Physician-Nurse Interactions in Critical Care

Sumaira Khowaja-Punjwani, BScN, MBEth, Charlotte Smardo, RN, Monica Rita Hendricks, MSc, John D. Lantos, MD

Nearly 20% of nurses leave their first job within a year of being hired. Many do so because they perceive the work environment to be unhealthy or nonsupportive. Nurse turnover is costly. When new nurses leave within 3 years of being hired, it costs the hospital $64,000, over and above salaries, to replace them. One of the hallmarks of an unhealthy work environment is poor communication between doctors and nurses. We present a case in which a nurse advocates for a young mother by questioning the doctor. She is reprimanded for doing so. We then asked 3 nurses to discuss the implications of such interactions for nurse satisfaction, patient safety, and a healthy work environment.

ICUs are stressful places to work.1 Nurses who start their careers in intensive care often don’t last.2 One of the primary reasons why nurses leave is because of an unhealthy work environment.3 One of the hallmarks of an unhealthy work environment is poor communication between doctors and nurses. Overall, nearly 20% of nurses leave their first job within a year of being hired.4 Poor communication leads to medical errors.5 Furthermore, nurse turnover is costly. One study estimated that when new nurses leave within 3 years of being hired, it costs the hospital $64,000, over and above salaries, to replace them.6 We present a case in which a nurse advocates for a young mother by questioning the doctor. We then asked 3 nurses to discuss the implications of such interactions for nurse satisfaction, patient safety, and a healthy work environment.

THE CASE

Erika, a staff nurse, had been working in the NICU for 3 months. It was her first job out of nursing school. She loved taking care of babies but was not sure what she was or was not supposed to talk about with parents. She was taking care of Georgina, a 3-month-old infant who had been born at 28 weeks, had developed bronchopulmonary dysplasia, and was about to be discharged. Georgina was the first child of her 22-year-old mother. The mother seemed quite anxious about caring for her at home. She asked Erika a lot of questions. For example, she was worried about being able to afford the medications that were prescribed and wondered if there were any cheaper alternatives. The infant’s discharge medications included monthly injections of palivizumab, daily furosemide, and an albuterol inhaler to be used as needed. Erika spoke to the attending physician about the mother’s concerns. He brusquely told her that he was prescribing what was best for the infant. Erika was upset about the doctor’s response and about how she was treated, but she kept silent about the issue and carried on with her work. The next day, Georgina’s mother again started asking her questions about medications, follow-up visits, and other medical questions. Erika started to answer, but one of the senior nurses, who was...
nearby, called her aside and advised her to not answer and, instead, to tell the mother that she would need to ask those questions directly to the doctor. Again, Erika felt uneasy. How should a relatively inexperienced nurse decide which parental questions to answer and when to bring up parental concerns to the doctors? How should nurses think about their obligations to advocate for their patients? Are there role-specific limits to what they should or should not say? Is the experience of the nurse in the vignette a common one? And do most nurses learn about these issues in school, from experience, or from senior nurses?

**Sumaira Khowaja-Punjwani, BScN, MBeth, Comment**

For all parents, and especially for young, first-time mothers, the hospitalization of their child is an extraordinarily stressful experience. Such parents have many questions and need a lot of support. Nurses spend more time with patients and parents than any other health professional. They are experts at effective communication and advocacy. A collaborative team of doctors and nurses can lead to better communication, which, in turn, leads to better patient and family outcomes. When parents’ anxiety is effectively addressed, children do better.

However, when nurses advocate for a patient, they face certain risks and obstacles associated with the setting in which they work. Therefore, it is quite possible that their attempts to advocate for patients may be punished rather than rewarded. Nurses may experience many barriers when addressing the rights, choices, or welfare of their patients. There are several factors that have acted as barrier for patient advocacy in this case that can be categorized into 2 broad domains, namely, interpersonal factors and organizational factors.

**Interpersonal Factors: Provider Attributes and Reputation**

Erika, the primary care provider (ie, the nurse) is inexperienced. This is not unusual in intensive care settings where nurse turnover is high. Still, Erika’s empathetic approach in addressing patient questions was absolutely right. Because she was a novice nurse, however, both the doctor and her nurse colleagues didn’t respect her. There are sometimes good reasons why colleagues do not respect a novice. Trustworthiness and credibility are established through prolonged engagement with peers. Even though Erika was skillful and was asking all the right questions, her concerns were not taken seriously. Erika, then, was understandably upset about the doctor’s response and the way she was treated. But she lacked the experience to handle such a scenario. The cumulative effect of such interactions is predictable. Erika learned to remain silent as a patient advocate. She felt a sense of powerlessness. She learned, from the response of the senior nurses, that silence in such situations was the appropriate role for a nurse. She will be unable to fulfill her role as a patient advocate.

**Organizational Factors: Work Environment**

The work environment and unspoken work culture plays a significant role in terms of determining the ways in which ethical dilemmas will arise and the way that they might be resolved. The NICU is a complex work environment. Doctors, nurses, and other health professionals all have specific roles, responsibilities, and accountability. It is crucial, in this complex world, to develop a collegial atmosphere to promote the smooth functioning of an interdisciplinary team. In this case, the physician’s response illustrated the ways that such smooth functioning can break down. His approach was hierarchical and authoritarian, rather than collegial and respectful. If there is no mechanism to correct such interactions, then there will be no way to promote patient advocacy within this organization.

**Organizational Factors: Group Influences**

Lack of support from peers is considered one of the greatest barriers for practicing patient advocacy. In this case, the senior nurse additionally asserted that Erika’s approach was incorrect. She, too, endorsed a hierarchical approach. Her actions, like the physician’s, are problematic for both patient advocacy and for nurse morale.

Nurses have always seen patient advocacy as a moral obligation. Every nurse learns it is their primary responsibility to protect patient rights and interests. Nursing advocacy integrates aspects of individuality, professionalism, experiences of empowerment, and exceptional care. Advocacy is not a single event. Rather, it is a process of analyzing, counseling, responding, shielding, and occasionally whistle-blowing. This obligation to patients represents an ideal. In actual practice, institutional and hierarchal constraints often prevent nurses from acting as advocates.

There are ways we can move closer to the ideal. Senior leaders in the NICU should insist on an interdisciplinary team approach for developing patient care plans to provide a sense of community versus conflict. Senior nurses must encourage less-experienced nurses to speak up when they have concerns and must support them when they do. For nurses, these goals can only be achieved through methodical teaching of nurse advocacy in nursing education programs. These ideas are consistent with state-of-the-art practices in programs to improve quality and safety. Thus, they are
harmonious with the central ethical obligation of all health professionals: to insist that the patient’s safety and needs should always be the highest priority.

Charlotte Smardo, RN, Comment

This scenario is a classic case of broken communication and poor team dynamics. It is also a sentinel event, which should stimulate a program of quality improvement.

There are multiple components in this scenario that are alarming. To begin with, Erika, the bedside nurse, is new to her role, and yet she is put in a situation where she feels unsure of herself and does not have the support she needs to act confidently. She attempts to converse with the physician, but he responds “brusquely.” This unfortunate negative interaction is potentially damaging to Erika. It could instill in her a sense of hesitancy about future interactions with physicians. For high-quality care in the NICU, nurses need to feel comfortable discussing their concerns with physicians. Hesitancy in this regard could lead to poor interprofessional communication and worse outcomes for patients.

What was the physician thinking? Perhaps he misinterpreted Erika’s questions as criticism of his decisions rather than a reflection of her need, perhaps due to her inexperience, for clarification and validation of the plan of care.

Once shot down by the physician, Erika will carry the negative baggage from this interaction into her next interaction with the mother.

The senior nurse makes things even worse. By telling Erika not to answer the mother’s questions, she is demanding that Erika close herself off. If Erika follows this advice, she will be unable to meet both the mother’s educational needs as well as her emotional needs. This mother clearly seeks some emotional support.

The young mother has entrusted the care of her fragile newborn to the professionals. They are failing her. This failure will prevent the mother from being able to provide optimum care for the infant. Fortunately, as this infant approaches readiness for discharge, her medical needs are not overwhelmingly complex. Still, the necessary teaching and support are negligently being withheld. To promote ongoing healthy bonding with her infant, this mother needs the confidence to care for her. It is the team’s responsibility to empower this mother and place her in a position to succeed in caring for her infant.

This scenario illustrates a dysfunctional care team. A discharge planner could help when discharging an infant from a critical care area. The discharge planner sees the “big picture” and may add other specialty areas as deemed necessary, such as social work, pharmacy, nutrition, etc. This enhanced team would be able to provide the mother with information as well as assistance with follow-up care and appointments. The discharge planner could be the nurse or could be a separate individual. But, in either case, it is essential that this person be empowered to question professionals, clarify plans and goals, and help parents understand what they will need to do at home.

The stakes are high for all involved. For the mother and infant, a poor discharge plan could lead to additional illness and readmission to the hospital. For Erika, the lack of a functional discharge team creates moral angst, which can lead to job dissatisfaction and burn-out syndrome.

New nurses require guidance and support to enhance their confidence in their own communication skills and style. Often, a charge or resource nurse is available to assist nurses in difficult or challenging scenarios. Erika could have definitely benefited from such peer support to “coach” her in effective communication with the mother and also the physician.

New nurses benefit from training to enhance their skills for crucial conversations.

The logistics of an ICU environment put the nurse in a unique position. Often, she is only caring for 1 infant and 1 family. She might spend her entire shift at 1 patient’s bedside. This allows considerable opportunity for family conversations. By contrast, physicians spend little time with each family. Empowering the nurse to raise questions allows the discharge team to perform tasks that the physician lacks time to accomplish.

When a medical institution makes a commitment to care for a certain population, in this case neonates, their obligation is not always limited to inpatient care; it must also encompass forward-thinking care, including, but not limited to, discharge planning.

If the appropriate resources and counseling had been made available to Erika, then her experience would have been positive, which would have led to better care and better staff morale. The effective team would discharge mother and infant safely and successfully. Clearly, that is, or should be, everyone’s goal.

Monica Rita Hendricks, MSc, Comment

Situations like the one in this case are common. When there are no rules or guidelines, these kinds of situations can play out in ugly and dysfunctional ways. In such cases, it becomes a power struggle in which the stronger or the angrier of the 2 professionals will win. But a NICU is no place for intraprofessional disagreements to be resolved by the survival of the fittest.

In this scenario, both the doctor and the nurse were trying to assert their
professional identities. The doctor wanted to be authoritarian and to not have his authority questioned. The nurse wanted to be an advocate and felt that advocacy was central to her professional identity. Both forget that they should be working as part of a multidisciplinary team focused on the best interest of their patient.

Neither professional thought to involve the patient, the frightened young mother, in their discussion and their decision-making. By excluding the mother, they were both violating the central tenet of shared decision-making. By not giving the mother the information she needed to make an informed decision, they were disempowering her and crippling her ability to make an appropriate choice. In their anger and self-centeredness, the doctor and nurse have also violated the boundaries of their relationship. This violation will have an impact on both their ability to work together in the future and on the patient’s outcome.

The senior nurse also missed an opportunity. She seemed to see her role as one of educating the junior nurse about the political realities of that unit. In doing so, however, she was reinforcing values that were likely dominant ones in that unit, and ones that made the unit a dysfunctional place to work and care for patients. Instead of reprimanding the junior nurse, her supervisor should have found a way to engage the doctor and the young mother in a discussion of discharge plans.

In the day-to-day operation of a busy NICU, these minor power struggles often go unnoticed. They likely result in the strongest, more powerful person getting to do as he or she likes.

This situation would be a good opportunity for the professionals in this unit to clarify their roles and their obligations. Nurses spend more time with patients than doctors. They are therefore in a unique position to help doctors by being the patient’s voice and the patient’s advocate. This role is central to professional identity. It has been taught to nurses from their first year of nursing education.

Many times, the physician might not be as available for their patient as the nurse. Recognizing this, the physician should empower the nurse and encourage her to speak up for the patient when she is aware of an unmet need. Only then can both the doctor and the nurse educate the patient about what she will need to do. Educated patients have better outcomes.

The experience of this junior nurse is, unfortunately common. If not addressed quickly and effectively, it will lead to bad patient outcomes. An experience like this may also contribute to a nurse’s dissatisfaction, which may lead her to leave her job. All of these bad outcomes are avoidable by bringing attention to the dynamics of interprofessional communication.

**John D. Lantos, MD, Comment**

The care of critically ill infants in ICUs requires exquisite teamwork. In children’s hospitals today, there are dozens of health professionals involved in the care of every critically ill infant. These health care workers must respect one another’s expertise, autonomy, and moral agency. A hallmark of hospitals that are therefore in a unique position to help doctors by being the patient’s voice and the patient’s advocate. This role is central to professional identity. It has been taught to nurses from their first year of nursing education.

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