in the prior hospitals that I used to work at. So I think that, that's a real neat thing here. One of the major reasons why I'm working here is because of the fact that we can sit down and talk about treatment and things and I can learn from that as well as the physicians learning from me.

For this participant, sitting down and discussing patient related therapies with physicians was not something that occurred in previous employment settings, but was one of the major satisfiers in her current one. She interprets this as a result of most physicians being good and receptive, which seems to have diminished the traditional barrier to collegial interaction. She implies an equality in the relationship whereby not only is the nurse learning from the physician, but the reverse is also true.

Another participant speaks of reasons for differences in the nurse-physician relationship between the critical care unit and the regular wards.

Nurse #2: Well, working in the unit is different than working on the floor. You have to be right on top of things because their condition can change at any minute being in a cardiac unit...It's probably because we do have to come to them with all the problems. Out on the floor you don't have as much interaction with the doctors and nurses.
Interv: Oh, you don't?
Nurse #2: No.
Interv: How come?
Nurse #2: I don't know why. Probably because in the unit there's so many things going on at one time with your one patient. That you're on top of these things and you're saying, "look, this is what's going on, this, this and this." Out on the floor you have maybe eight or ten patients. You can't be making up labs on every single patient. You can't be focusing on the little things that we focus on. You don't have to go to the doctor's every five minutes. Where in here, we're literally at the doctor for every little thing.

This nurse sees the issues of the acuity of the patient's condition and the size of the nurse's workload as important factors in establishing a collegial relationship with physicians. Serious patient acuity requires that the nurse have in-depth knowledge of the patient's condition and frequent changes in that condition result in more frequent contact with physicians than on the regular floor. In addition, because of these factors, the critical care nurse has a smaller patient caseload, allowing her more time to become expert on the patient's condition and to interact with physicians.

Several participants note the lack of availability of physicians as another difference between settings and another barrier to collaborative interaction. One selection will be presented here.

Nurse #8: ...Actually, in the community hospitals I worked in the docs were at home. I always worked evenings. There was no one there. A community hospital in the evening is a facility run entirely by nurses. There's maybe one or two ER [Emergency Room] docs, and sometimes a radiologist or anesthesiologist coming and going for various
types of things. But in general on the inpatient floors, it's nursing unless you call someone at home. And a lot of times when you call someone at home, you've gotten them out of their beds, and wake their families, so you always have that kind of tentative feeling about that. You have to feel really convinced that you need them and also they're on the phone, they're at home.

This participant is pointing out that there is little opportunity for a relationship if one of the actors is missing. She also expresses the barrier to interaction that is posed for the nurse by the physician's off-duty status. She sees the bridging of that gap as only justified by the most serious of needs. She continues on to speak of the difference made in the relationship when the physician is more available.

Nurse #8: I was always intimidated by, especially in community hospitals, it's a different atmosphere. A lot of the physicians are older, established people in the community, very, very, highly respected, not that I don't have a lot of respect for the people here, but the collegiality is greater here. There's more feeling of being in the trenches together when it's the resident you're dealing with. But with the attendings, they're older, and more powerful, and very well respected, whereas in the community hospitals, in my experiences, the nurses were not that particularly highly respected necessarily...I also think that the fact that they are resident makes it a more, it kind of equalizes things a bit more, that you're not just working with the attending. You feel more on an equal footing, I think, with the residents than you do with the attendings, partly just because it's kind of the job functions that you fulfill. You actually are in there in the trenches working together for the whole shift, you know, off hours, weekends, nights, the works.

Interv: So you rub elbows more?
Nurse #8: Yes.
Interv: That's not true of the attendings here?
Nurse #8: Well in the community hospitals it certainly wasn't true and even here. No, it's not particularly true. It depends on the attending and in the ICU's you tend to rub elbows with the attendings quite a bit. And also we happen to have very cordial, I happen to have really cordial relationships with most of the attendings here. But I don't think that's true on all the services, and all the units, and out on the floors that the attendings know it all.

For this participant, according very high respect for physicians and low respect for nurses in community hospitals was intimidating. In her view, combining higher respect for nurses in this medical center with extended interaction with more junior physicians resulted in an equalization of their status and a feeling that could be termed as comraderie. The extended interaction with residents was a result of the structure of the medical center where each service has a resident on duty twenty-four hours a day. The intensive care unit setting also resulted in extended interaction with attendings, which for her, was different than in the community hospital. The extended interaction resulted in a different atmosphere and cordial, less authoritative relations with most, but not all, of the attendings.

Most of the participants echoed the importance of familiarity in the nurse-physician relationship. One participant provides an example of the link between familiarity and respect.

Nurse #7: I think once they sense you're pretty much on top of things with your patient, I think they learn to respect you a little bit more for what you have to say, and I think it's again when you have this communication. A lot of doctors that I wasn't
that friendly with or I didn't know that well, the more that I got contact with them and vis versa, now I think they have more respect for me...It takes time to build relationships. It takes time to build trust. It takes time for people to appreciate each other.

This participant sees the time it takes to build a relationship as a normal process, engaged in by individuals. Familiarity represents this process through which individual physicians and individual nurses learn each other's competence over time and learn to respect and trust one another. Another participant provides an example of the link between familiarity and the recognition of the importance of the nurse's contribution.

Nurse #3: The way physicians will purposely go out of their way to continue communications. Talking to us, going out of their way to talk to us, to find us, to ask certain particular questions about the care or whatever. Where as occasionally, there's some physicians that come that don't spend a lot of time on our floor. That come for consults. So they don't know us, they don't work with us, and you can see in what they do, their behaviors that we're not as valued. Like you'll be standing there and instead of asking the nurse what medications they're on, they will turn around, run down the hall after another physician and ask them, and then they will have to come up the hall and look in the chart to get specifics. Where as we're standing right there. So that kind of behavior says, "I'm not worthy to tell him, so he's seeking out." That might be an example.

For this participant, physicians become familiar with the importance of the contributions made by critical care nurses through working with them. Physicians show their recognition of that importance by going out of their way to communicate with nurses. She believes that a physician who
is not familiar with the group of nurses does not value their contribution as much. The lack of recognition of their value is seen by this participant in not consulting with the nurse in an area that she sees as a part of her role and expertise: medication specifics. To her, not asking for this type of information gives her the impression that the physician thinks she is not worthy, that the physician does not recognize the important contribution nurses make. To her, working together with physicians increases their familiarity with contributions made by nurses and is an important issue in terms of the physician's recognition of the value and importance of that contribution.

In summary, the nurses saw several differences between their current employment setting and other areas where they've worked. These differences included the norm of physician importance, norms regarding questioning and discussing patient related issues between nurses and physicians, and the frequency of interaction between nurses and physicians. The differences were seen as barriers to collegial relations by creating psychological, and often times, physical distance between the two groups. These barriers were bridged by norms supporting the equality of the importance of both physicians and nurses, by time for the nurse to develop expert knowledge of the patient's condition and by the opportunity for extended interaction
between nurses and physicians. Qualities of the present nurse-physician relationship which are thought to be important include the nurse's freedom to question physicians, open discussions focusing on patient-related issues and familiarity between nurses and physicians. The next section focuses on the nurse's view of learning as it influences the nurse-physician relationship.

Learning Atmosphere

Each of the participants brought up the issue of learning as a factor that influences the nurse-physician relationship. This section explores the participant's views on the causes, mechanisms and effects on the relationship of learning issues.

Many believed that physician openness to discussion of patient related issues with nurses was related to being in a university medical center with an associated medical school. In this first example, the participant is discussing why physicians will sit down and talk with nurses.

Nurse #3: I think it's because of the teaching facility. I think that there's a lot more discussion that constantly goes on, and people [physicians] are more open to learning, and the way to learn is to think out things and go through a thought process and rationalizing things, and it's all part of the educational atmosphere and I think that that opens itself to that kind of behavior.

This participant believes that physician openness to learning and to teaching nurses is a product of an educational atmosphere or norm resulting from the
organizational structure of the medical center as a teaching facility. Nurses are more easily included in the discussion because this process is an accepted mode of learning behavior. The next selection provides an example of the influence of the learning norm on questioning behavior of nurses.

Nurse #4: ...It's a teaching hospital where docs are learning. We have a lot of medical students. It's a teaching institution. We have a lot of fellows and stuff like that, who are learning. So it's all learning. You're just not afraid to ask why. You're not afraid to ask questions here.

Interv: So is the asking questions part of your learning and that's an OK kind of thing?

Nurse #4: Yes.

Interv: So the "why" questions aren't seen as a challenge but are seen as a quest to learn?

Nurse #4: Yes, some of the times. Some of them are seen as a challenge but mostly, I mean I'm not out to get anybody, everybody is here for one thing, and they're learning too. The why questions are more like, "well, why do you want to do this," not like, "I think you made a mistake." It's how people say it.

In this example, the nurse continues the theme that questioning is an ordinary event which is accepted because one of the major goals of the medical center is to teach physicians. Her questioning behavior is non-hostile in intent and she sees the phrasing of the question as way of conveying that intent. In her opinion, the phrasing of the question expresses her intent as a challenge, a quest for learning or a teaching tool. This example also introduces another important theme, wherein this nurse alludes to the nurse's teaching relationship with physicians. It is
acceptable to question physician-learners as it may help
them learn. Another participant phrases this theme more
directly.

Nurse #8: ...I think that we have a teaching relationship
with the residents here a lot of the time and
that's been an interesting thing to me.

Interv: How does that work?

Nurse #8: Well you know, they come through our ICU
[Intensive Care Unit], it's a very, very
specialized clinical area, no one can know
everything about it and certainly the staff nurses
here don't, but we do know how things are done in
this unit and we do have a lot of practical nuts
and bolts experience that the residents on their
way through haven't gained. Just in the day to
day operations of patient care in the unit. A lot
of times they just ask us how things are
done...They're here as part of their educational
experience to learn from us. They are. That is
true...They're here to get further education and
we're part of that. Also they're here to teach
us.

This participant sees the nurse-physician relationship
as one of teacher-learner. The nurse's years of experience
and knowledge acquisition provide greater expertise not yet
mastered by the new residents. Along with this view, she
sees the primary reason for the physician's presence in the
medical center as that of learning. Both of these factors
allow her to take on the teacher role. She emphasizes the
theme of equality in the relationship, rather than
dominance, by pointing out that the physicians also teach
nurses. She continues on to discuss one outcome of these
learning roles.
Nurse #8: So that's been an eye opener for me...
Interv: How has it been an eye opener for you?
Nurse #8: I guess that it's made me realize a lot, how much in-depth knowledge I really have that I would not have given myself credit for otherwise. I think part of it's age too. I think when I was younger, I always thought that, well these people have gone to medical school, they're a lot smarter than me, but that is not the case. Sometimes just the experience of having been around patients for many years has made you an expert. So in that way, it's made me realize my expertise and I think teaching does that in any case.

This participant believes that dealing with physicians who know less than she, has forced her to recognize her own expertise. She has revised her former opinion that only people who went to medical school have in-depth knowledge and can be experts. She now believes that experience is also a good teacher. Being a teacher herself has helped in that realization.

Another selection provides an example of how the learning theme influences interactions between nurses and physicians. She was discussing the general relationship between physicians and nurses.

Nurse #6: ...But occasionally you will get one that comes down the pike, and because she or he has MD after their names, they don't look at you as a nurse with seventeen years, or eighteen years or twelve years of critical care experience. It's because they are an MD. That if they tell you a CVP of 1 means they need to get a diuretic, then by god that's what we're going to do. You know what I'm saying?
Interv: What do you do?
Nurse #6: Go over their heads. Climb the ladder. I mean, this is a learning experience for them. Most of the residents that come through here, well, just to give you a picture, in twelve years of working here, I think maybe two residents have gone on into pediatric critical care. So basically you're
dealing with a group of residents that come in here knowing that they don't want to do critical care but they're doing it because it's part of the program. They have to do it.

This nurse is describing a situation where she sees her expertise as greater than that of the physician. Because it is a learning experience for the physicians, and because many physicians in this unit are there only because it's part of their program, they are not expected to know everything. This chain of logic allows the nurse to go over the physician's head and consult with another physician higher in the chain of command. That the medical chain of command exists is inherent in this scheme, highlighting another difference between this setting and that of a small community hospital or a non-teaching facility. Later, she describes how she implements her sense of responsibility for teaching physicians.

Nurse #6: I will go and ask them things first. I don't automatically go over their heads even if I've been told they're a terrible resident. If you have a resident and a newly extubated patient, I'm not going to walk by you and pick up the phone and page the attending. I'm going to tell you first. You are the resident in here. It's a learning process for you too. But if you can't come in and look at a patient who is retracting to their back bone, who is black and who is out of it because of lack of oxygen, if you can't recognize that I need help from my superiors and you instead pick up your Harriet Lane and look at albuterol, then I'm going to go above your head. That's an acute example but I'm in an acute care area...I try to make it a learning environment for them.

This nurse clearly feels a level of control in dealing with crisis situations. She is the one who selects the
physician who will assist her in dealing with it. She consciously implements her sense of teaching responsibility by including the new resident, by going to the new resident first, even if they may not be the most expert in the situation. If however, the novice physician does not act quickly and correctly, she will go above his or her head. Other components regarding the theme of going above will be more fully presented in a later section.

In summary, nurses perceive the teaching mission and structure of the medical center as significant factors underlying the openness of the present nurse-physician relationship. Norms of learning create patient-related discussion between nurses and physicians and allow nurses to ask questions without necessarily being seen as confrontive. The structure provides nurses with the opportunity to interact with physicians who know less than they, allowing the nurses to develop a recognition of their own expertise and control in dealing with crisis situations. Using the educational schemata, nurses interpret that expertise as reason to be an active participant in the teaching process. In the learner role, the physician is not expected to know everything. This component provides an additional dimension to the openness and collegiality of the nurse-physician relationship in this setting, as will be presented in the following section.
Reliance

Almost all of the participants brought up the issue of physician reliance on the nurse as a factor that influences the relationship. This section explores the participant's views on the causes, mechanisms and effects on the relationship of the reliance issue.

More than half of the participants see reliance as the result of physician inexperience.

Nurse #1: A lot of the interns that are in their first year, rely more on the nurses because this is their first time in the units and doctors rely more on the nurses. A lot of the residents once they get higher up will totally disregard what the nurses say...It varies from doctor to doctor depending on their personality.

For this nurse, physician reliance on the nurse, as a result of their newness to critical care, takes the form of acting on what the nurses say. She, and other participants, see less of that form of reliance as the physicians gain more experience. Another example illustrates more specifically how nurses see these dynamics.

Nurse #3: That the interns and the residents, being new, might not come across a particular problem, where as we've seen it many times and they'll be kind of stuck and say, "gee, I don't know what to do," and then we'll be able to offer suggestions for treatment and say, "well I have seen this before, and this is the way it's usually treated and this is what works." Which they'll take that suggestion and usually check it out with the resident or the next one higher, if we're talking to the intern, and kind of bounce it off the attending. They'll generally say, "Yes, that's right, did the nurse tell you that? Yes, that's what we do." So after a few times like that if it's the middle of the night, they won't call the resident, they'll just say, "OK, that sounds like
a good plan of action and I agree with that," and they'll just write the orders. That's the kind of care the patient will get.

This nurse is describing a situation wherein the physician expresses his or her lack of knowledge, either verbally or symbolically. The nurse, because of her greater experience, points to the proper methods of dealing with the situation. While at first physicians will consult with their superordinate physician, two factors prompt the young physician to discontinue this practice. The superordinate provides confirmation of both the nurse's suggestion and also the appropriateness of her role in providing that suggestion to the young physician. This allows the young physician to rely on the nurse's experience directly, without seeking the superordinate physician for confirmation.

Beyond inexperience, all other participants saw another reason for physician reliance on nurses: nurses' greater level of contact with patients.

Nurse #7: I think the physicians, particularly here in the unit, rely tremendously on the nurses for their input. We have very critically ill patients. The doctors sometimes don't get to the machines until later, late in the morning, or they may be involved with a case where they may be taken away for something...

This nurse believes that physician reliance on nurses for their input is based on the critical status of the patients in combination with the physician's absence from
the area. Physicians are absent because they have something else to do. Another participant discusses the issues of nurse input and physician absence.

Nurse #2: A lot of times the doctor won't go in and spend some time with the patient. They just go from patient to patient. Unless you go to the doctor if there's a problem with the patient, otherwise they might not see the patient for the whole day. Or might pop in to listen to their lungs so when they write their note they can say what their lungs sounded like. Otherwise they look at our flowsheet. They go by what we tell them during the day.

In this nurse's view, physicians depend on nurses' information regarding the status of the patient's condition. Physicians do not routinely spend a lot of time with patients unless there is a problem, whereas the nurse is with the patient for an extended time. One basis for the nurse's input to the physician is the information gathered during this time.

A third basis nurse's saw for physician reliance on them was their technical knowledge, as portrayed in the following.

Nurse #7: It would be interesting to research doctors on their relationship with nurses, because we used to be way down here and now because of our technical training and our advancement along the way, we're... A lot of interns, they rely, you ask them, they used to say to us, "we learned a lot from you people." It's interesting.

Interv: So what do you think they would say if someone did that research?

Nurse #7: Again, there's a lot of things. I think some would recognize the fact that nursing plays a very important role in helping them become better in what they do. We keep them in line.
Interv: What does keeping them in line mean?
Nurse #7: If we feel they're being lax about something, we let them know.
Interv: And you think they appreciate that?
Nurse #7: Yes.
Interv: How come?
Nurse #7: Well, they'll let you know, "yeah, you're right. Maybe we should have started that maybe a couple of days ago." Or like a lot of times they forget to order something on our patient, and I'll say, "bedrest, what do you think?" and they'll say, "oh, that's a good point." They respect us. Again they can't stay on top of things all the time, they should try but they do get distracted as we get distracted so we're going to have to rely on each other.

For this nurse, reliance occurs because physicians get distracted. Because of the nurse's technical knowledge, she is in a position to recommend what the physician may have forgotten. She views the acquisition of technical knowledge as resulting in a rise in status for nurses, such that physicians now rely on and learn from nurses, because of that respect for nurses' technical knowledge.

In summary, nurses perceive that lack of physician experience, lack of patient contact and human failings lead to more reliance on the nurse in the critical care area. Because of nurses' experience, patient contact and technical expertise, physicians are open to, seek and rely on nurses' input, which nurses view as primary characteristics of the collegial relationship, as was presented in an earlier section. The next section focuses on nurses' understandings of why physician's sometimes do not seek their input.
Personality

Almost all of the participants brought up the issue of personality as a factor that influences the nurse-physician relationship. This is frequently expressed by the participants as an I-am-the-doctor attitude. This section explores the participant's views on the causes, mechanisms and effects on the relationship of personality issues.

Nurse #4: The interns and residents change over in July. They're brand new. Right out of medical school and they don't really know how to be a doctor and relate with a nurse. I think that's a lot of the problem there with the new interns. Some of them are scared to ask you something and some of them will order stuff. It's just a different type of relationship now. I think as the year goes on and they learn what your role is and they learn more what their role is, then it becomes a lot easier. As far as the residents go that are here, because we usually have an intern and a resident that are on every day. They usually have been here for awhile and they know what to expect. It's hard in our unit because we have a lot of autonomy. We don't give our own orders but we will go, as opposed to the doctor coming to us saying, "...I need...," instead we go to the doctor and say, "can I give him potassium." Most of the residents have been here as an intern or this is their second time around as a resident and they know what to expect...There's a little bit of hassle there but it usually works out.

This nurse accounts for the new physician's reluctance to ask nurses for their input as a result of their fear, their lack of knowledge regarding how to be a doctor and their inexperience in dealing with nurses. She views the nurses in her area as acting with autonomy and assertiveness in their interactions with physicians, which may be
unexpected by the new physicians. She frames this as a different type of relationship, which is a problem and a hassle for nurses. As physicians gain experience, they learn better what to expect. She continues her explanation of physician reaction to the nurse's unexpected assertiveness.

Nurse #4: Just the fact that they don't know what their role is. So they'll come up and ask you to do something, but they're not really sure why they're asking you to do it. Then you question them, and I think they're put back a little by that. "I'm the doctor, why are you questioning me?" It's hard because there's so many different personalities. Some of them you will find, "well, I'm the doctor, why are you questioning me."...It's part of their insecurity. They might be taken off by the fact that I said, "well, why." "Well, I just said that I'm the doctor." We question a lot of things. I think that's just the way nursing is nowadays. At least in this medical center it is, I think. Which makes it good. It's like you're a team. You're not a nurse and you're not a doctor.

In this example, the nurse believes that young physicians feel insecure due to a lack of knowledge about clinical issues. She sees fresh out of medical school physicians and those inexperienced in critical care areas as surprised at the nurse's questioning behavior norm. This nurse believes that young physicians don't expect it, due to their lack of knowledge about the physician's role. Some of them, depending on their personality, react to this insecurity by forming the I-am-the-doctor attitude, implying that they believe that doctors have superior knowledge and are not to be questioned. She believes that questioning is
a normal part of the team relationship between physicians and nurses, and experienced and secure physicians accept the nurse's questioning. Therefore, the physician who claims, verbally or non-verbally, I-am-the-doctor, is seen as immature in this setting. This superior type of behavior violates this nurse's definition of teamwork, which is based on the equality of the importance of their knowledge.

Another nurse continues this theme.

Nurse #6: I think it sometimes comes out in their attitude and the way they treat, maybe they're so nervous that they have to establish some type of hierarchy. "I am the doctor."...Maybe it's a reflection of their own security coming in here. I don't know. They feel that they can't come across as weak...They don't want to come across that they don't know because after all they are the physicians.

Once again, the I-am-the-doctor attitude is seen by this participant as being based in nervousness and insecurity caused by a lack of knowledge. She believes that the physician's intention when exhibiting I-am-the-doctor type of behavior is to establish a hierarchy, a superior status to impose boundaries on their relationship. This participant sees the claim to superior status as a cover up of the physician's lack of knowledge and the physician's insecurity regarding that deficit, through a show of strength and bravado. She believes that they think a lack of knowledge is incongruent with the physician role. The final example portrays a different reason for similar behavior.
Nurse #2: A lot of the residents won't listen to you.
Interv: Why do you think that's so?
Nurse #2: I don't know. I think a lot of it has to do with their personalities. A lot of them are on an ego trip. "I'm the doctor." A lot of the interns fresh out think that too. Once they get their MD behind them. "I'm the doctor and I said to do that, and you will do that."

For this participant, the I-am-the-doctor attitude occurs not only in new physicians but also in those with more experience. She attributes the physician's not listening to this attitude, which is personality-related. She views it as an ego trip, a sense of superiority, which results in the physician taking complete control of care and treatment.

In summary, the participants believe that some physicians react to the insecurity of inexperience and to the nurse's norm of assertiveness by developing an I-am-the-doctor attitude. For other physicians, the attitude is caused by a high sense of their importance or status. This attitude creates a barrier between the nurse and the physician and results in physician's not listening to the nurse's input. Nurses view this attitude as a personality related issue because most physicians, who have identical experiences, react differently, as seen in previous sections. Not listening is seen as a violation of the collegial relationship norm. The next section will present interview data in regard to how the participants interpret the subjective conditions and situations they experience in the nurse-physician relationship.
Subjective Conditions

This section of the data presentation focuses on the participant's perceptions and explanations regarding subjective phenomena which influence the nurse-physician relationship. It seeks to answer the question: How do the participants perceive and explain subjective conditions that they experience? It will be recalled that subjective conditions have to do with the internal reality of the individual, which is internally constructed by individuals and groups through a process of thinking and acting in the world (Berger and Luckman, 1967; Billig, 1976). This presentation will be divided into two sections: getting along and going above.

Getting Along

Getting along is a phrase often used by the participants to describe how nurses and physicians relate with one another. This section explores the meaning of getting along, the participant's reasons for seeing it as important, their understandings of why some individuals do not get along, their informal prescriptions for getting along behavior and outcomes of getting along that they see as important.

Getting along has to do with treating people well, being friendly, agreeable and helpful, as the next few selections portray. Treating people well has to do with
equality issues. One type of situation in which equality is an issue is the handling of disagreement. In the first selection, the participant is describing one of the attending physicians.

Nurse #1: He was always very pleasant, polite, if he didn't agree with us, he made it known that he didn't agree with us, but that's not something that's wrong. People disagree with us, and people have different ideas and just because we disagree doesn't mean that there's a problem. So actually we get along quite well with the ICU attendings. The new ones seem to be fine. They seem to treat us well.

This participant defined her relationship with physicians in terms of getting along well. Getting along meant to her that people treat each other well and are pleasant and polite. She doesn't see the hiding of disagreement as an important aspect of getting along, but places her emphasis on methods of dealing with that disagreement, that is, not treating people as if they are inferior and wrong. Another participant applies this principle to dealing with new physicians.

Nurse #5: The interns, I think, are more difficult to deal with because you want to give them the leeway. You don't want to be nasty about telling them, "that's the wrong thing to do, back up, let's think about this." Most of them are willing to listen to what you have to say. There's always an occasional one that comes along and doesn't want to hear it. "This is what the book said and that's the way it goes."

This nurse also implies that telling someone that they are wrong is inappropriate because it contains elements of being blunt and superior. Because they are learners, it is
not seen as acceptable to treat new physicians that way. This nurse sees that interns are more difficult to deal with because the nurse has to think more about her approach, so as not to be overly judgmental of them. She doesn't want to tell them they are wrong, but needs to find a way to correct them. Listening to what she has to say eases this dilemma for her. The occasional one who claims status to superior physician book knowledge and insists on his or her decision, makes it more difficult for the nurse to avoid being critical. But insisting that the physician listen to the nurse violates a second element of equality, recognition of one another's knowledge, as shown in the following selection.

Nurse #6: I try to get along with all of them. I don't go up to a young resident and say, "Look, I've got eighteen years of experience, listen to me," because I respect them as a physician. I will treat a medical student the same way. I respect the position that they're in. But I expect the same type of respect back.

This nurse is using the word listen in the do-as-I-tell-you sense. She sees her years of experience as providing a basis of knowledge which she sees as giving her more knowledge than the young resident, but she avoids expressing that superiority by not being overly directive with the new physicians as a way of getting along. She views the avoidance of superiority as an element of respect that she would extend to even the lowest status and least knowledgable physician. To be superior is disrespectful,
but she expects that the norm will be reciprocated by the physician, in that her knowledge will also be respected, as shown in the following.

Nurse #6: For instance, if I call them up to report that the CVP is one, I know that the patient needs fluid. But when they come up and you'll say to them, "the CVP is 1, what do you want to do about it," and they go into this big long dissertation about, "well, it should be at this level and therefore, we're going to give them fluids." I'm calling because I recognize that, that a CVP of 1 is not right. I don't need to get a whole explanation ... So I guess sometimes I resent that there's not enough respect for the knowledge base that a nurse that works in the ... critical care nurse has to have.

This nurse is describing the response she expects to her respectful approach to the physician. A response which gives her information about normal parameters does not recognize her knowledge base. She sees this as condescending, as treating her as though she has inferior knowledge, which sparks resentment on her part. Her expectation is that both she and the physician act in ways which show their respect for one another's knowledge base.

A third element of equality in getting along is authority, as shown in the following.

Nurse #2: I got mad at one of them last week as a matter of fact, because I was in charge and being in charge you have to regulate who is coming in and out so you know how many beds you have, and I heard that we were getting a patient, and I walked around the corner and I missed the first half of the conversation. I said, "can you tell me why this patient is coming in, I need a diagnosis." One of the doctors turned around to me and said, "because I said so," and walked away from me. I just stood there fuming for a little while when the intern
Interv: said, "that was very inappropriate, do you want me to hit him for you?" It was straightened out. I told him it was uncalled for, to be rude.

Interv: You said that to the doctor who told you "because I said so?"

Nurse #2: Yes, because it was and he apologized and tried to explain to me why the patient was coming in.

Interv: Is that normal or routine for someone to call it and say that that was inappropriate?

Nurse #2: Yes, most of the nurses will yell right back at them. The majority of the nurses out there yell right back, but most of the doctors are good and you don't get that too often, but when you do they really get you mad. There is no need for that. Most of them are pretty good.

For this participant, the physician's response to her question by reference to his superior authority was rude. The response did not recognize her legitimate need to know but classed her as an inferior who did not need to know reasons, only orders. Her response was internally oriented, she fumed. She saw that her evaluation of the physician's comment was supported by another physician, who offered to intervene. The intervention was offered in a manner which disavowed the physician's superior status. The physician reciprocated with getting along by apologizing. She viewed this situation as infrequent, and labelled most of the physicians as good for not engaging in that type of behavior. She indicates that most of the nurses will not tolerate being treated in a superior manner, but will respond to rudeness with a quick or sharp answer, not literal yelling.
Another participant expands on the theme of courtesy, as an aspect of getting along.

Interv: So what your saying then is that when we treat you with respect you tend to be helpful?

Nurse #1: Sure. It's like anyone else. If you call down to have the angio booked and for instance, could you squeeze me in, it's just like if everyone is helpful things run a lot better, if you could squeeze me in then I'll make sure I'm down there on time, out on time, it's for anyone that you would do it for. I think that's the way it works for the most part. There have been people who come in, that haven't gotten along and it's been no fault of ours. We try and give you the benefit of the doubt, for the most part, most of us do and all we ask is that you treat us with respect and we will do the same for you. Obviously there are exceptions to every rule. There are some people who no matter what, won't cut anyone any slack...

For this nurse, getting along means respectful consideration and simple courtesy. She sees this consideration as the norm of behavior, and expects reciprocal consideration in return. Respectful consideration results in things running better. Those who don't reciprocate are seen as not getting along. They are viewed as the exceptions to the normative rule, but are still extended considerate behavior as the benefit of the doubt. She continues on to explain her view of behavior which is the opposite of getting along.

Nurse #1: They're nurses who are just burned out and need to be, and again, any job or whatever, that no matter what, if the resident doesn't know what to do, well they just think they're horrible. You have to cut them slack, so he has to call somebody. The same things with the residents. They're just people who want more than you can possibly give in the time span that they want it. These things are one person. I can't do all this and do this too at the same time. They're just unreasonable about
those kinds of things. It tends to work like that, but as I said, hopefully they are exceptions to that rule...We are very busy. It's a very busy unit and you can't expect the residents to act like the attendings because they're not. They don't know everything, neither do you.

Getting along, for this participant, also includes not expecting more of individuals than they can give and not thinking poorly of them when they don't meet those expectations. Nurses have limits on their time; residents have limits on their knowledge. Not cutting any slack means being unreasonable about expectations, which can apply to either nurses or physicians. Again, she sees individuals who fall into this category as exceptions. She continues on to explain why she thinks people behave unreasonably.

Nurse #1: I don't know. It could be a lot of things. It could be too many things. For the physicians, it could be they're burned out, that they're stressful, it could be lack of respect for other people and particularly I suppose it could be nurses. For nurses, it could be that they're burned out, that they're stressed out.

She sees burn out, stress and lack of respect for others as causes of not getting along. She explains how stress can influence getting along.

Nurse #1: I think what happens is that you know they have that kind of acuity, small things seem to set them off or things that maybe wouldn't bother them like something stupid like your husband called and they were in an accident but it was a small accident, whatever, just something very small, it could set them off and ruin their whole day, get them totally irritated at the rest of the world. There's that same stress for the nurses. you have a patient who is very ill, say you have to do a CT scan, the CT scan is down one floor and in a relatively isolated part of the hospital. Well, if you have a patient who is on high oxygenation
type thing it's kind of scary traveling by yourself, you have that total responsibility. Granted you can get to a phone to call someone, but that takes time. At this point, you're with the patient, you're in charge of the patient, the patient codes you run the code because you're by yourself. That tends to put a lot of pressure on people. It tends to make them a little more irritable than normal. Some people can handle it better than others. It all depends on how comfortable you are obviously, and how long you've been doing it, but once again, it's usually young people like the physicians and they're in their twenties and the nurses, they're in their thirties but still, you're still responsible for human life. Not even thinking of the suit issue, no one wants that person to die on them. No one wants to not do something that they could have done to help someone live. Just the normal everyday stress.

This nurse is saying that the direct responsibility for human life, that nurses and physicians in critical care experience every day, is stressful. It can make people irritable, particularly if they are young and have little experience dealing with the stress. For this nurse, getting along means coping with this stress so as not to allow one's irritation to cause one to become inconsiderate of others.

The next example expands the reasons for not getting along and points out again nurse's views of acceptable ways of interacting in regard to the equality issue.

Nurse #2: There's a lot of different personalities. Some nurses look for trouble because that's just the way they are. They'll nit pick at everything that the doctor says. I'm not one of those that would do that. I'm not one of those that would say, "Oh, no; no that isn't quite right." You know, nit pick at everything or come at them in an argumentative way. If the doctor comes to me in an argumentative way, then I'll be on the defensive. Same with if the nurse comes barreling up to the doctor, "I want you to do this and that." Well, all the doctor will do is turn
around with a sharp answer and it looks like he's the jerk. Where a lot of the times the nurse is being inappropriate. So they might say that this doctor is a complete jerk where nobody else in the unit had any problems with him. It's just a personality clash.

Interv: What do you think is going on with those personalities?

Nurse #2: I don't know, but a lot of them come on kind of tough on the doctors. I don't think there's need for that. I mean, they're interns and residents that are learning too. They think because they've been here for ten or fifteen years, they think that they know exactly what to do and they know what's right and this is it.

This participant sees that being argumentative and disagreeing with the physician over little things as nit picking. She sees it as inappropriate for nurses to use their superior experience as a reason to be tough on the doctors, because the physicians are in the process of learning. She also views it as inappropriate to initially confront someone in an argumentative fashion. She sees these actions as a function of the nurse's personality. It is acceptable in her opinion to give a sharp answer or to be on the defensive if confronted with inappropriate behavior, and sometimes physicians are blamed wrongly when they respond to what she sees as provocation.

In the next example, the participant provides some insight into the view of argumentative behavior as provocative and another understanding of what nurses view as a benefit of getting along.

Nurse #4: It's how people say it. "I think you made a mistake." "I think you need to order this and not this." It's just easier and more, I find if you
relate nicely to people, they'll relate nicely to you. If you just say, "well, why do you want to do this," and if they can give you a good answer.

For this participant, how people say things is an aspect of relating. It is important to her that she relate this way because she holds that the phrasing of her comments influences the type of response she gets back. She implements this general assumption in her interactions with physicians as a means of correcting them. Another participant expresses a similar view.

Nurse #5: If you respect the people around you, everybody is going to respect you too.

This participant's general assumption is of a reciprocal nature. She sees that her respectful treatment of others will result in similar behavior in return. The converse of this dynamic might be that those who do not treat others with respect are likely to not receive respectful treatment in return. Therefore, an underlying dynamic of getting along may be a belief that initial behavior conditions or determines the subsequent behavior.

In the next selection, the participant articulates another element in the getting along philosophy.

Nurse #1: There's always going to be a few people who you're not going to get along with, that's anywhere. I just treat everyone else with respect. Treat them again the way you want to be treated.

This participant uses a standard of respectful treatment as the basis of getting along. Her reason for prescribing such treatment of others is her philosophical
assumption embodying the golden rule. Respectful treatment is important because it establishes the framework for how she wants others to treat her. She views the occasional person with whom she will not get along as an accepted fact of life and not at all unusual.

The next selection shows that getting along is related to being agreeable.

Nurse #2: ...You have to work together. You have your two patients, they have the whole unit but they have to deal with each individual nurse. Some nurses do have strong personalities, which they might have a slight personality clash, but I pretty much get along with all the doctors. I try to be agreeable.

This participant also defines her relationship with physicians in getting along terms. She sees being agreeable as an element in getting along, which is important because physicians and nurses have individual dealings with one another in terms of patient responsibilities. Having a slight personality clash due to a strong personality is the opposite of getting along.

Further definition of getting along is provided through contrasting accounts of not getting along, which is usually seen as a result of personality.

Nurse #7: It's just their personalities. I don't know what you call it, those you can forget about, but others that weren't as friendly.

Friendliness for this nurse, is an important factor in the relationship. She views personality differences as a reason for unfriendliness.
Other participants explain how personality can effect getting along. In this next example, the participant is explaining the advice she would give to a nurse replacement.

Nurse #2: On the whole, I would tell them that most of the doctors are very nice and easy to get along with on both the social and professional level. That you do have to feel out each doctor individually.

Interv: How do you mean, feel out?

Nurse #2: Work with them for a number of days. If you've been with them for twelve hours a day for a while, you can get a pretty good feeling of what they're like. How they're going to be if a problem does arise. You can usually tell by that. On the whole, as long as she's doing her job, that usually they're fine and are easily approachable. There's some individual doctors that will give you problems and she'll find that out. Only a few.

Every time they come back to the unit we say, "Oh, no," and we say, "it's only a month."

Interv: They're only here for a month at a time?

Nurse #2: A month at a time. If you can make it through the month with that one doctor that you don't like, or there might be a personality clash, that happens everywhere, just make it through the month.

This nurse sees getting along as having both social and professional components. The professional level involves the nurse's view of how physicians resolve patient related problems. The social level involves the physician's approachability, which is contingent on the nurse's professional competence. Getting along involves getting to know each physician individually, which will occur because of the close contact nurses have with physicians. It includes liking the physician, which may not occur because of a personality clash. Her advice in dealing with the personality clash and not getting along is to wait it out till the physician leaves.
The next selection shows that getting along is related to personal affiliation. She is discussing how she prioritizes physicians and patients.

Nurse #6: I think I'm rambling here.
Interv: It says to me you have a system of priorities and team work with the physician is not the priority, the care to the patient is the priority.
Nurse #6: Oh, it is. Within a team framework. I want to do it within a team framework. That has always been my goal to be within a team framework. But if you asked me what's more important, every resident in here like me personally, and respect me, or that my patients get safe care, then that's obviously the most important thing. You couldn't go to work day in and day out if you didn't get along with the people that you worked with in your team. That would be hell on earth. I make every effort to get along with people. If you asked most of the residents that have worked with me a lot of them have always enjoyed me. I'll have the senior residents bringing the juniors up and introducing me to them because I'm known to be like a little mother, and take them around, and this and that. But there are still the ones that have that attitude, "I'm the doctor."

Getting along, for this participant, is secondary to patient safety, but is still very important. Getting along results in personal affiliation, that is, liking, enjoyment, and respect and is a critical aspect of teamwork, without which she would find working unendurable. Her efforts to get along include what she sees as mothering, taking residents around. She views physicians with an I-am-the-doctor-attitude as not fitting into her getting along scheme, implying that the attitude also prevents the development of a personal relationship.
Nurse's beliefs around giving positive feedback emphasize this personal aspect of getting along. The participant in the following example was speaking about physician's respect.

Nurse #7: They'll make a comment like, "you're one of our better ones, getting them off the machine." Things like that. Just enough to let you know they have respect for you for some of the things that we do. And I also let them know, if I thought they intervened appropriately or anything in a situation. I'll tell them, you know, I appreciated something you did, or I saw or whatever. We try to be a happy family.

For this participant, giving positive feedback is a way of conveying respect and appreciation. She uses a family framework as a way to explain the rationale for the mutual exchange of positive feedback, in which such feedback is an aspect of being family.

Another example portrays a participant's feelings when such positive feedback is not given directly.

Nurse #6: Frequently at the high level of physicians, I'm talking at the attending level, they're not as apt to come and say, "good job, I think you're a great nurse, you did great care with that patient." It will get filtered down to you through a resident. I've had more, in all the years that I've been here, I've had more residents come to me and say, "Dr. James said if you want to know about head trauma, ask Heather." Or I've had my head nurse come to me and say, "Dr. Matthews said you did a superb job with that family." Come to me. It would mean far more to me than money...But to me, there are other issues that are much more important than that and one of them would be to have a good working relationship with these physicians. To be part of a team.
This participant experiences different approaches to giving positive feedback by residents and attendings. She sees giving positive feedback as a way of expressing respect and appreciation. She emphasized the idea that, for her, being part of a team means giving positive feedback directly, which contributes to working well together. Having a good working relationship is very valuable to her. She believes that positive feedback is more meaningful when delivered directly. She continues on to explain why she considers direct feedback a part of teamwork.

Nurse #6: If you're going to come after me if I screwed up, then come after me when you think I did a good job too. Because I'm a human being. I need positive feedback...I've known that man for ... years and anything positive which he has ever said about me, which there have been many things in the last ... years, was filtered to me through someone else... It's one of the most disillusioning things in my almost eighteen years as a nurse, is that people in general, who are in the business...of taking care of other people are frequently the most inconsiderate of each other. I could cry thinking about it but I can't. To me it's one of the most disillusioning things. It always has been. You know, my nurse manager will say, "choose your battles." You can't make people care.

This participant sees fairness as the minimum standard to guide team member behavior. However, she believes that after a lengthy association, the nurse-physician relationship should be more personal, that the physician should care about her as a human being with human needs for positive feedback. For her, indirect feedback violates this expectation. She labels it as inconsiderate, and finds it
hurtful. She bases her prescription for direct feedback in the framework of this more personal relationship.

Other participants discussed prescriptions for getting along in terms of helpfulness.

Nurse #1: For instance, usually in our ICU if a patient is a thirty-eight five [centigrade temperature], we will automatically culture them. Instead of waking someone up in the middle of the night and asking them, say should we run a culture to this person, which you probably think they're going to say yes, you just do it. It's ridiculous to wake someone up in the middle of the night to ask them a question like that. Just little things. I mean, it's not like we can make a whole rotation a lot easier. We can't take away patients, we can't do their paper work, but there are little things that obviously we can do to help out. Make things go a little smoother, a little bit easier. So I think for the most part the middle relationship between the residents and the nurses is OK as long as everyone understands each other. I suppose it just comes down to a basic human mutual respect that everyone should have, like for the guy working at McDonalds.

This participant views not waking the physician for something she knows needs to happen as part of the respectful consideration that is her framework for getting along. One does these things because and when one can. She frames these behaviors as helping out. Helping out is not an extraordinary endeavor. For her, it is simply an expected part of getting along, that one would extend to any individual. Not being helpful, then, violates her expectation of basic human mutual respect. One aspect of the nurse-physician relationship that is emphasized by this nurse, is the physician's recognition and understanding of nurse's intention of helping out, when the nurse
independently implements an action without consulting with the physician. If this nurse didn't act independently, she would be violating her own standard of basic respect. As long as the nurse and physician understand each other, the relationship is evaluated as OK.

One of the outcomes of getting along has to do with the resolution of disagreements.

Nurse #2: We have two people that are very hard to get along with that cause a lot of problems in the unit. It's like nobody to turn to. At least if there is somebody able to respect you, they're good and they know what they're doing, you always go to that one person. You might call the fellow or you might call the attending... at least there's somebody else that will listen to you. If it was just the intern and the resident and that's it, then you would have no place to go. there's always a chain of people we can go to.

For this participant, physicians who are hard to get along with do not listen to or respect the nurse, and do not know what they're doing. This participant sees that one of the major problems caused by physicians who are hard to get along with is that this physician cannot be relied upon when the nurse needs help. The nurse must then access the physician chain of command for that assistance. Without that chain of command, she believes that she would have no recourse. Another selection portrays a similar benefit.

Interv: So how does that make a difference? Having cordial relationships with the attendings?
Nurse #8: Well, it smooths things out a lot. I just makes it easier to get your work done if your relationship is cordial. It also gives you another avenue of approach if you do get to a point where you're butting heads with someone over
patient care. It's not something I like to do, but you can go over the resident's head and talk directly to the attendings if you need to. If you have won their respect, you can get places with them.

For this participant, having cordial relationships with the attendings includes having won their respect. She expresses a dislike for going above the resident to a more senior physician, but does so when necessary. Having a cordial relationship with the attending, wherein she is respected, is viewed by this participant as giving her a higher measure of influence with the attending in those situations.

In summary, the nurses see getting along as an important element of a collaborative relationship. The participants believe that getting along means relationship-oriented behavior that both physicians and nurses engage in. It includes being pleasant, polite, friendly, helpful, respectful, courteous and non-superior. Getting along norms circumscribe verbal behavior in regard to mistake-making, initial approach, expectations of other's capacity to perform, positive feedback and dealing with those less experienced and knowledgable. Nurses engage in getting along in order to influence the responding behavior of others and to establish a frame of reference for the type of behavior they prefer from others. The metaphor of getting along also includes the more personal aspects of the nurse-physician relationship. The participants view the personal
and professional aspects of getting along as on a continuum: a minimal level of professional getting along is necessary for teamwork; a fuller vision of personal getting along involves family-like and close-personal relationships as an underlying standard. The nurses view those not getting along as manifestating a personality problem or as the result of stress. Getting along results in smoother relations and eases the path of the nurse if she is required to go above the physician to one higher in the medical chain of command. This issue will be explored further in the next section on going above.

**Going Above**

Going above is a phrase frequently used by the participants to describe how they deal with conflict with physicians. This section explores the participants' perceptions of the meaning of conflict, types of unresolved conflict, causes of unresolved conflict and nurse's conflict strategies.

Most nurses viewed conflict as an infrequent event in their relationships with physicians. They distinguish between conflict and disagreements, the latter of which is seen as normal and is resolved through normal team functioning.
Interv: What do you see as conflict?
Nurse #4: Like a discussion. Like a, "I don't agree with doing it this way." I think, like I said, here it's like your opinion counts which is nice. There are some conflicts here, but I think the physician really has the bottom line and they're the one's that write the order. I don't write the order. He can't make me do something I don't want to do and really don't believe in doing it. They can't force me to do it. I don't think there is really a lot of conflict. I think it's more like negotiating.

Interv: So in a context of team, like you have here, you see conflict as disagreements, then people have a discussion?
Nurse #4: We have a lot of input and everyone comes to one decision.

Interv: So you're usually happy with whatever the outcome is, the decision is. Has there ever been a time where you haven't been?
Nurse #4: Not that I can think of.

In this nurse's view, conflict involves a nurse's disagreement with the proposed plan of care. She sees that the nurses have influence through the importance placed on the nurses' opinion, which usually results in a single decision. Unresolved conflict, when it does occur, usually involves the physician's order. This participant views the physician's order as ultimately belonging to the physician. However, she believes that if she were ever to continue to disagree with the order, the physician does not have the power or authority to force her to comply.

Another participant defines team by the peaceful negotiation of disagreements.

Interv: How does that teamwork work. What do you mean by that?
Nurse #5: A lot of collaborative effort. If there's a problem, they're willing to sit down and talk to
you about it, and we're willing to sit down and talk to them about it and hear each other out. That type of thing.

Interv: And that's important?
Nurse #5: Very important.
Interv: How come?
Nurse #5: Well, we can come to a decision everybody is comfortable with and after you brainstorm a problem, everyone is learning something from it. I think that's the most important part of it. We're all learning from it. The patient gets the advantage of having a lot of input from everybody.

For this participant, the very essence of collaboration and teamwork is the discussion of problems, each party talking about it and listening to the other party's issues. For her, the result is learning and a better solution for the patient.

Conflict, or disagreements which are not resolved through normal team functioning, are a source of discomfort for the participants.

Nurse #5: I don't like conflict. I'm not comfortable with it. I avoid it and I obviously created a lot of conflict that night when I refused to do what they asked me to do because I thought it was wrong and I don't want to be in that position. I'm not here to make the decisions. I'm here to carry them out.
Interv: But you obviously had something to say about that decision though.
Nurse #5: Yes.

For this participant, conflict is a disagreement which is not resolved through normal team functioning. She expresses an aversion to that type of conflict. She prefers that physicians make the correct decision so that she is not placed in a position of having to refuse to do what the physician asks because she believes it is wrong. In her
opinion, the refusal created an uncomfortable situation which she would prefer to avoid. However, due to reasons which will be explored later in this section, the nurse does not actually avoid the conflict.

The following example frames the meaning of conflict to the participants.

Nurse #8: I really don't like conflict. It's just so uncomfortable to me. I would just like everyone to get along. It's nerve racking for me. I won't avoid it at all costs. I certainly won't avoid it at all costs. Although I truly hate it.

For this participant, conflict which is not resolved through normal team functioning is the opposite of getting along, which is of great importance to the participants. It symbolizes the failure of team functioning, wherein disagreements are resolved to everyone's satisfaction. She voices the nurses' common aversion to this type of conflict, but also a resolve to pursue it. The reasons for this resolve will be explored next.

When conflict does occur, nurses clearly distinguish between different general types and causes of conflict. Their view of the type and cause of conflict influences their thoughts on the methods that are most appropriate to deal with the conflict.

Nurse #2: On the whole we have pretty much the same basic knowledge. So if one of the nurses isn't getting along with the doctor over technical things on what should be done with the patient, we all pretty much have the same, in what we do in the unit, protocol, that we'll back her up and say "no, this is not what we do around here." It's not right. Sometimes you might have to go to a
doctor if there's a problem between a doctor and a nurse, straighten that out. If there's a patient coming in, something like that. Personal stuff, if it's personal between a doctor and a nurse, they just have a personality clash, that that's between them. But on technical stuff, we all back each other up.

This participant distinguishes between two types of conflict: the first type having to do with the technical aspects of patient care and the second type having to do with personal issues, which she sees as caused by a personality clash. In the former case, other nurses intervene with the physician to help resolve the disagreement. In the latter case, which does not affect patient care, the issue is left up to the individual physician and nurse to deal with. In the next selection the participant is recounting the advice she would give to a nurse replacement.

Nurse #1: I would just remind her to cut people slack. If you treat someone you don't even know, don't make a quick judgment. People have other things going on in their lives that you don't know about. I usually give a person one more chance. Just a couple. Usually I give them more than one chance. You just treat people with respect, if he doesn't return for you the respect after one or two times, then that's different. You just try to get along the best you can if for some reason you don't get along...

Interv: You can always?
Nurse #1: I guess it depends whether it was a real patient care issue or not. If it's a patient care issue, I would talk to the attending and say, "listen, this guy is a jerk, he doesn't know what he's doing" or something. If it was just a personality conflict, there's nothing you can do to change someone's personality. I would just go with the flow and ignore their behavior.
This nurse's advice is to avoid being judgmental, give people several opportunities before judging them. If after several attempts at getting along, the physician continues to be disrespectful, she views it as a personality conflict. She defines personality conflict as consistently violating the getting along norms caused by an enduring personality trait. In her view, cause of the conflict and the type of conflict are intermingled. She distinguishes therefore between conflict in regard to patient care issues and conflict in regard to persistent violations of the getting along norms. She does not see personality issues as impacting on patient-related issues. If a patient-related issue was responsible for a disagreement, she advises going to the attending to deal with it. She advises ignoring personality issues, because they are not open to change.

The next participant is discussing how and why she makes a similar distinction in regard to dealing with other nurses.

Nurse #6: If it in any way involves the health and well being of the patient, I will confront it. But if it's a personal thing about me, I'll internalize it. I'll keep it inside...I'm here to take care of these patients, and I'd rather internally be hurt or pissed off and take it out on myself than to risk someday I'm going to need help with a patient. They're not going to want to help me.

This nurse focuses on the nature of the issue and sees a difference between patient-related types of issues and personal types of issues, without regard to cause. She sees that confronting an issue poses a risk to future help with
patient related needs. The only thing that justifies risking that future help is a present risk to a patient. Therefore, she doesn't confront others over personal issues, but internalizes the emotion. In another selection, she illustrates another reason the participants expressed for their sentiments about dealing with personal or personality conflict.

Nurse #6: If there is a personality conflict, you have to rise above it. In my seventeen years here at the medical center, there's very few people I would invite to my home for tea, but there are many that I can work with on behalf of the patient.

She views the working relationship she has with individuals as different from, and more important than, the personal friendship relationship. She believes that to establish that working relationship, one must rise above the personality conflict. By rising above the conflict, she means that the effects of the personality conflict must be internalized to prevent a risk to the working relationship, which is necessary to provide patient care. The next example portrays another participant's view of personality conflict.

Interv: So how do you feel when they respond to you, "well I'm the doctor?" How do you feel about that?
Nurse #4: I'm pretty down to earth. I really kind of understand. Most of them will do it once or twice and then they'll realize that we really do want to know why. I'm used to it. I've been here for a long time. I've seen a lot of them come in their first year as intern. You just watch them grow. It's amazing. It's like after three years, they're just different people. Some of them get very close to you...Initially when they came, it's hard. It's because it's a medical center. You
can watch them. If you've been here and you do, you watch them grow and it's amazing. Little boys into men. It is, some of them look like little kids and after three or four years. It doesn't really bother me. They don't offend me or anything...It's part of their insecurity.

This participant viewed the physician's personality issue causing the I-am-the-doctor-attitude as being based on insecurity. She understands their insecurity and does not take offense because her experience has been that they will grow out of their insecurity once they realize the nurse is not challenging them. Another participant discusses the emotional impact of personality conflict.

Nurse #3: A personality thing most of the time. Usually it's a lack of communication...The personality might be that the person has developed an attitude...When I say attitude, I'm kind of using it like the slang meaning of like developed cockiness, which I think is basically they're not receptive. They're not listening. They're not effectively communicating and it's the basis for them being cocky or whatever. They're not listening and I think that that creates the conflict problem. When somebody has an attitude and they're not receptive, that tends to raise anxiety with whoever is trying to communicate with them and that develops into the conflict. Whoever has the attitude, the other person then gets defensive and then doesn't want to communicate anymore.

For this participant, personality becomes a problem because it interferes with communication. She sees that when a person has a superior attitude, they are not listening to information being conveyed by another. This raises the anxiety level and defensiveness of the other, resulting in conflict. She sees this type of conflict as
disrupting the routine team functioning, but not having
direct impact on patient care. She continues on to describe
her method of dealing with conflict.

Nurse #3: Actually when I see conflict, I try to resolve it
and then just get on with things. I don't hold it
in my memory.

Interv: How come?

Nurse #3: There's other important things that you need to
remember. You don't need to remember those
things. You resolve it, get on with life. Get on
with the patient care, team care.

Interv: And what happens if you don't forget about it?

Nurse #3: Usually there's a reason. Usually it's unresolved
and there are times that you try to resolve things
and there is just no resolution to it and people
go on. The doctors, if there's a conflict with
the doctor and the doctor has the problem, the
doctors are only here for six weeks and you might
in the six weeks not resolve that conflict, even
though you've attempted to communicate and do all
the right things. Make him part of the team, and
communicate with the team, and do all those things
that you've learned to resolve conflict.

The methods this nurse uses when attempting to resolve
a personality conflict are geared toward communicating and
making the physician part of the team. The emphasis here is
on resolving the conflict with the physician, on building
the relationship with physician wherein they can work
together. If unresolvable, she sees this type of conflict
as unmemorable and tries to forget it.

A very different picture emerges when nurses view
conflict in terms of serious threat to patients.

Nurse #6: And I generally go a long way into giving the
benefit of the doubt. But when it comes to the
well being of the patient, Ms. Collegial has to go
out the window.
This participant sees going above to a higher medical authority as the opposite of the collegial relationship. She will engage in going up the ladder if the issue involves a life threat to the patient. She does not go to the senior resident if she has a non-serious disagreement with the physician. She prioritizes the situation, and if she is certain that it is serious and requires immediate action, will go above. The next example illustrates another method of dealing with serious patient threat.

This participant also views going above as crossing the physician, which is made easy for her because she believes she will get the support of the higher physician. In
dealing with a life threatening situation, she recounts that she either goes above the resident or deals with the situation herself and informs the physician later. She frames this type of conflict as an infrequent experience.

Another participant provides an example of a different method in dealing with serious patient threat and emphasizes a second element in the nurse's decision to act.

Nurse #8: I tell them right out front. If I think something is a blatant experience, they just made a miscalculation or an error, I always say, "are you aware that you ordered X amount of milligrams of a drug to this patient who weighs 5 kilos?" So usually at that point the person will say, "Oh, silly me." In general it's just a slap of the paddle or whatever. If someone really wants to do something that is blatantly unsafe, I refuse. I just tell them straight out, "I think this is unsafe and it's really an unwise course of action and I won't be doing it."

Interv: And then what happens?
Nurse #8: Well, usually, I've never had a problem. I've never gotten into a real situation where a person has just totally insisted on that position. In general, they'll call an attending physician. And I wouldn't stand up like that unless I was quite sure I was right.

This participant points out what she perceives to be an error, which is usually corrected at that point. If the physician insists, and if the situation is clearly unsafe for the patient, she refuses directly. She sees refusal as standing up. She viewed being sure that the situation was unsafe as an important issue in her decision to refuse. She indicates that if she were not sure, she would not stand up.
Another example highlights the issue of certainty in the nurse's decision. She is discussing conflict between nurses and physicians.

Nurse #2: There's some of that. There's definitely some of that. A lot of times, the nurse wins. There's usually a strong reason why they don't want to follow that doctor's order and it usually comes from years of experience in the unit. It usually comes from knowing the patient. Whereas the doctor will come in not knowing the patient. First day on and will come up with "let's try this." They've tried it before or they haven't tried it before, but we know it won't work. Different things like that. The nurse usually wins.

This nurse sees the cause of conflict as a physician's order that the nurse has a strong reason for not following. By strong reason, she means that the nurse clearly knows that the order is wrong. She views the usual pattern of nurse's winning as support that the nurse's reason was correct. She views the basis for the nurse's strength as the knowledge gained from the nurse's years of experience in the critical care unit and the nurse's contact with the patient.

The next selection may provide some insight into the role played by certainty in making this decision. She is discussing events which are stressful.

Nurse #1: These tend to play a very important role in what goes on, whether it's a floor nurse who doesn't realize that a K of four six [4.6] isn't something that you need to call about considering four five [4.5] is what we consider normal. What happens is they get all irritated because they have to answer the page, wait for the person and say "Hi, so and so's K is four six." "Well,
that's fine." I think myself, I would be irritated if someone called me with something like that. So I think it's their stress level, their anxiety level.

Interv: You mean the nurse?
Nurse #1: Both. Whether she see's something big and they say no. One person gets irritated at the other person, but then a lot of the times, I think it works both ways at this point, it's kind of difficult to word. There are nurses who are not very intelligent, or doctors who are not very intelligent, it goes both ways, and when you have a physician come up to you to give you a foolish order, it's just I think it's the same as a nurse who calls you with something foolish or wants something foolish because they don't know any better, or because they're not thinking or whatever the case may be. But that definitely works both ways, when you say, "well, why are you telling me, or why are you calling to ask me this when it's very obvious, that type of thing, it works both ways. I think when people say doctors think nurses are stupid, well, it's not that those are all nurses, the doctors think they're...-well, it just goes both ways.

This participant believes that it is reasonable to be irritated when someone, through lack of knowledge or not thinking, contacts another about something that is normal, or wants something that is not appropriate. She refers to these mistakes as foolish, and people who make them as being labelled stupid. Certainty may be an issue in the nurse's decision to confront a physician because of a desire to avoid being seen and labelled in this manner. Another selection may provide additional insight into the relationship between certainty of knowledge and conflict. The participant is discussing the relationship between conflict and collaboration.
Nurse #8: I think that there's a lot of, oh, you know, historical and power base things, constructs that make it difficult for nurses to collaborate in patient care. So sometimes in seeking out collaboration you just have to be willing to risk conflict. It's difficult I think for women in particular and it's difficult for nurses, conflict. I don't know, I think part of it is based in the educational system and your culturation as a nurse. I don't know how things are anymore either. I think that things are much better in university studies and that kind of thing, but when I was younger, I think, the power in relationships was just so unequal. You couldn't really dream of having real collaborative relationships. But now, I think it's a reality in some instances, it's just that you have to be willing to go out on a limb...And you have to really be willing to add something sometimes. Not just let things slide. It's easier to let things slide and to feel, "maybe I shouldn't suggest this that or the other thing." You have to be willing at some point to risk conflict. To say, "this is what I think we should be doing," even if someone else isn't going to agree with you. Be willing to defend your position...People will be willing to ask you your opinions if they know you have one...I think that sometimes they're reluctant for whatever reasons. Maybe it's a lack of knowledge, but I think more likely it's a lack of self respect. I think that you don't give yourself credit for what it is that you know. What it is you area of expertise is. I think that a lot of times nurses think, "Oh well, these guys are physicians, they know everything," rather than seeing that their areas of discipline are, they overlap, they're complementary, but there are a lot of things about taking care of people that they simply do not know. It's just not their discipline.

For this participant, conflict involves risking disagreement, going out on a limb by stating a position and defending it. She views conflict as difficult for women and particularly for nurses because of their socialization. She believes that nurse's may be reluctant to risk conflict with physicians because of historically unequal power
relationships, a belief that physicians know everything and a lack of realization that nurses can contribute knowledge that physician's do not possess. She thinks that this lack of realization of knowledge may be due to a real knowledge deficit but more likely is related to a lack of self-respect, wherein the nurse does not give herself credit for her own knowledge base. She believes that nurses who are uncertain of their knowledge are reluctant to risk conflict with physicians. In order to achieve a collaborative relationship, this participant believes that nurses need to master this reluctance to voice their opinions to physicians. Her view is that physicians are willing to listen if they know nurses have something to say. For her, stating a contrary opinion is collaborating.

The next example portrays the link between knowledge and certainty as central issues in the nurses decision to disagree with the physician. The participant is discussing reasons why nurses do not go above.

Nurse #6: There are people that won't, and there's also I think, nurses that don't have the clinical experience behind them and they may not want to discuss an issue with a resident. There may be a resident whose never had a nurse in his life come up to him and say this dose is too high or this dose is too low. But after a certain amount of time dealing with this, you know point one to point two of a certain medication per kilo is what they should get, and if they're ordering ten times what they should be getting, you are obligated to speak up for that patient. They can't speak up for themselves.
For this participant, lack of clinical experience is an acceptable and understandable reason for not confronting a physician. She sees that experience brings knowledge and knowledge brings certainty of what is right and what is wrong in terms of clinical treatment. She views the nurse as under an obligation to speak up for the patient once the nurse has enough knowledge to determine the appropriateness of treatment. This obligation is based on the patient's inability to speak up for themselves. She continues on to explain why this obligation exists for her.

Nurse #6: Why? My patients, well, I'm sure it's true of all patients, these are sick children. I'm here to take care of them. I'm here to advocate for them. That's why I'm here. That's why I went into nursing...I like being with the patients. And if somebody is perceived by me to be doing something that is not in the best interest of the patients, who is why I'm here to take care of, and that can sometimes be seen as confrontational even though they may not mean it as such. I don't know if this has anything to do with it, but I think sometimes the fact that I don't have any children of my own, I see all these patients as my kids. Not to the pathological point, but I just feel a lot of times I have to be more than just a nurse. I'm their advocate. We get a large population of kids that the parents aren't here and somebody has to be here to step in and stick up for these kids.

This participant sees patient advocacy as part of her role as a nurse. Patient advocacy to her means confronting those things she sees as not in the patient's best interest. She expresses that her intention when advocating for a patient may be read as confrontational, but that meaning is inaccurate. Her primary motivation is the best interest for
the patient, whom she views almost as family members. She reasons that her view of patients may be based on her own lack of children, but sees it as also based on the absence of other family members to serve the advocacy role. For her, speaking up is advocating. Another nurse explains her relationship to patients.

Nurse #4: That's why we're all here. We're all here for the patients. That's the bottom line...It's hard to say. Some of them I've known for many years. They keep coming back and it's like they're almost family. You just know them. I get close and attached.

In this nurse's view, patients are the fundamental cornerstone for her job. She views her relationship with patients as almost family-like, having close and warm feelings of attachment. Another example portrays this advocacy role.

Nurse #3: Usually you just try to be the patient advocate and just really, you know, even though you might have a personal problem approaching a physician, you do it because you're the advocate for the patient and you want to see the patient get appropriate treatment, at least what you might think is appropriate.

This nurse again interprets her role as patient advocacy. In her role as advocate, she sees her goal as achieving whatever she views as the appropriate treatment for the patient. Her obligation to advocate for appropriate treatment for patients includes overcoming hesitancy to approach a physician with whom she may be having a personal problem. Patient issues supersede personal difficulties in
importance. For her, approaching the physician is advocating. Another nurse expresses her role in terms of patient protection.

Nurse #8: I feel like I'm there to protect my patient, in any field I guess but particularly in pediatrics. It just becomes so obvious that you are your patients first line of defense, so that I feel like I'm kind of a gatekeeper in a way. That's my job. I'm just always watching out for that person's benefit and I don't mind standing up. I'm not a real stand up kind of person. I'm actually more or less meek and mild, but I'm ready to stand up to protect the kids.

This person interprets her nursing role as that of first line defender of the patient. She sees herself as the gatekeeper between the physician and the patient. In order to fulfill that role, she believes that she needs to rise above her own personal tendencies and be willing to confront physicians in order to protect patients. For her, confronting the physician is protecting.

Several of the participants discussed styles of engaging in conflict. In the next selection, the participant is describing her view of getting along.

Nurse #1: I'm a realist. I understand the way things run but if you just try, take a cleansing breath, try to let it roll off you back, I think it's a lot harder for you personally, don't vent your feelings because obviously that's not good for you it doesn't do anyone any good. If you yell at me, I will yell back at you. It doesn't get you anywhere.

This participant sees that things run better and easier if people try to control their feelings. She considers yelling to be an indication of loss of control, with
negative outcomes. Yelling only occasions reciprocal yelling. In the next example, the participant sees manner of interacting in a conflict as impractical for resolution.

Nurse #7: You find too in a big facility that if you start yelling at people, you won't survive... If you both look at each other as the enemy, you've got big conflict. We all need to work together, it's a common goal. If we're apart, it's much longer to get together. Sometimes you just bite your tongue. I think the way in which you communicate things to people. If I yell at the doctor, my manner has a lot to do with it... The way I express myself, or the way the doctor expresses himself to me makes a big difference on how well we're going to resolve a conflict or maintain a conflict.

This participant links yelling with non-survival in a big facility and as an indication that the other party is viewed as the enemy. She sees that the view of the other party as the enemy as contrary to working together toward a common goal. Yelling, to her, indicates a manner that will make resolving conflict more difficult. Another selection shows a professional norm regarding the manner of interacting in a conflict situation. She was discussing a situation where she regretted yelling at two physicians.

Interv: What would have been different had you been more diplomatic?
Nurse #5: I wouldn't have felt bad in the end about yelling and I was yelling. I don't yell. I can't remember a time where I ever got that upset with a doctor, never.

Interv: Did anything happen after the incident?
Nurse #5: One of them came back about a week later and apologized to me.

Interv: And he apologized to you?
Nurse #5: Yes, and I apologized to him and that was it. I've seen them both since and they always say "Hi," and everything so I don't think they hate me. But I did feel bad.
Interv: So losing your temper is something you don't like to do?
Nurse #5: No, we're supposed to be the professional here and cooperate with each other and it didn't happen that night for some reason.

For this nurse, yelling violates her sense of professionalism and cooperativeness. It is not her normal behavior. She saw her yelling as a measure of how upset she was with the physician and she was concerned about the impact on her relationship with the physician. She expressed relief that the relationship was not damaged. Her concern was not about the conflict itself, which is described below, but about the manner in which she conducted the conflict.

Letting go was a phrase often used by the participants to describe the issue over which they experienced the most conflict with physicians. The next selection describes the basis for this conflict.

Nurse #5: It gets to be a battleground. In here it does anyway, the bottom line is the physician is the one that writes the orders. There's a conflict if you don't agree with what they're saying or their treatments. I'll give you an example that just happened a couple of months ago. I had a lady who had been in here for a couple of weeks and she wasn't getting any better. She was getting worse. And finally, the family made her a DNR [do-not-resuscitate] but she was still intubated...Well, this lady had a seizure, with a blood pressure of 220 over 120 and a heart rate of 200. I called the doc about three in the morning and they wanted me to treat the blood pressure. That's not what I saw. I saw this woman who was obviously uncomfortable having a seizure and I refused to do it. I told them to call the attending because she didn't need her blood pressure treated, she needed the seizure treated. It was painful for her and I could see that. In the end, they decided they
would treat the seizure, but it took 15 minutes of watching this poor lady suffer before we could come to an agreement...She was at the end of her life and we all knew it, and I wanted her to be comfortable. I didn't want her to suffer and she was suffering.

This nurse frames this conflict as occurring because she disagreed loudly with the physician's plan of care. In this case, the nurse's concern was for the patient's comfort. The woman had been sick for a long time and was at the end of her life. This participant saw that treatment would not change that end. She did not agree with the physician's intention to bring the blood pressure under control, that is, to treat it. Because she saw treatment as futile, her concern was to alleviate the patient's suffering. This nurse's method of dealing with the conflict was to go above. For her, the patient's suffering was serious and she felt an urgency to achieve her goal quickly.

The next example characterizes this situation as common and adds definition to the issues.

Nurse #1: I think probably the biggest issue in my ICU tends to be no letting go...There's always that triple A they want to make, a good 92.

Interv: I'm not sure what that means.

Nurse #1: OK, a good 92 means to them that, I mean it's a huge surgery. A ruptured triple A is a huge surgery and they're all sort of complications that can go along with it. You're, you know, 50 or you know, whatever, and triple A's tend to do horribly, even when they're young. Someone who's 92 years old I think you should be allowed to be, given them the option to be, just run the whole gammut on them, it could be weeks and weeks in the ICU intubated and in a lot of respects, you know you're going her for scans and there for scans, because they're into real dialysis. Basically end up a vegetating, actually not a vegetating state,
but end unresponsive due to whatever. I think they have a hard time letting go. Talking to the families saying there's no more we can do for them. What we are doing now is just prolonging the inevitable.

This participant uses the phrase "a good 92" to symbolize a situation where she sees treatment as futile because of the age of the patient and where she views the usual outcomes as negative when older people undergo extensive surgical intervention. Her concern for the futility of the treatment is heightened by her evaluation of the way these patients experience their recovery period: she believes that they do horribly, she thinks that they suffer from being intubated for long periods of time and she holds that they are disturbed by many trips to other areas of the hospital for diagnostic scans. She believes that physicians find it difficult to refrain from further treatment and to let the patient die. She continues on to explain that nursing and medicine hold different perspectives on this issue.

Nurse #1: Because we're taking care of the patients and although it sounds horrible, we always feel like we're torturing them...I don't know what goes on inside their heads. Physician's are basically good people, I would obviously give them the benefit of the doubt. I don't think they do this to torture people. I really think that they think they could help these people, if they could save them as opposed to say let this person die with some dignity...I really think they do this because they think they can help them. I don't think they're doing it obviously just to torture them. I really think that they think that they'll pull through and do OK, but the reality is that they probably won't. We're not conveying anything like that, but what we're saying is we feel much
worse because we feel we are the people who are doing, for example, torturing these poor, poor people. Sometimes whether a person is to get a renal failure or something who is like in so much pain to do whatever, an open belly, or whatever, I mean, you can see it in their faces. When people have been intubated for weeks and then we end up tracking them, it's that type of thing and we feel very badly about it and we try and come and say, "do you know what we're doing to these people? You see them all nice and tucked in bed after we clean them up and you can look at their labs. We feel differently. We hate torturing these people." I just think they feel in their own mind they can help everybody. I think it's just their mentality.

This participant believes that physicians as group, have a different mentality because they do not witness the pain endured by patients. She holds that nurses see the pain and feel that what they are doing to the patient is torture because nurses are at the bedside and are responsible for implementing the treatment procedures. Because of the physician's distance from the patient, they focus on the goal of treatment, which is curative and helpful. Because of the nurse's proximity to the patient, nurses focus on the process aspects of treatment, which is painful and inevitably hopeless. Her method of dealing with this conflict involves discussion with physicians, focusing on attempts to convey this different perspective, and going above, as in shown in the next selection.

Nurse #1: We had a few incidents where after the person, we tend to get involved and voice our opinions as far as this person should be in a convalescent home and it's obviously their right to say it's my patient and why keep going. We've taken a couple of cases to the Ethics Committee afterwards and said this was just horrendous, and they don't make
any judgments, they just look at the case. That's basically all they do and say where things are to be done differently. They don't side with one person. I think that would cause a lot of friction, I mean, couldn't do that here. Side with one person and say yes, doctor is right, nurse is wrong; nurse is right, doctor is wrong. I don't think that would work anyway. It would cause great...

Interv: Like?
Nurse #1: Well, I think it would be an awful lot of resentment and as long as it's a learning experience for someone, I don't think it needs to be said, who went wrong. I just think if someone learned from it whether it was the physician or the nurse.

This nurse sees that nurses have a right to voice their opinions because of the nurse's relationship to patients. She believes that the outcome of the Ethics Committee's decision, framed in non-judgmental terms, will not disrupt the nurse-physician relationship, by causing friction and resentment. Siding with a physician or nurse, indicating rightness or wrongness, she sees as leading to such an outcome. Her goal is that the parties to this conflict learn. For her, conflict in perspective is an opportunity for a learning experience.

Another participant sees perspective on death as a major difference between nursing and medicine. She begins by speaking of medicine as a profession.

Nurse #8: I think it's a great endeavor. It's just a great profession. It's nothing I'm interested in. It's very, very different than what nursing is to me.
Interv: How would you describe your view of nursing.
Nurse #8: Well, I think that nursing, how would I say it, I guess I think that in nursing we try to provide care and comfort to people in various states of health and illness. One of the things that I've taken note of, particularly in the ICU, because
not all of our outcomes with our patients are positive, we send patients to the morgue. It happens, people die, and I think for the physicians that's a terrible defeat. Not that we haven't all struggled together. We all want the patient to survive, and get better and go on to have grandchildren. It just doesn't always happen. But I think it's an entirely different experience for the nurses who in the absence of any hope to the patient's recovery, have still been able to provide them with care and comfort. You know, provide them with a reasonable kind of death. It's always more of a defeat for the physicians when things don't work out.

Interv: How so?
Nurse #8: I guess just because their orientation is toward cure. Ours isn't. Ours is towards care. So really, it's not as goal oriented, the nursing. Whether the patient gets better or gets worse, is sicker today or tomorrow, that really wasn't the object of the game. It's have you been able to provide the patient with the care and comfort they need along their road which ever way it goes.

This participant believes that physicians and nurses experience death differently because of the orientation of the two professions. She believes that death means defeat for a physician, because the outcome of cure was not met. For a nurse, she believes that death is not the same type of defeat, as the profession's goal is focused on the process of care and the provision of comfort.

In the next example, the participant portrays the letting go conflict in terms of role and experience.

Nurse #3: Yes, and there are times when improvement is not in the cards. In that case, comfort. Sometimes people come in and they're terminal and we're not going to make them any healthier...Sometimes it's our position to help people be comfortable enough to die...Sometimes it's even helping the physicians cope with it. "It's OK to let the patient go." Some of the interns and residents especially are, that I've been in practice for ten years, they've only been in practice for one or
two, and probably one of their hardest things is seeing somebody die because here they've been educated to help everybody and make everybody better. Coming out of medical school they have all this knowledge and their goal is to see everyone go home and helping somebody die is very different for them and a lot of physicians are not comfortable in that role...So you kind of have to act like the advocate again, and be the intermediary between the family, the patient, and the doctor and make the doctor comfortable with his decision, make the family comfortable with their decision, and sometimes I've had to hold a physician's hand while unplugging the ventilator and reassuring them as well as the patient. It's something new to them and it's difficult for them. It goes against their human nature. It's not something that is easy to do and sometime I've had to give them support...If they have to disconnect the ventilator, that's probably the hardest thing that I've seen them have to do. Usually for the physician it feels like they're killing somebody...Disconnecting is removing lift support.

This participant believes that it is the nurse's role to provide comfort, to patients, families, and physicians, when there is no hope for a cure. She believes that young physicians are uncomfortable with death because of their inexperience and the emphasis in medical school on curing. She sees that death defeats the physician's goal of curing. Physicians need time and experience to adjust their perspective. She views her greater experience and her role as patient advocate as the reasons to act in this situation. Her support to the physician during this experience is based on her view of the cause of the physician's reluctance to let go, as shown in the following.
Nurse #3: If that makes them feel uncomfortable then the next time they have to go through it, they're not going to make the family feel comfortable. They're not going to make the patient feel comfortable...If you can help the physician feel more comfortable with that and be less anxious, and he doesn't project the anxiety, then hopefully in the future that's what will result from the situation and not be a negative situation. So in the future maybe he'll be a little more compassionate. I think it's just a learning thing and these situations are always so horrible for people.

This nurse sees the situation as one of anxiety produced by inexperience. She views the physician as being in the process of learning and provides support in that learning. Her goal is to increase the physician's comfort and compassion, thereby increasing the patient and family's comfort. She views the situation not as one of conflict, but as one of inexperience.

In summary, nurses view disagreements with physicians as a normal part of team functioning. Conflict, when it occurs, is a violation of getting along. The participants distinguish between two different types of conflict issues: personal and patient-related. Personal conflict is based in personality differences and results in nurse's internalizing the conflict, ignoring it or attempting to resolve it with the person directly. The second type of conflict issue seen by nurses is patient-related. Patient-related conflict is based in knowledge that the situation is a serious threat to the patient and results in the nurse confronting the physician and going above to a higher medical authority.
For the participants, this action of confronting or going above is based in their perception of their roles as patient advocates. It is therefore not only an acceptable behavior, but an obligatory one. The nurses saw it as important for both physicians and nurses to maintain a professional manner during the conduct of a conflict. A third type of issue was identified by the participants as the one over which they experienced the most conflict, expressed as letting go. This conflict was seen as being based in differing perspectives between medicine and nursing and resulted in nurses attempting to help the physicians learn more of the nursing perspective of caring.
CHAPTER 5

SUMMARY AND CONCLUSION

Introduction

The purposes of this chapter are to summarize the major patterns and themes in the participants perceptions of the meaning of the nurse-physician relationship, to discuss the relationship of the patterns and themes with the current literature on the nurse-physician relationship, and to explore the implications of the study. It will be divided into three sections: summary, discussion and implications, and conclusion.

Summary

This section summarizes the major themes and patterns in the participants perceptions of the meaning of the nurse-physician relationship in their intensive care unit setting. The major themes and patterns, and the relationships between them, are presented in Figure 3.

The metaphor used by the participants to describe the nurse-physician relationship was that of a team. Team was defined as members of different professions, working together on an equal basis in order to accomplish the same goal, effective patient care. The major components nurses viewed as important in accomplishing team were physicians
listening, physicians seeking out nurses' opinions, physicians placing high value on nurses' opinions, nurses participating in decision-making and nurses asking questions. This process is symbolized in Figure 3 with the open arrows. Nurses see their role on this team, in this relationship as equals to the physician in the planning and provision of care to patients.

Nurses see their involvement in the planning and provision of care to patients as important because they believe that the knowledge they possess will result in better decisions and better care for patients. Nurses see their knowledge as deriving primarily from extended patient contact, but also from technical/scientific information and from years of experience where they have increased their clinical skill. Nurses believe that they have more patient knowledge than physicians because of greater contact, that they have greater clinical skills than new physicians because of their longer clinical experience and that they have equal to or somewhat less technical/scientific knowledge than physicians due to the physician's longer school experience. Nurses believe that alone, physicians do not have adequate patient information, experience and clinical skill. To not involve nurses, by asking for, listening to and acting on nurses' knowledge, is jeopardizing patient care, because nurses' knowledge is then excluded from the order writing process, as is symbolized in
Respect is important for nurses because for them, respect is the recognition of the importance of the knowledge they possess. Through respect, nurses see that they are invited to contribute their knowledge and participate as equals in the process. They see the physician's role as writing the order, and their own role to add input, because of the physician's greater textbook knowledge and schooling. When nurses' input is sought, heard and acted upon, nurses feel equal despite the structural and formal inequalities of the nurse-physician relationship.

The inequality noted by the participants was the physician's ultimate authority to write the physicians order. A team or collegial relationship, in which nurses participate in the formation of that order and physicians are not held as higher or more important authorities, means to the participants that the physician is no longer the sole owner of that order, that the nurses' contribution makes a difference and that patient care is improved. In this type of relationship, the structural inequality is muted and not an issue.

The participants think several factors in their current setting influence the nurse-physician relationship, which are different in community hospitals and non-critical care units in the same facility. They believe that low nurse
Figure 3: Intensive Care Unit Nurses' Perception of the Meaning of the Nurse-Physician Relationship
caseloads in the critical care unit result in more time to become expert on their patient's condition and more time to interact with physicians. They believe that the acuity of the patients in the critical care units and the physician twenty-four hour coverage pattern also foster extended interaction with physicians. Different norms regarding physician importance reduce the distance between physicians and nurses, lowering barriers to nurse-physician interaction. Extended interaction with physicians increases the familiarity physicians have for the expertise and knowledge of the nurses, leading to recognition that nurses' contributions are important, which leads to respect.

The nurses perceive the teaching mission and structure of the medical center as significant factors underlying the openness of the collegial nurse-physician relationship. Norms of learning create patient-related discussion between nurses and physicians and allow nurses to ask questions without necessarily being seen as challenging the physician's authority or greater scientific knowledge. The structure provides nurses with the opportunity to interact with new physicians who know less than they, allowing nurses to develop a recognition of their own expertise and control in dealing with crisis situations. Using the educational frame of reference, nurses interpret their expertise as reason to be an active participant in the teaching process.
In the learner role, physicians are not expected to know more than the nurses. Nurses perceive that lack of physician experience, lack of physician contact with patients and human failings lead to more physician reliance on the nurse in the critical care area. Because of the nurses' greater experience, patient contact and technical expertise, physicians are open to, seek and rely on nurses' input.

The participants believe that some physicians react to the insecurity of their inexperience, to the self-importance and status of their position as physician and to the nurses' norm of assertiveness and autonomy by developing an I-am-the-doctor attitude. This attitude creates a barrier between the nurse and the physician and results in the physician not listening or seeking the nurses' input. Nurses view this attitude as an enduring personality related trait, as most physicians, who have identical experiences, react differently and more collegially. They see those exhibiting this attitude as exceptions to the norm and as rare occurrences. The participants either ignore this type of attitude or view it as based on immaturity, and either internalize it, attempt to resolve it with the person directly or wait for greater physician experience to resolve the attitude, unless it involves a patient issue.

Nurses see getting along as an important element of a collaborative relationship. Handling patient related
disagreements through open discussion toward consensus is seen as a normal part of team functioning. In order to get along, it is important that physicians and nurses both see differences of opinion as neither right nor wrong and that physicians and nurses are approached politely, with appropriate expectations of the other's capacity and with respect for the other's knowledge base. Nurses engage in getting along in order to influence the responding behavior of the others and to establish a frame of reference for the type of behavior they prefer from others.

The metaphor of getting along refers to relationship behavior and includes the more personal aspects of the nurse-physician relationship. The nurses see that a minimal level of getting along is necessary in order to accomplish teamwork. A greater level of getting along involves family-like relationships between physicians and nurses who have had long periods of association. Getting along results in smoother relations and eases the path of nurses who go above the physician to one higher in the medical chain of command.

Conflict, when it rarely occurs in this setting, is seen as a violation of getting along relations and outside the normal team processes, as symbolized by the solid arrow diagram to the right of center in Figure 3. Nurses view conflict as important to engage in when normal negotiating processes with physicians break down and when the nurse believes with certainty that the physician's actions or
orders are a serious threat to the patient. Certainty and serious were seen as important factors in overcoming nurses' discomfort with conflict. Conflict may be uncomfortable for some nurses because it violates getting along norms or because of personality factors, gender or nurse socialization. Nurses will only risk the relationship with the physician or other nurses if the situation involves serious threat to the patient. Nurses may avoid conflict with physicians if the nurse is uncertain of her knowledge or lacks clinical experience.

Because nurses see their role as one of patient advocacy, they view confrontation, refusal or going above to a higher medical authority as appropriate and obligatory in these cases. Having a higher medical authority to go above to is another aspect of setting, in that community hospitals seldom have a medical chain of command. The nurses see it as important for both physicians and nurses to maintain a professional manner during the conduct of a conflict.

The issue identified by the participants as the one over which they experienced the most conflict with physicians was letting go, allowing patients for whom further medical care would be futile to die. When not seen as an immediate threat to the patient, this conflict was seen as being based in differing perspectives between medicine and nursing which has not been tempered by
experience. This view resulted in nurses attempting to help the physicians learn more of the nursing perspective through discussion and normal team processes.

**Discussion and Implications**

This section discusses the relationship between the patterns and themes in the participants' perception of the meaning of the nurse-physician relationship and the current literature. This discussion has three purposes. First, it establishes the external consistency of the findings of the study by showing how and where the findings are consistent with previous findings in the literature and how the findings conform to related cultural and social phenomena. Secondly, by contrasting the findings of this study with those of the literature, the discussion encourages a different perspective and perhaps a different set of conclusions. According to Kuhn (1962), "it is precisely the data that refuse to submit to our guiding paradigms that offer, when differently construed, the hope of important theoretical advances" (McCracken, 1988, p. 51). Third, this discussion will point out implications of these conclusions. The discussion will be divided into three sections: the nature of the problem, factors which influence the problem and the characteristics of the nurse-physician relationship.
The Nature of the Problem

The view of the nature of the problem to be studied focuses research attention on the issues and factors that are researched as part of the problem (Kuhn, 1970). The view of the nature of the problem then serves to exclude factors and issues as much as it serves to include others. If the view of the nature of the problem is too narrow or not focused properly, factors and issues which may bear on the problem will be overlooked, much valuable research time wasted and the problem will continue to exist. This section reviews the two major views in the literature on the nature of the problem to be studied in the nurse-physician relationship and contrasts them to the findings of this study. The findings suggest an alternative way to view the nature of the problem and discusses three related issues which have received little consideration in relation to the nurse-physician relationship.

The literature in regard to the nurse-physician relationship views the nature of the problem to be studied in two ways, which can be expressed through the metaphors of battle zone or demilitarized zone. The first broad view of the nurse-physician relationship conceptualizes it as inherently conflictual and seeks to understand how the conflict originated and is maintained. It looks at the relationship as an arena of conflict because differences between nurses and physicians distort communication and lead
to misunderstanding. This view focuses on communication as the problem. The second broad view of the nurse-physician relationship conceptualizes it as overtly non-conflictual and seeks to understand the forces that prevent conflict from occurring. It looks at the relationship as an area of stifled or unrecognized conflict because of differences in authority and power which prevent direct communication and meaningful, equal interaction. This view focuses on power as the problem. What neither of these broad views specifically articulate is the goal or ultimate focus of the communication, the interaction or the conflict.

The findings of this study contain elements of both broad views, communication and power. Interestingly, nurses use military metaphors to refer to the communication issue. One nurse, in discussing her positive evaluation of the team relationship, noted that her opinion was respected and carried weight with the physicians. For her, this represented not feeling like the enemy. The military metaphor was used in this case to describe the opposite of communication in the team relationship. Another nurse indicated that the relationship was sometimes like a battleground as prelude to describing a conflict situation with a physician in which the physician and nurse disagreed about a treatment decision in patient care. The military metaphor in this case was used in reference to a breakdown in communication in normal team functioning, wherein
disagreements are discussed professionally and consensus is achieved. Power was expressed as an issue in the nurse-physician relationship in terms of its being the opposite of physician respect for nursing knowledge. When the physician respected the nurse's knowledge, and included it in the decision-making process, the traditional power relations were seen to be outmoded. The military metaphor is therefore no longer appropriate in describing the nurse-physician relationship.

These findings suggest therefore a more specific articulation of the goal or focus of communication, interaction and conflict in the nurse-physician relationship. They suggest that the definition of the nature of the basic problem is nurse participation in medical decision making based on nurses' knowledge. Participants in this study focused on knowledge as a central issue in their collegial relationship with physicians. When the knowledge of the nurse was respected, sought and included in the medical care planning process, in short, communication, the superior authority or power of the physician in terms of order writing was not seen as a major issue. Nurses saw differences in the source and nature of physician and nurse knowledge, but saw the recognition of and respect for the nature of nursing knowledge from these different sources as the pivotal factor in their inclusion
or exclusion from the medical decision-making process. When they were excluded from this process, there was conflict.

The nature of the problem involved in the nurse-physician relationship then, according to the nurses' perspective, is one of inclusion/exclusion, or participation in medical decision-making, by reason of the importance or lack of importance placed on the knowledge nurses contribute to the process. The metaphor participants used to express this relationship was team. The relationship itself was neither inherently conflictual nor overtly non-conflictual, in their view. Both elements of getting along, which can be seen as non-conflictual and going above, which can be seen as conflictual, were involved, but at different times and under different circumstances, depending, in large part, on the inclusion or exclusion of the nurses' knowledge in decision-making. Communication and its adequacy, as highlighted in the literature, are necessary mechanisms of the decision-making process, but are not the central issues. Authority, or physician power is seen as an issue in the team relationship only in terms of its facilitation of or barrier to nurse participation in medical decision-making.

According to the participants, in a collegial relationship, both physicians and nurses influence the work of the other. There is little barrier to nurses' participation in medical decision-making because physicians and nurses recognize their reliance or interdependence upon
one another. For nurses, physician reliance takes the form of the contribution made by nurse's superior knowledge of patients and nurses technical/scientific competence and, in the case of new physicians, nurses superior experience. Interdependence means that although each team member has different roles, each contributes something to the tasks performed by the other, in this case, knowledge. This is consistent with the characteristics of a collegial relationship proposed by Weiss (1982).

There is some support in the literature for decision making as central to the nature of the problem in the nurse-physician relationship. Several have noted decision-making about patient care as a major factor in the relationship (Devereux, 1981a; Feiger and Schmidt, 1979; Knaus, Draper, Wagner and Zimmerman, 1986; Stein, Watts and Howell, 1990). Nurse decision-making as an issue has been linked with nursing expertise and with nurse empowerment (Gordon, 1992). However, it is not specifically articulated that it is medical decision-making that is the fundamental issue being discussed nor do they discuss how nursing knowledge contributes to such decision-making.

This study found that nurse participation in medical decision making was seen by practicing nurses as not only the central issue in the nurse-physician relationship, but also that knowledge is a critical component in nurse participation in medical decision-making. Findings of this
study show that nurses believe that they have important information to contribute to medical decision-making. They believe that the accomplishment of the common goal of patient care requires that the traditional barriers to nurse participation in medical decision-making be removed, allowing their knowledge from patient contact, experience and science to influence the medical decision. The nurses saw the recognition of the importance of their knowledge, by themselves as well as by physicians, as a critical factor in their participation in medical decision-making. Not only did physicians need to recognize the value of the nurses' knowledge in order to invite nurses to participate in decision-making, but also nurses needed to recognize and respect their own knowledge in order to take the initiative in voicing and contributing that knowledge.

Other sources in the literature provide support for the idea that knowledge is central both to medical decision making and the authority to make medical decisions. One of the reasons given for the society's questioning of the assumption of medical superiority is knowledge based. It was the information explosion that eroded the concept of the physician as the repository of all knowledge (Hite, 1977; Stein, Watts and Howell, 1990). The contemporary health care system has been developed on the basis of medical autonomy, wherein it has been assumed that only physicians have sufficient medical knowledge to diagnose and treat
illness, in short, to make medical decisions. This autonomy, in large part, has been based in the view that medical knowledge is superior to the knowledge held by other groups (Ashley, 1977; Friedson, 1970; Hoekelman, 1975; Kalish, 1975; Rushing, 1962; Stein, 1967; Tellis-Nayak and Tellis-Tayak, 1984; Webster, 1988).

This framework of thought not only supports the idea that knowledge is a central issue in medical decision making but also shows how it is central in the nurse-physician relationship. Intergroup relations theory (Sherif and Sherif, 1969) posits that the necessary and sufficient condition that accounts for the rise of intergroup conflict is the competition for mutually exclusive goals. The nurses in this study disagreed with physician autonomy in decision-making, based on their view that nurses have important knowledge not held by physicians and that therefore medical knowledge is incomplete. The nurses are motivated to contribute nursing knowledge because they believe that it will complete and improve the medical decision, thereby improving medical care to patients. Protection of and advocacy for patients is seen by the nurses in this study as a moral obligation. If the nature of the nurse-physician relationship is framed in terms of nurses' participation in medical decision making, based on the nurses' view that medical knowledge by itself is incomplete, medical autonomy can be seen as the goal under competition. Medical
autonomy, by definition, precludes participation by members of any other group in medical decision making. The functional relationship between nurses and physicians then may be one of conflict or cooperation, depending on nurses' inclusion or exclusion from the medical decision making process which is ultimately based on physicians' and nurses' views of the importance of nurses' knowledge in terms of the provision of patient care.

There are several implications of knowledge related nursing participation in the medical decision making process as the focus of the nature of the problem in the nurse-physician relationship, in terms of expressing nurse's disagreement with medical autonomy due to incomplete knowledge. First, nursing participation in medical decision making emphasizes the interdependence of medicine and nursing, as seen by the participants in this study. Interdependence reframes the issues both of medical autonomy from other professional groups and of nursing autonomy from medicine. Neither group is independent from one another, but the skills and knowledge of both are required to accomplish medical care. This represents a major difference between the views of the practicing nurses in this study and those of many nursing leaders. The nurses in this study see autonomy as participation with the physician in the making of medical decisions. The professional nursing view in the literature sees nursing autonomy as independence from the
physician (Benne and Bennis, 1959; Mechanic and Aiken, 1982; Roberts, 1983; Weiss, 1982). While both the nurses in the study and professional nursing literature emphasize equality of the nurse and the physician, the former focus on disagreeing with the autonomy of medicine and the latter focus on disagreeing with nursing's subordinacy to medicine. It seems that both are focusing on the same objective, that is, equality with physicians, but disagree on the path to achieve that end. Nursing leaders have not directly challenged the concept of medical autonomy but have struggled instead to identify nursing's unique role and contribution to health care to support independence from the physician, which has not been entirely successful (Weiss, 1982). One of the reasons for that lack of success may be that practicing nurses do not agree with independence from the physician as a goal or as a mechanism to achieve better patient care. To recognize the interdependence of medicine and nursing and to include nurses' knowledge in medical decision making might mean that the concepts of both medical and nursing autonomy need to be challenged.

Secondly, using knowledge based nursing participation in medical decision making as a framework would allow researchers to broaden the research questions that are asked in terms of the nurse-physician relationship and also to begin to explore new ways of challenging medical autonomy. Answers to these research questions may then be applied
towards further development of methods to accomplish
collegial relations between nurses and physicians in
settings where team does not exist. Three areas of research
questions can be derived from assumptions made by the
participants in this study which were of particular
importance in their perspectives on the value of nursing
knowledge as a contribution to medical decision making.
These assumptions represent issues which seem to have been
resolved in the team relationship and may be the bases for
nurses' participation in medical decision making in other
settings as well. It may be that factors which influence
the resolution of these assumptions among physicians and
nurses are critical in the development of the collegial
nurse-physician relationship.

The first assumption involves the question, what counts
as knowledge. Although all the nurses in the study save one
had some college education, the nurses most valued their
knowledge from patient contact. They secondarily saw their
knowledge as deriving from years of experience and from
technical/scientific information. The nurses made a
distinction between these sources of nursing knowledge and
the source of physicians' knowledge. Physicians knowledge
was seen as deriving primarily from text-books and
additional years of medical school training. In the nurses'
view, their knowledge derived from patient contact was as
important as was physicians' knowledge.
The distinction in the sources of medical and nursing knowledge made by the nurses is the essence of the very old epistemological debate on the nature and grounds of knowledge. The debate centers on what forms of knowledge can be obtained, whether it is hard, real and capable of being transmitted and acquired, such as scientific knowledge learned through school, or whether knowledge is more subjective and based on experience (Burrell and Morgan, 1979). Both epistemological positions are held to be legitimate but the functionalist position, that of knowledge being scientific and primarily learned through books and schooling is predominant in American society (Miller, 1976; Nisbet, 1982). The belief that knowledge is real, hard, scientific and capable of being transmitted and learned, contradicts nurses' claims of equally important knowledge, and holds that knowledge as of lesser, if any, worth. The belief that knowledge is subjective and experienced supports the nurses' beliefs. The issue in reference to the nurse-physician relationship then becomes situated in this epistemological context, and subject to prevailing standards in the health care industry, which emphasizes knowledge as hard and scientific.

Belenky, Clinchy, Goldberger and Tarule (1986) believe that the prevailing standards for conceptions of knowledge have been shaped by the male dominated majority culture. The found that women enhance objective knowing with a
conception of knowledge as personal and subjective. Views on the importance on nurses' knowledge may therefore be influenced by gender-related standards of objective modes of knowing.

In looking at the assumption of nurses' knowledge in this way, we may begin to conceive of and understand other forces which challenge the credibility of the nurses' perspective in this culture, and the importance of their knowledge. We may begin to see why it may be difficult for some physicians and nurses to see nurses' knowledge as important and why the issue of the nature and source of nurses' knowledge may be a source of conflict between nurses and physicians. We may also begin to value the accomplishment of respect for nurses' knowledge in this facility.

This issue has been addressed in the literature regarding the nurse-physician relationship to date only by Ehrenrich and English (1973), in their historical analysis of the history of exclusion of female healers. They found that lower class women healers were condemned as witches because of their lack of formal education. Several research questions are implied by a focus on the nature of knowledge. What other forms or types of nursing knowledge do nurses of color, other gender and other settings believe are important in terms of their participation in medical decision making? What are physicians views on the sources and value of
nursing knowledge? What factors are most salient in the formation of nurses' and physicians' views? As findings from a qualitative study are not intended to be generalizable (McCracken, 1983), research in regard to the extent with which nurses in other settings hold similar beliefs about knowledge in regard to the nurse-physician relationship becomes necessary. Insight into these research questions may be central to the development of the collegial nurse-physician relationship.

The second assumption in perspectives on knowledge has to do with the nurses' view that individual patient knowledge is important in developing a plan of care. The question becomes, should abstract scientific principles be applied regardless of the context of their application? Is knowledge of the individual patient important in making care plan decisions? Gilligan (1982) found that women were more likely to use idiosyncracies of the context as an important factor in deciding whether an abstract moral principle should be applied to the situation. She found that men were less likely to use situational or contextual factors in making moral decisions, and that in Kohlberg's (1973) scheme of developmental psychology, making decisions based on abstract applications of principle, without regard to idiosyncracies of the situation, was viewed as more mature reasoning. Views of the importance of nurses' knowledge of individual patients in making care planning decisions may
therefore be related to perspectives on methods of objective or subjective reasoning and what one sees as mature and immature, or male and female methods. Making decisions in regard to the planning of patient care based on individual patient considerations may or may not be accepted as a decision-making methodology and may be a source of conflict in the nurse-physician relationship. This finding suggests that gender issues may be involved in the nurse-physician relationship in a different manner than what has been studied thus far, that is, in relation to differences in reasoning.

This aspect of gender in relation to the nurse-physician relationship has been addressed in the literature to date only by Cooper (1989), who presented differing perspectives on moral decision making in terms of perspectives on autonomy, interdependence and detachment. Differences in the valuing of individual versus abstract rules for decision making in medicine and nursing have yet to be explored. Several research questions are implied by a focus on methods of reasoning. How do physicians and nurses of color, another gender and different settings view the importance of knowledge of the individual patient in medical decision making? How does the inclusion of nursing knowledge of individual patients change medical decision making? Are there certain types of medical decisions that nurses are more interested in than others? What are the
effects of nurses' participation in terms of the quality and/or effectiveness of patient care? Answers to these research questions may be central to the development of methods designed to create a collegial nurse-physician relationship in settings where it does not exist.

The third assumption in perspectives on knowledge relates to the question of who is entitled and capable of holding and applying knowledge? Nurses in this study viewed their knowledge as also deriving from technical/scientific information and from additional technical responsibilities, which in the past were reserved for physicians. One participant viewed the physician's lack of involving her in answering medication related questions as the physician thinking of her as unworthy. Issues of nurses' and women's entitlement to and capability of knowing have been raised and studied in the literature in regard to the functions of secrecy of medical knowledge (Campbell-Heider and Pollack, 1987), and to class and gender issues related to women's exclusion from, or restraint in scientific learning (Ashley, 1977; Ehrenreich and English, 1973; and Roberts, 1983). Different answers to the entitlement and capability of nurses to hold and use scientific and technical knowledge may be a source of conflict in the nurse-physician relationship.

Several additional research questions are implied by a focus on the entitlement and capability of nurses to hold
and use scientific knowledge. How do physicians and nurses of color, another gender and different settings view the importance of nurses having technical and scientific knowledge? What factors influence physicians' and nurses' recognition of nurses' scientific and technical knowledge? What factors influence nurses' ability to gain technical and scientific knowledge? Answers to these research questions may be central to the development of the collegial nurse-physician relationship.

These three assumptions of the participants in this study support knowledge-based participation by the nurse in medical decision making as the nature of the problem in the functional relationship between nurses and physicians. Viewing the nature of the problem in this manner through these assumptions suggests a broader view of research questions which are appropriate in the study of nurse-physician relations. This analysis of the central issue in the functional relationship and the assumptions on which it is based also provides insight into specific properties of the nurse-physician relationship which are unique to that relationship and are not necessarily reflected in a clear way in studies which focus on the generalized social forces of sexism, classism and oppression in terms of the nurse-physician relationship. It supports Alderfer's (1987) contention that there is an interactive effect between social identity and organizational identity which may be
missed by a focus on the societal level of analysis alone. Using intergroup relations theory, this study has shown some specific ways in which predominant beliefs in American culture may influence the functional relationship between nurses and physicians which have received little consideration in the literature.

In summary, the findings of this study suggest a new paradigm for the nature of the functional nurse-physician relationship. They suggest that the nature of the problem is knowledge based nurse participation in medical decision making. These findings and the framing of the nature of the problem in this manner are externally consistent with much of the research literature on the nurse-physician relationship. The findings contrast with those of the literature, however, by pulling together or forming relationships between issues which have heretofore been treated as separate. Specifically, this study has clarified the relationships between knowledge and decision making in the nurse-physician relationship which are embedded in a cultural context which values gender related visions of the nature of knowledge, modes of knowledge reasoning and entitlement to and capability of holding and applying knowledge. The linking of knowledge and decision making with an interdependent nurse-physician relationship challenges current professional values of autonomy or independence in both nursing and medicine. This paradigm is
based on the framework provided by intergroup relations
theory and provides a broader vision of the research agenda
involved in the further understanding of nurse-physician
relations. The assumptions, which were of particular
importance to the nurses in terms of the value of their
knowledge as a contribution to decision-making, seemed to be
shared among most of the physicians, according to the
beliefs of the participants in this study. Factors which
nurses believed to have influenced the view of physicians
and nurses in terms of the importance of nurses' knowledge
were identified by the participants. Those factors will be
discussed in the next section.

Factors Influencing the Relationship

Factors which influence the nature of the relationship
as found in the literature represent theoretical frameworks
through which to study and understand the nurse-physician
relationship. These include psychological, developmental,
interpersonal, group ideological, and social issues of class
and gender. This section discusses the factors believed by
the participants to have most influenced their collegial
relationship and suggests the applicability of an intergroup
relations framework in the understanding of factors which
influence the nurse-physician relationship.

Participants viewed the development of an I-am-the-
doctor attitude by some physicians as a manifestation of an
ego problem or as a result of insecurity and inexperience in their new area. This finding is consistent with that of Stein (1967), who believed that young physicians develop phobias against making mistakes and convert that phobia into a belief that they are omniscient and incapable of making a mistake. It is also somewhat consistent with the theory posited by Kalish and Kalish (1977) who hypothesized that the preexisting personality structures of young people who chose medicine as a profession emphasized a high degree of individualism and desire for independence, which was strengthened in medical school to become a feeling of omnipotence. However, they viewed this omnipotence as generalized among all physicians and as a source of either nurse deference or nurse conflict, which is inconsistent with the beliefs of the nurses in the study.

The participants viewed physicians who exhibited this attitude as exceptions to the norm, as rare occurrences. They saw the attitude as a barrier between the physician and the nurse, resulting not necessarily in deference or in conflict, but in ignoring the behavior, internalizing it, attempting to resolve it with the other person, or waiting for greater physician experience to resolve the attitude. If the attitude involved a patient issue, then the nurse would engage in conflict by going above.

Also a contrast to findings in the literature was the nurses' belief that a nurse's personality was responsible
for nit picking at the physicians and treating them horribly when they weren't adept. This contrasts with Kalish and Kalish's (1977) hypothesis that nurses' personalities were by nature deferent due to a generally lower socioeconomic group than physicians and to systematic culling of overly questioning and rebellious students in nursing school. Again, however, nurses' personality was not seen by the participants as a factor influencing the nature of the relationship itself, as hypothesized by Kalish and Kalish (1977), but were seen as individual instances which interfered with getting along. Also somewhat related to nurse personality were expressions of discomfort with conflict. Nurses expressed this discomfort as a personal tendency, which they also thought may have been related to nurse and gender socialization. These findings suggest that personality theory is insufficient to understand factors which influence the nature of the nurse-physician relationship.

Several studies suggest that gender is responsible for nursings' subordinacy to medicine (Campbell-Heider and Pollack, 1987; Christman, 1965; Ehrenreich and English, 1973; Hite, 1977; Kalish and Kalish, 1977; Lovell, 1981; Turnbull, 1982). Gender was seldom raised by the participants as an issue and was not a major theme or pattern in the nurses' views of factors influencing the relationship. One nurse noted the increasing number of
women physicians and said that she believed that they were more compassionate and family-oriented than men physicians. Another nurse thought that the rising number of women physicians changed some of the basic assumptions in the nurse-physician relationship, but no other nurse alluded directly or indirectly to this idea. The only gender related issue that related to a major pattern or theme was the possibly gender related discomfort nurses sometimes felt when in conflict with physicians. The participants did not feel subordinate to the physicians, but rather felt as equals. As discussed in the previous section, gender and other societal level issues influence the context in which the nurse-physician relationship is embedded, but these findings suggest that a gender framework alone is insufficient to understand other specific factors which also influence the nature of the nurse-physician relationship.

Differences in perception based on differences in ideology, work and education of physicians and nurses were proposed by many in the literature to influence the nature of the nurse-physician relationship (Bates, 1971; Mathers, 1983; Pellegrino and Dake, 1966; and Peeples and Francis, 1968). Nurses in the study were consistent with this literature to the extent that they believed that letting go of terminally ill individuals was a manifestation of differences in perspective on care and cure between nurses and physicians. The participants did not see the nature of
the relationship as dependent on these factors, but only as a single issue which influenced their behavior in specific circumstances. These findings suggest that differences in ideology are insufficient to understand factors which influence the nature of the nurse-physician relationship.

Nurse-physician familiarity with one another's competence was viewed by some researchers as a factor in the nurse-physician relationship (Devine, 1978; Hodes and Van Crombrugghe, 1990; Prescott and Bowen, 1985; Weiss, 1982, 1985). Of these, only Devine (1978) viewed familiarity based on frequency of interaction between nurses and physicians as a factor affecting the nature of the nurse-physician relationship. She studied the ward structure of two hospital wards and found that interns interacted differently and more frequently with nurses than did the physicians. In this study, structure of the medical center was thought by the participants to influence the nature of the relationship not only between nurses and interns, but also between nurses, residents and attending physicians. These findings suggest that structure alone is insufficient to understand factors which influence the nature of the nurse-physician relationship.

The major factors that the participants believed had influence on the nature of the relationship were related to setting. They included specific norms, such as of physician-nurse equality and of questioning and open
discussion. They included structural factors, such as twenty-four hour availability of physicians and the presence of medical students, interns and residents. They included patient complexity issues, such as speed of change in condition and need for very close and technical nurse involvement. These factors prevented physical and psychological distance between the nurses and the physicians, allowing extended interaction and the development of familiarity, through which physicians and nurses not only recognized and respected the nurses' knowledge and contributions, but they also came to see the physician's reliance on nursing. The participants believed that physicians recognize and accede to this reliance. The nurses frame these recognitions as respect and see them as responsible for the team relationship.

The nurses noted that the relationship between the nurses and physicians was learned. In their previous settings, they noted that norms of behavior regarding physicians were taught to them by older nurses who had worked in the facility for many years. In their current setting, they noted that their behavior towards physicians was a change for them. They became more assertive and contributory because that's just how nursing was in that facility. Many participants weren't sure if things had changed in community hospitals during the interim.
These findings show that the factors most important to the nature of the functional relationship between nurses and physicians are organization specific. Organizational norms, structure and function are specific organization level indices which are not completely dependent on the overriding cultural and societal level factors. These findings support Alderfer's (1987) theoretical distinction between social identity groups and organizational, departmental groups by emphasizing that membership in an organizational group adds other issues to relations between groups beyond social stereotype. The influence of social stereotype is therefore moderated by the organizational setting.

These findings are significant for several reasons. First, they are consistent with and explained by Sherif's (Sherif, Harvey, White, Hood and Sherif, 1961) theoretical position regarding the resolution of intergroup conflict. He believed that the way to change the functional relationship between groups was to change the attitudes and cognitions of the groups toward one another. He believed that extended interaction is an essential element in the recognition of interdependence in the pursuit of a superordinate goal (Sherif, 1966). The nurses in this study referred to this interdependence in terms of physician reliance upon the nurse. Superordinate goals are compelling goals that each group urgently desires, which require the cooperation and coordination of each group's efforts and
resources to accomplish, in this case, complex patient care issues. Common goals are not sufficient to accomplish changes in cognition and attitude toward one another because no interaction between members of the two groups is necessary, such as in the community hospital and non-critical care wards where complexity of patients is less of an issue, less interaction is required and attitudinal barriers exist to that interaction. The interaction between the two groups in pursuit of the superordinate goal provides opportunities for members of the two groups to work out, develop and learn new procedures or norms for interacting. In the critical care units, working together under conditions of high stress, client complexity and nurses' greater knowledge, the norms and patterns of the traditional relationship are dysfunctional. When the new norms that are established during the interaction are successful for the attainment of the superordinate goal, they are then carried over into other related situations, such as interactions during non-crisis related events.

These findings, and others discussed in the previous section, suggest that intergroup relations theory may be sufficient to understand factors which influence the nature of the nurse-physician relationship. Intergroup relations theory also posits that the necessary and sufficient condition that accounts for the rise of intergroup conflict is the competition for mutually exclusive goals (Sherif and
Sherif, 1969). In this instance, if the nature of the nurse-physician relationship is framed in terms of nurse's participation in medical decision-making, medical autonomy is the goal under competition. Medical autonomy accounts for much of the status and power differentiation between nursing and medicine. Cooperation, the opposite condition of competition and conflict, is achieved by shifting the focus to a realization or learning of mutual interdependence in the pursuit of superordinate goals, in this case, the familiarity with nurse's knowledge and the importance of its contribution toward the accomplishment of complex medical care for patients. The medical education setting may assist in diminishing the power and status differences between physicians and nurses, increasing the permeability of the boundaries surrounding nurses' and physicians' definitions of autonomous nursing and medical practice, allowing nurses to participate in medical decision making (Alderfer, 1977; Alderfer, Tucker, Morgan and Drasgow, 1983).

Secondly, because of their consistency with Sherif's and Alderfer's theories on intergroup relations, these findings are suggestive of methods which could be useful in fostering more collaborative relationships in other settings where interaction between physicians and nurses is more problematic. Other forums can be developed which foster the recognition by physicians and nurses of the value and importance of nurses' knowledge and experience as
contributions to medical decision-making and therefore, their interdependence in pursuit of patient care goals. Such forums include the development of microcosm or interface groups. Microcosm groups, formed of members and facilitators from both groups in a relationship in a specific setting, have been found to show and improve the intergroup race relations in an organization (Alderfer, 1977; Alderfer, Alderfer, Tucker and Tucker, 1980; Alderfer and Smith, 1982). Interface groups follow a problem-solving model by focusing on the functional relationship between members of conflicting groups and have similarly been found to be effective in labor-management and in interdepartmental relations (Blake and Mouton, 1984). As both methods emphasize the improvement of functional relations between groups which are embedded in larger societal differences in power, they seem particularly appropriate to the improvement of nurse-physician relations in settings where collegial relations do not exist.

Third, these findings are significant because they suggest that views of nurses' subordinacy or equality are mediated through an organizational norm. Change methods can then be effective on the organizational level. To resolve issues in the nurse-physician relationship, it is not necessary to change society's view of women, of knowledge, of the caring function, or of class distinction or of health care professions' paradigms of the roles of nurses and
physicians. The behavior of nurses, according to the participants in this study, and perhaps that of physicians also, is based on the cognitions formed as a partial result of norms and expectations of the specific organization or setting in which they work. This results in a much more narrow focus, which is much more within the means of ordinary people to influence.

In summary, the findings of this study suggest that individual and societal level frameworks alone are insufficient to understand the nature and dynamics of factors which influence the nurse-physician relationship. They suggest that nurse-physician relationship cognitions, attitudes and behaviors are learned and that cultural and social group identities are influenced by specific settings through organizational norms, structure and function. These factors in the setting influence the nature and extent of nurse-physician interaction, subsequent familiarity and opportunity to recognize their interdependence in pursuit of the superordinate goal of patient care, based on recognition of nurses' knowledge. Because of the influence of specific setting on the learning of the nurse-physician relationship, intervention methods which emphasize the recognition of interdependence may be particularly appropriate and useful. The next section will discuss the content of the nurses' cognitions regarding the characteristics of the nurse-physician relationship in their current setting.
Characteristics of the Relationship

Characteristics of the nurse-physician relationship as found in the literature focus on the interaction patterns between nurses and physicians. This section discusses the characteristics believed by the participants to be most important in their collegial relationship.

Lack of respect for nursing expertise was cited in the literature as one of the most frequent reasons for nurse dissatisfaction with the nurse-physician relationship (Devereux, 1981a; Nursing91, 1991); and as the intensive care unit nurse's highest stressor (Spoth and Konewko, 1987). Knaus, Draper, Wagner and Zimmerman (1986) found that respect between physicians and nurses was an important characteristic of interaction in intensive care units with lower patient death rates. Yet the meaning of respect for the nurses in those studies and why respect was considered to be important by nurses was not identified. For the participants in this study, respect was a major theme. For them, respect is shown through physician seeking out the nurse's opinion, listening to it, discussing it and acting upon it in making medical decisions. This is consistent with the finding by Chandler (1992) that nurses felt empowered when physicians sought and considered their input. For the nurses in this study, these behaviors represent the most important characteristics of the nurse-physician relationship because nurses believe that, through respect,
their input and knowledge are seen as important contributions to medical decisions, without which medical decisions would be incomplete. Therefore, respect means to the nurses that their knowledge and contributions are valued and recognized, which allows them to participate in medical decision making. This study contributes to knowledge regarding respect by identifying the meaning and results of respect and the behaviors nurses viewed as respectful.

Much of the recent literature depicts nurse's attitudes toward physicians as hostile and adversarial (Bates and Kern, 1967; Ginzberg, 1981; Stein, Watts and Howell, 1990; Weiss and Remen, 1986). Contrarily, the participants in this study viewed their attitudes toward physicians as generally cordial, collegial and positive, again because physicians sought, heard and acted upon their input. Situations where relations were uncordial, uncollegial and negative were seen as violations of that norm. Nurses considered themselves to be assertive many times, but were concerned that they be polite and courteous. Questioning physicians and making recommendations for medical treatment interventions were, for them, a normal part of the team process, which were also governed by rules of politeness and courtesy, and were not intended by nurses to connote challenge or disrespect to the physician's knowledge. Nurses respected physicians for the education physicians receive in medical school and expect the same measure of
respect in return for nurses' knowledge. Someone viewing the nurses' assertiveness, questioning and recommendation making, however, may conclude that these nurses were acting in a hostile and adversarial manner, unless the meaning of their behavior was explored with them.

Miller suggests that "dominant groups tend to characterize even subordinates initial small resistance to dominant control as demands for an excessive amount of power" (Miller, 1976, p. 117). Therefore, the male social and medical organizational identity of the researcher may have influenced their interpretations of nurses' assertive behavior which may not correspond with the understanding and meaning that behavior holds for the subject. As Miller (1976) also notes, women researchers are also subject to belief in the dominant male paradigm which may influence their interpretations of nurse behavior. Interpretation then is enhanced by allowing nurses to speak for themselves to explain the meaning of their own behavior and what it represents for them.

Getting along was how the participants referred to relationship building and maintaining behaviors which they thought were important. There was no element of nurse deference to physicians in the nurses' conceptualization of getting along, other than what they expected from physicians in return. For the participants, getting along had clear reciprocal expectations for physician behavior. Getting
along norms in relation to the maintenance of equality through non-evaluation and giving the benefit of the doubt are consistent with Gibb's (1965) framework of defensive communication. He postulates that verbal language which contains elements of evaluation, control, superiority and certainty arouse defensiveness which interferes with and distorts communication. Framed in this manner, what may be construed as deference among nurses when viewed through the predominant male value system of establishing dominance and superiority, is a strength and a manifestation of women's culture (Gordon, 1991a; Miller, 1976). The nurses in this study could be seen as being in a theoretically dominant position in relation to new interns and residents. Their emphasis on helping them learn and grow and on maintaining equality in the process exemplify the skills, values and activities that have been the basis of women's claim to difference. This study represents one situation in which women's values are not compromised but seem to have been embraced by many physicians in the team relationship. It contributes to knowledge by demonstrating a mechanism through which women's culture creates an egalitarian, democratized process. Viewed in this manner, this study may be of interest to feminist researchers who are concerned with identifying processes through which women's culture influences the male workplace.
Much of the literature frames increasing nurse-physician conflict as a result of nurses' increasing anger and hostility toward physicians (Bates and Kern, 1967; Ginzberg, 1981; Stein, Watts and Howell, 1990; Weiss and Remen, 1986). Nurses in this study expressed the idea that conflict with physicians may disrupt the relationship or be viewed by physicians as intentionally conflictual. Their understanding of the reason for conflicting with physicians was not in terms of an underlying hostility toward physicians, but instead was the view that their role as patient advocate required them to act to protect the patient. This is consistent with the literature which depicts the nurse's role as patient advocate (Baldwin, Welches, Walker and Eliastam, 1987; Damrosch, Sullivan and Haldeman, 1987; Hite, 1977; Winslow, 1984). The nurses viewed this role as patient advocate not as placing them in an adversarial position with physicians, because they see physicians as working toward the same goal as the nurses, but as potentially placing nurses in violation of their norms of getting along. These norms were unofficial rules of conduct which emphasize courtesy, professionalism, equality and learning from mistakes. Nurses did not see themselves as being in a position of divided loyalty between physicians and patients, but acknowledged that physicians may misunderstand their motivation to engage in conflict.
Conflict for them was clearly related more to a threat to patients than to anger and hostility toward physicians.

Several researchers saw lack of conflict as a result of the physician's superior hierarchical position, the nurses' dependence on physicians for assistance in meeting patient care needs or as gender-related deference to male dominance (Hofling, Brontzman, Dalrymple, Graves and Peirce, 1966; Katzman and Roberts, 1988; Rushing, 1962). The participants did not express a concern regarding physician displeasure if the nurse was resistant to the physician's instructions, as found by Hofling, Brontzman, Dalrymple, Graves and Peirce (1966). Nor did they express a consistent need to frame their disagreement in deferential terms to prevent a threat to the physician's willingness to listen to her in the future, as found by Rushing (1962). One nurse did discuss this type of issue, but it was in reference to other nurses. Instead of framing her comments in deferential terms, she internalized the disagreement, unless it involved patient related issues. However, the norm of politeness and courtesy could be misconstrued by a researcher as implying deference and fear, if viewed through the lenses of the predominant male hierarchical paradigm. The nurses in this study viewed lack of engagement in conflict as a result of lack of knowledge or experience, a lack of self-respect for nursing knowledge and fear of being foolish. Nurses saw their patient advocacy role as requiring them to overcome
any personal or gender related reticence to engage in conflict. This study therefore found different reasons for nurses' lack of engagement in conflict than those in the literature thus far. An emphasis on knowledge based nurse participation in medical decision making may then enhance nurses' self-respect and increase nurses' contribution to medical decision making.

In the literature, rude, arrogant behavior by physicians was a reason for nurse dissatisfaction with the nurse-physician relationship (Nursing91, 1991). Wilcox, Fritz, Russel and Wilcox (1983) hypothesized that rude and hostile behavior may be seen as justified due to the speed with which medical intervention sometimes needs to be delivered. According to the views of the nurses in this study, rude behavior on the part of the physician violates getting along norms. They see an emotional reaction to stress as a sign of inexperience, wherein individuals have not yet learned to control their emotions. Some nurses reported that they try to ignore this type of behavior, by giving the person the benefit of the doubt. Ignoring could be taken for acceptance, which is not the case in this study, unless the nurses were asked to explain the meaning of this behavior for them.

The nurses distinguished between disagreement with physicians and conflict with physicians. The former they saw as an inherent component of the team process through
which different ideas and differences of opinion were discussed and mutual consensus was reached. They saw conflict as the result of their knowledge being excluded from medical decision-making. It may be that nurses in other settings also think of conflict in this way. Not having a functional process in place in which to handle disagreement, all disagreements may be seen and handled as the participants in this study saw and handled conflict. The accomplishment of team relationships between nurses and physicians in other settings may then decrease what is currently viewed as conflict by nurses.

Several sources in the literature address the issue of a resemblance between the nurse-physician-patient relationship and that of a family, wherein traditional husband-wife roles are played out by the physician and nurse with the patient taking the role of the child (Ehrenreich and English, 1973; Katzman and Roberts, 1988; Lovell, 1981). Within this family metaphor were concepts such as wifely obedience and subservience, motherly care to patients and husbandly absence and dominance. Some of the participants in this study expressed views of patients and physicians which were directly family-like, but family-like in terms of affection and caring, and in establishing working relationships that were mutually respectful and equal. Dominance, subservience, obedience and physician absence were characteristics of nurse-physician relationships that
the nurses had experienced in previous settings, but were not present in the team relationship, even though family like references were made. In the current setting, nurses watched interns grow from boys to men, gave encouragement and positive feedback to keep it a happy family and felt for patients as though they were friends and family members. Therefore, a family metaphor is not inappropriate to characterize the team nurse-physician relationship, if the family metaphor is based more on the contemporary values of a dual-professional marriage. An appropriate way of expressing the goal of the getting along norm is keeping the peace, and the equality, in the family, wherein both physicians and nurses have responsibilities for the maintenance of the relationship. This difference in meaning may be overlooked by research methodologies that do not focus on understanding the meaning intended by the participant.

In summary, the findings of this study support the applicability of qualitative methods to understanding the meaning of nurses' behavior. The qualitative findings of this study showed some important ways in which the nurses' meaning of their behavior may have differed from that of researchers using non-qualitative methods (see Table 2). Understanding how nurses themselves see and understand their relationships with physicians has provided some insight into conflicting research findings regarding nurse deference,
Table 2: Different Interpretations of Nurse Behavior

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Literature</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude toward Physicians</td>
<td>Hostile, Adversarial</td>
<td>Cordial, Collegial</td>
</tr>
<tr>
<td>Functional Relationship</td>
<td>Conflict, Deferrant</td>
<td>Team, Assertive</td>
</tr>
<tr>
<td>Deference</td>
<td>Fear, Hierarchy</td>
<td>Getting Along Norms</td>
</tr>
<tr>
<td>Rudeness</td>
<td>Urgency of care, Source of nurse dissatisfaction</td>
<td>Immaturity, Violation of getting along</td>
</tr>
<tr>
<td>Conflict</td>
<td>Anger, Hostility</td>
<td>Patient threat, Certainty</td>
</tr>
<tr>
<td>Lack of Conflict</td>
<td>Fear, Hierarchy</td>
<td>Uncertainty, Lack of Knowledge</td>
</tr>
<tr>
<td>Disagreement</td>
<td>Conflict</td>
<td>Normal part of team process</td>
</tr>
</tbody>
</table>

nurse attitudes toward physicians, and nurses conceptions of conflict. The findings suggest that nurse beliefs regarding getting along may be an expression of women's culture. Facilitating team relationships between nurses and physicians may increase nurse contributions to and verbalized disagreements with medical decision making, while, at the same time, reducing conflict and increasing nurses' satisfaction with the nurse-physician relationship and with their jobs. These findings and implications may be of interest to policy makers, nurse administrators,
physicians, medical and nursing educators, other patient advocates, organization development consultants and feminist researchers.

Conclusion and Recommendations

The purpose of this study was to explore the meaning of the nurse-physician relationship from the perspective of practicing nurses in intensive care units. The study sought to respond to the issue raised by Taylor and Bogdan (1984) by attempting to understand how nurses themselves see and understand their relationships with physicians.

This study identified and discussed the major themes and patterns in nurses' perceptions and the mechanisms through which those themes and patterns are interrelated. It found that nurses viewed the nurse-physician relationship as a team. This study was the first to systematically examine the properties of the team relationship from the perspective of the practicing nurse. Furthermore, it established that a team relationship between nurses and physicians, which is truly satisfying to the nurse participants and which supports the nurse in the recognition and application of her knowledge, is possible in a non-experimental setting.

Identifying the cognitive formations of the participants, the characteristics of the team relationship and the mechanisms through which it developed in this
setting, provides new insight into a variety of strategies for improving the nurse-physician relationship in settings where it is not present, which are not articulated in the literature. The major conclusions and recommendations of this study will be presented in three areas: the nature of the nurse-physician relationship, factors influencing the relationship and the characteristics of the relationship.

The basis of the team nurse-physician relationship was collegial interaction, defined as physicians showing respect for nurses' knowledge by seeking, listening to and acting upon nurses' recommendations. Nurses believed that their contribution to collegial interaction was the provision of important information to medical decision making through nurses' knowledge of individual patients, their clinical experience and their scientific training, without which, the medical decision would be incomplete. The findings in the themes, patterns and mechanisms suggested a new paradigm in the view of the nature of the problem in the nurse-physician relationship: nurse participation in medical decision making, based on nurses' knowledge. By framing the nature of the problem in terms of interdependence in medical decision making, this study challenges the paradigms of medical and nursing autonomy.

These findings are the basis for several recommendations for action. First, although the literature often notes physician lack of respect from nurses as a
problematic issue in the nurse-physician relationship, it
does not define the meaning of respect from the nurses' perspective nor does it identify which specific behaviors nurses would interpret as respectful. Practicing physicians may therefore not have a clear idea of what nurses mean by respect. It may be helpful to include the findings of this study in that regard in interventions designed to improve relations between physicians and nurses.

Secondly, additional research is needed in terms of nurses' definitions of respect in other settings, in order to expand and confirm the findings of this study. Also lacking in the literature is qualitative research of physician's perspectives on the relationship in this and other settings. Identifying physician's beliefs in regard to those behaviors nurses see as respectful and differences in these beliefs between physicians in different settings would be useful in assessing similarities and differences between nurses' and physicians' cognitive frameworks. Such research on nurses' and physicians' definitions of respect would be particularly useful if conducted as one facet of the preliminary data collection procedure in an organizational development action research project in a single hospital or health care facility. Indeed, the identification and discussion of similarities and differences between the nurses' and physicians' meaning
systems may constitute the appropriate organizing framework for action research intervention in a hospital or hospital sub-unit.

Third, by proposing a new paradigm for the central problem in nurse-physician relationship, this study highlights the need for the professions of nursing, medicine, law and policy making to re-think the supports still provided to the concept of medical autonomy. Medical autonomy precludes, by definition, nursing participation in medical decision making. Precluding such participation risks continued poor outcomes to patients and continued nurse dissatisfaction, burnout, low productivity, turnover and stress. Such outcomes are contrary to the public health interest of the law and the government and to the humanitarian interest of the health care professions. By emphasizing nursing autonomy from medicine, the profession of nursing emulates the medical standard of autonomy, reinforces autonomy and independence as an appropriate standard of practice. Due to the information explosion and the increasing specialization of medicine, due to the impact of non-collaboration and medical independence on poor patient care, and due to the views of practicing nurses toward interdependence between nurses and physicians, it is simply no longer practical, ethical or strategic to continue to advance medical or nursing independence as an appropriate standard. Rather, interdependence between physicians,
nurses and patients in making medical decisions is the more appropriate standard, toward which changes in law, education and ideology need to be made.

Fourth, a new paradigmatic view of the central issue in the nurse-physician relationship suggests a new relationship between the study of nursing knowledge, decision making and the nurse-physician relationship which have thus far been treated as separate topics in the literature. It resolves the contradiction in the literature regarding whether conflict is good or bad, and needs to be promoted or resolved. It suggests a new direction for researchers and educators in terms of identifying and validating the nature and sources of nurses' knowledge, methods of reasoning and the entitlement and capability of nurses' to hold and to use scientific knowledge. Answers need to be sought in terms of such questions as what forms or types of nursing knowledge do nurses of color, other gender and other settings believe are important in terms of participation in medical decision making; what are physicians views on the sources and value of nursing knowledge; what factors are most salient in the formation of nurses' and physicians' views; how do physicians and nurses of color, other gender and other settings view the importance of contextual knowledge in medical decision making; how does the inclusion of nursing knowledge of individual patients change medical decision making; what are the effects of nursing participation in
terms of the quality and/or effectiveness of patient care? Answers to such questions would be of value not only in furthering the understanding of issues in the nurse-physician relationship, but would also provide data to support changes toward collegial and interdependent relationships between nurses and physicians in settings where they do not presently exist.

The second area of major conclusions and recommendations is in terms of factors influencing the relationship. The study found that nurses viewed the team nurse-physician relationship as learned and as setting dependent, based on structural factors which promoted nurse-physician interaction, familiarity and reliance and based on norms of equality, respect, questioning and open discussion. These factors resulted in physicians and nurses recognizing the interdependence of nurses and physicians and hence, in the development of a collegial relationship, wherein nurses participated in medical decision making.

These findings demonstrate the applicability of intergroup relations theory (Alderfer, 1981; Sherif, 1966) as a frame of reference for understanding and improving nurse-physician relationships. Theoretically and as demonstrated in the results of this study, recognition of interdependence between members of two groups through extended interaction provides opportunity to create new norms of interaction between two previously conflicting
groups. Because of the applicability of intergroup relations theory, methods and interventions in organizational development, which are based on intergroup relations theory may be useful for improving the nurse-physician relationship in individual settings. Such methods include the utilization of microcosm group or interface group formats. Interventions which are designed to increase interaction between nurses and physicians and to create norms of equality, respect, questioning and open discussion of medical decisions may prove to be the most productive in improving the nurse-physician relationship.

Contrarily, interventions based on individual/interpersonal or societal level theoretical frameworks may actually be destructive to nurse-physician relationships. Individual/interpersonal level frameworks, as was demonstrated in the review of the literature, focus on an individual's emotions, personality traits, level of maturity, individual competence and conflict resolution style. According to the findings of the present study, sometimes individual personality can be problematic in the nurse-physician relationship, but was not the central issue. Focusing on changing an individual's abilities and characteristics along these dimensions may be helpful to an individual, but does not address or change the underlying functional relationship of competitiveness in terms of nursing inclusion/exclusion from medical decision making.
An individual/interpersonal focus can also serve to inappropriately blame the individual nurse and the individual physician for failure to resolve conflicts, due to inexpert interpersonal and negotiation skills, when the real issue may be norms of medical autonomy. Emphasis on individual/interpersonal level theoretical frameworks therefore may be disempowering and destructive to nurses and physicians, because they do not address the central intergroup issue in the relationship: medical autonomy versus interdependence and nurse participation.

Likewise, focus on societal level issues of gender, class and race, although related to the central dynamic of medical autonomy, propose solutions which are only indirectly related to the central issue. Improvements in the nurse-physician relationship must wait until society solves its problems with sexism, classism and racism. Interventions at the societal level framework are on the order of revolutionary societal change, which are probably beyond the energy, imagination and interest of most nurses and physicians in day-to-day interaction. Such a theoretical focus is helpful in describing the embeddedness of the nurse-physician relationship in the broader cultural context, but are disempowering on the level of specific intervention.

It would therefore be helpful, both practically and theoretically, for researchers, educators and those
empowered to intervene in nurse-physician relationships, to adopt an intergroup perspective. The intergroup perspective integrates the three theoretical levels of analysis, provides theoretical and practical understanding regarding the central dynamic in the nurse-physician relationship and offers direction for intervention which has been effective in improving similar hierarchically embedded intergroup conflicts. Adopting this approach in research, education and intervention may have significant benefit for nurse and physician empowerment and for improving nurse-physician relationships.

In terms of the characteristics of the nurse-physician relationship, this study found that nurses viewed their nurse-physician relationship behavior as governed by getting along norms, which include mutual respect, equality, courtesy, professionalism and learning from mistakes. It found that nurses distinguished between disagreement and conflict with physicians. Finally, it found that nurses' reasons for engaging or not engaging in conflict with physicians were related to patient threat and nurses' certainty of their own knowledge.

These findings highlight the need for the development of mechanisms which support nurses in openly voicing and discussing disagreements with plans for medical care with physicians and in the development of systems which provide overview of the resolution of such disagreements. Nurses
may need support and encouragement in voicing disagreement due to the hierarchical nature of the nurse-physician relationship, to gender socialization regarding disagreement and to lack of realization of the importance of their own knowledge. Physicians may need support and encouragement in listening to and hearing nurses' disagreements and recommendations due to similar reasons. Without such mechanisms, the negative effects of the traditional nurse-physician relationship may continue to prevail: disagreement may not occur, or may occur in such emotional proportions that nurses refer to it as conflict.

Finally, these findings suggest the applicability of qualitative methods, which, by allowing nurses to speak for themselves, to explain the meaning of their own behavior and what it represents for them, results in a different understanding of nurse behavior. It results also in a different evaluation of that behavior: instead of a manifestation of feminine weakness, it can be seen as a manifestation of women's strength; instead of needing to be changed, it can be seen as needing to be emulated.
APPENDIX A

INTERVIEW GUIDE

Introduction (Opening Grand-Tour question)

"I'm interested in exploring the perspectives you have regarding the nurse-physician relationship. To get things going, could you tell me what's going on at present around the nurse-physician relationship here at (Name of facility)?

Grand-Tour Theme Questions

- "How would you describe your experiences with physicians?"
- "What do you see as the most important things when you think about the nurse-physician relationship?"
- "How would you describe your view of physicians?"
- "How would you describe your view of medical practice?"
- "How would you describe your view of patients?"
- "How would you describe your view of the relationship between physicians and patients?"
- "How would you describe your view of nursing?"
- "How would you describe your view of the relationship between nurses and patients?"
- "How would you describe your view of conflict?"
- "How would you describe your view of the role conflict plays in the relationship between physicians and nurses?"
- "If you were to be away from the unit for a few months, what would you tell your temporary replacement about nurse-physician relationships so that she would be able to act sensibly in your absence? You can assume that your replacement is someone you can trust and is as generally and technically competent as yourself..." (to elicit participants thoughts about those aspects of the situation which are difficult to articulate, perhaps because they are in regard to sensitive political data, but are important) Floating Prompts
- "What do you do, feel or think about ...?" (to elicit the participant's description of the themes in their life-world)

- "What was that like for you?" (to elicit emotional, descriptive and cognitive depth)

- "Why is the (issue, outcome or factor the participant is describing) important?" (to elicit more descriptive information)

- "Why is the outcome you describe either preferred or not preferred?" (to identify the idiosyncratic network of goals, objectives and ideals which are relevant for the participant to the issue)

- "Why does this matter to you?" (to elicit the significance the idea has for the participant)

- "Could you tell me about an alternative that would be more satisfactory to you?" (to elicit the participant's view of the optimal situation)

- "What reasons come to mind as explanations for (whatever issue, situation, outcome or factor the participant is describing)?" (to elicit the participant's view of the causes of the phenomenon they are describing)

- "Why is it like that?" (alternative prompt to elicit the participant's view of the causes of the phenomenon they are describing)

- "What is the difference between `a' and `b' in your perspective?" (to elicit contrast)

- "You've mentioned the word "________" a few times; what does that mean to you?" (to elicit the participant's interpretation of the meaning of the concept they've used)

- "What do you mean, exactly?" (to elicit greater depth)

- "You've been saying that..." (if the participant dries up and seems unable to easily articulate her/his thoughts)

- "That's very interesting, I wonder if you could say a little more about that?" (alternative prompt if the participant dries up and seems unable to easily articulate her/his thoughts)

- "What was the most striking about the incident?" (to increase depth regarding situations)
APPENDIX B

BIOGRAPHICAL DATA

Today's Date: ___________    Time: ___________
Place: ___________________________________

Code #: __________________

Date of Birth: ___________    Age: ___________
Place of Birth: ___________________________________

Gender:    Male    Female

Current Place of Residence: ___________________________________

Marital Status:    Single    Married    Divorced    Widowed

Children:    None    One    Two    Three    Four    More

Brothers:    Yes    No

First Name:    Age:    Highest Level of Education

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Sisters:    Yes    No

First Name:    Age:    Highest Level of Education

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
Father: ____ Age: ____ Occupation: 

Highest Level of Education: 

Mother: ____ Age: ____ Occupation: 

Highest Level of Education: 

Class Background: ______ Ethnic Background: ______

Participant's Level of Education:

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<th>Degree</th>
<th>Year of Graduation</th>
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Position in Organization: ____________________________________________________________

Previous Positions Held: 
Type of Facility/Unit: Position: Years in Position: 

________________________________

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________________________________

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APPENDIX C

CONSENT FORM

I am Karen Peret, a doctoral student at the University of Massachusetts in Amherst and a Nursing Administrator at Monson Developmental Center in Palmer. The subject of my doctoral dissertation is "A Qualitative Study of the Meaning of the Nurse-Physician Relationship from the Perspective of Nurses in a University Medical Center." I will interview nurses in this medical center in order to see the world of nurse-physician relationships as nurses do.

Thank you for your interest in participating in this research project. I will ask you some brief questions about your background before we begin. The interview itself should take approximately two hours to complete. There are no right or wrong answers to the questions; I am interested in what your perspectives of the nurse-physician relationship are.

As a participant in this research project, you have several rights. First, your participation in the interview is entirely voluntary. You should have had no pressure from anyone to volunteer; you are free to refuse or to decline to answer any of the questions; you are free to withdraw from the interview at any time. Secondly, this interview and your answers will be kept strictly confidential and will be available only to myself and the professors who will review my work at the University of Massachusetts in Amherst. The interview will be audiotaped and the tape will be transcribed by a person unconnected with the facility in which you work. Your name will not appear on the tape or the transcribed typewritten copy; it will be kept on a codelist which will be stored in a locked cabinet in my home. The codelist will be destroyed after you have been sent a copy of the analysis of your interview and a copy of the final dissertation if you desire one. In the final dissertation or in any subsequent publication or presentation, I will present only group information; any excerpts from your interview that may be used will not include sufficient detail about you for anyone who knows you to determine that it was you who gave that information.
As stated above, I will be happy to provide you with copies of the audiotape, the typewritten transcript and a final copy of the dissertation. If you have any questions about this project, please feel free to ask during the interview or at a later time. You may contact me at:

Karen Peret
Sturbridge Road
RR #2, Box 105
Holland, MA 01521
(H) 413-245-9452
(W) 413-283-3411 ext. 286

____________________________________________
I, __________________________________________, have read the above statement and agree to participate as an interviewee under the conditions stated in this consent form.

____________________________________________
Signature of the Participant

____________________________________________
Date

____________________________________________
Interviewer

Please check which of the following you would like to have a copy of:

_____ audiotape of interview

_____ typewritten transcript

_____ final dissertation

Address for those requesting copies of material:

____________________________________________

____________________________________________

____________________________________________
APPENDIX D
OPEN LETTER TO STAFF NURSES

Dear Staff Nurse: 

April 1, 1992

My name is Karen Peret. I am a doctoral student at the University of Massachusetts in Amherst. I am working on a research project for my dissertation which focuses on nurse's perspectives of the nurse-physician relationship. I am interested in interviewing a small number of staff nurses with a variety of educational backgrounds about their perspectives on this issue. All interviews will be kept strictly confidential.

If you are interested in being interviewed, please fill out the information at the bottom of this letter and return it in an envelope addressed to me in care of the Nursing Office. I will contact you within the next two weeks to arrange a convenient time for your interview.

Thanks ahead of time for your interest in this project.

Sincerely,

Karen K. Peret

I am interested in being contacted for an interview:

Name: ________________________________

Position: ____________________________ Work Unit: ____________________________

Phone Extension: ______ Basic Nsg. Ed: AD DIP BS

Best times for an interview (approximately two hours): ____________________________
REFERENCES


Magee, M. (1989). Don't treat nurses as if they were invisible. Postgraduate Medicine, 85(1), 67-68.


