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PHYSICIAN-NURSE RELATIONSHIP
- NURSES' PERCEPTION IN INTERNAL MEDICINE AND SURGICAL UNITS

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ABSTRACT

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Name of thesis PHYSICIAN-NURSE RELATIONSHIP. NURSES' PERCEPTION IN INTERNAL MEDICINE AND SURGICAL UNITS		
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This research focused on the perception of nurses who worked in the internal medicine and surgical units on physician-nurse relationship. The aim of the research was to find out the types of physician-nurse relationship in clinical settings, the associated factors and how patients could benefit from physician-nurse collaboration.

The research methodology was quantitative descriptive approach by survey design. For data collection, a questionnaire with 20 fixed questions was targeted at all 125 nurses working in the internal medicine and surgical units over a period of six weeks. The number of participants that partook in the study was 73 which represented 58,4% of the target group.

The results indicated 5 different types of physician-nurse relationships existed; the most common type was collegial relationship. Several factors were responsible for the types of physician-nurse relationship that existed; predominantly nurse autonomy and accountability. It also indicated that professional collaboration and patient education were beneficial to patient care.

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1 INTRODUCTION

The perception on physician-nurse relationship is complicated because it is believed to have many conflicts. The physician-nurse relationship like other professional relationships is not determined by a single factor but by a combination of factors. These associated factors will determine whether the outcome of a relationship would be positive or negative.

This research is aimed at providing healthcare professionals with information regarding different types of physician-nurse relationships in clinical settings, their associated factors and ways they could be improved. The improved relationship would lead to an improvement in patient care and subsequently raising the standard of care.

The general purpose of this research was to unveil the physician-nurse relationship from a nursing perspective. Information was collected from nurses working in the internal medicine and surgical units of Central Ostrobothnia Central Hospital in Kokkola, Finland. Professional teamwork in these units is essential similar to many other specialised units because it increases physician-nurse interaction and affects the physician-nurse relationship. The physician-nurse relationship impacts the care and outcomes of patients. The interest in this subject was motivated by the researcher's desire to observe optimal patient care from physician-nurse relationship.

The research problem was to determine the types of relationships that existed between physicians and nurses, the associated factors to these relationships and ways that patients can benefit from physician-nurse teamwork.

The results revealed five different types of physician-nurse relationship existed; the most common type being collegial relationship. Several factors were responsible for the types of physician-nurse relationship that existed; predominantly nurse autonomy and accountability. It also indicated that professional collaboration and patient education were beneficial for patient care.

2 THEORIES AND CONCEPTUAL MODELS IN NURSING

Theories and conceptual models in nursing were developed by nurse theorists. These theories and conceptual models were subsequently utilised by nurse researchers. It is imperative to note and appreciate the contributions made by nurse theorists, which have led to nursing theories' application to nursing research. These theories and conceptual models formally explain nursing discipline and nursing process, with the viewpoint of the theorist or model developer emphasised (Polit & Beck 2008, 145). Discoveries do not generate theories, conceptual frameworks and models but creation and invention. Theory construction does not only depend on facts and observable evidence but also the theorist's ingenuity to obtain facts and derive meaning from them. Theory building is a creative and intellectual venture that can be engaged in by any insightful individual based on existing evidence and carefully knitting the observation and evidence together to produce an intelligible pattern. (Polit & Beck 2008, 144.)

Nursing theories help to propel research and knowledge extension. Both nursing theory and nursing research are reciprocal and mutually beneficial. Theory guides and initiates ideas for research; research utilises the existing theory and provides a foundation for new theories. (Polit & Beck 2008, 144.)

Some important theories and their theorist with relevance to nursing research are outlined. The Nursing theories can be divided into four types: Needs-based theories, Interactive-based theories, Outcome-based theories, and Humanistic-based theories. (Nursing theories 2010.)

2.1 Needs-based theories

Leininger (2006) developed the theory of culture care diversity and universality which stated that "caring is a universal phenomenon but varies trans-culturally" (Polit & Beck 2008, 146). Plowden and colleagues (2005) research on cultural and social factors that influence high-risk behaviour among inner-city HIV positive African Americans benefitted from Leininger's theory (Polit & Beck 2008, 146).

Besides that, different cultures perceive, know, and practice care in different ways, yet there are some commonalities about care among all cultures of the world (George 2002, 491). Culture was defined as "learned, shared, and transmitted knowledge of values, beliefs, norms and lifeways of a particular group that guides an individual or group in their thinking, decisions and actions in patterned ways" (George 2002, 510). Care as a noun was defined as those "abstract and concrete phenomena related to assisting, supporting or enabling experiences or behaviours toward or for others with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (George 2002, 511).

Neuman (2001) designed the health care systems model which stated that "Each person is a complete system; the goal of nursing is to assist in maintaining client system stability". Jones-Canon and Davis (2005) used Neuman's model as a framework in their study on coping strategies of African-American daughters who functioned as caregivers (Polit & Beck 2008, 146). The Neuman systems are founded on two major components – stress and the reaction to stress. The inherent parts of the model are the environment, health and nursing. (George 2002, 341.)

2.2 Interactive-based theories

Allen (2002) developed the McGill model of nursing which stated that "Nursing is the science of health-promoting interactions. Health promotion is a process of helping people cope and develop; the goal of nursing is to actively promote patient and family strengths and the achievements of life goals". An example of a nursing research based on the McGill model is Cossette and colleagues (2002) work on nursing approaches associated with psychological distress reduction among patients after myocardial infarction. (Polit & Beck 2008, 146.)

Orem (2003) in her model called Self-care deficit nursing theory stated that "Self-care activities are what people do on their own behalf to maintain health and wellbeing; the goal of nursing is to help people meet their own therapeutic self-care demands". Kreulen and Braden (2004) used Orem's model to develop a

model of relationship between self-help–promoting nursing interventions and health status outcomes. (Polit & Beck 2008, 146-147.)

Orem's theory is composed of three theories which are interrelated - self-care, self-care deficit and nursing systems. This is supported within these three theories are six central concepts of self-care; self-care agency, therapeutic self-care demand, self-care deficit, nursing agency and nursing systems as well as the peripheral concept of basic conditioning factors. (Foster & Bennett 2002, 149.)

The contribution of Orem's work remains as an outstanding tool because of its versatility and pragmatism to nursing practice. She provided interpretation to nursing's metaparadigm of human beings, health, nursing and the society. She also played a vital role in defining three steps in the nursing process parallel to the six step nursing process. They are diagnosis and prescription, design of a nursing system and planning for the delivery of care and production and management of nursing systems as compared to assessment, diagnosis, outcomes, planning, implementation and evaluation. The nursing school curricula and nursing information systems have been designed based on Orem's theory of self-care. Her work continues to impact nursing globally as it offers a unique way of looking at the nursing phenomenon. (Foster & Bennett 2002, 149.)

Watson (2005) founded the theory of caring which stated that "Caring is the moral ideal, and entails mind-body-soul engagement with one another". Hemsley and colleagues (2006) used Watson's model in a phenomenological study of the transformational experiences of nurse healers (Polit & Beck 2008, 147). Watson played a vital role in the reorientation of nursing from a biomedical, mechanistic model to one of caring as an interpersonal, interactive process. However, she attempted to explain the whole being of an individual but undermined the importance of the physical. Watson believed that caring-healing consciousness of a caring occasion unveils potential for healing beyond body and self, leading to harmony, wholeness, health and spiritual evolution. (Kelley & Johnson 2002, 422.)

2.3 Outcome-based theories

Levine (1973) developed the conservation model, which stated that "Conservation of integrity contributes to maintenance of a person's wholeness". Melancon and Miller's (2005) research on "the effect of massage therapy versus traditional therapy for relief of lower back pain" used Levine's model (Polit & Beck 2008, 146). Levine's work touched on adaptation, conservation and integrity. Conservation is achieved through the process of adaptation and its purpose is integrity. "Adaptation is the life process by which, over time, people maintain their wholeness or integrity as they respond to environmental challenges" in effect, it means that an individual is in relationship with his or her environment. Adaptation is characterised by concepts such as historicity, specificity and redundancy. "Conservation defends the wholeness of living systems by ensuring their ability to confront change appropriately and retain their unique identity" (George 2002, 226-227).

Levine's theory is founded on four principles of conservation such as the conservation of energy of the individual; the conservation of the structural integrity of the individual; the conservation of the personal integrity of the individual and the conservation of the social integrity of the individual (George 2002, 228).

Newman (1994; 1997) postulated the health as expanding consciousness model which stated that "Health is viewed as an expansion of consciousness with health and disease parts of the same whole; health is seen in an evolving pattern of the whole in time, space and movement". Berry (2004) used Newman's theory to study behaviour changes and personal self discovery in women who maintained weight loss for one year or more (Polit & Beck 2008, 146). She synthesized a new view of health formed from disease and non-disease to explain the theory of health as expanding consciousness. She also explained pattern of a person and environment, stating that humans are unitary beings moving in time and space, thereby creating a harmonised organisation. Change was associated with periods of organisation and disorganisation (George 2002, 533).

2.4 Humanistic-based theories

Parse (1999) established the theory of human becoming which stated that "Health and meaning are co-created by indivisible humans and their environment; nursing involves having clients share views about meanings". Jonas-Simpson and colleagues (2006) used Parse's theory to study the experience of being listened to among older adults in long-term care settings (Polit & Beck 2008, 147). Deductions on the principles, concepts, and theoretical structures of human becoming were obtained by assumptions made by Parse's theory on humans and health. These postulations were based on Roger's principles and concepts and the works of Heideger (1962, 1972), Sartre (1963, 1964, 1966) and Marleau-Ponty (1973, 1974) on existential-phenomenological thought. Roger's three major principles used by Parse included helicy, integrality and resonancy. She also used four other concepts and pan-dimensionality as part of the theoretical basis for her own postulations about man and health. Parse fused these principles and concepts with the following tenets and concepts of existential-phenomenological thought: intentionality, human subjectivity, co-constitution, coexistence and situated freedom (Hickman 2002, 429).

Parse's postulations lead to three principles of human becoming. These principles are as follows: Principle I – "Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging". Principle II – "Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating". Principle III – "Cotranscending with the possible is powering unique ways of originating in the process of transforming". (Hickman 2002, 433-435.)

Parse's school of thought of human becoming is a science system of interrelated concepts which describes the unitary human's mutual process with the universe in cocreating becoming. Human participation in health is the fundamental tenet of the ontology of human becoming. (Hickman 2002, 429.)

Roger (1970, 1986) in her theory called science of unitary human beings stated that "the individual is a unified whole in a constant interaction with the environment; nursing helps individuals achieve maximum well-being within their

potential". Wright (2004) used Roger's theory to study the relationship between trust and power in adults as a way of illuminating nurse-client relationships (Polit &Beck 2008, 147). Roger's conceptual theory is being credited for its broad scope and its applicability to all nursing practice settings. It has a great impact on both nursing education and nursing practice. It has also contributed enormously to the growth of nursing research and development of further theoretical knowledge (Garon 2002, 284).

Roy (1999) founded the adaptation model which stated that "Human are adaptive systems that cope with change through adaptation; nursing helps to promote client adaptation during health and illness". Shyu and associates (2004) in their study of environmental barriers and mobility among elders in Taiwan tested Roy's model (Polit & Beck 2008, 147). Roy's model outlined the important concepts of nursing as the human adaptive system, the environment, health and nursing. There is a constant interaction between the human adaptive systems and the internal and external environmental stimuli. It is either active or reactive to these stimuli (Galbreath 2002, 330).

3 PHYSICIAN-NURSE RELATIONSHIP IN CLINICAL SETTING

3.1 Overview of physician-nurse relationship

The Oxford English dictionary defines a Physician as a person who is trained and qualified to practice medicine and is also referred to as a Medical Doctor (MD). A Nurse refers to a person who nurtures or cares for others; a registered nurse (RN) is a qualified nurse who has been entered into an official register. Relationship refers to a connection formed between two or more people or groups based on social interactions and mutual goals, interests or feelings. (Oxford English Dictionary 2010.)

Physician-nurse relationship can be defined as the professional interaction, co-operation, communication and collaboration that exist between physicians and nurses. Collaboration is working with colleagues towards an agreed objective and is advanced through consultations with patients and colleagues. (Bor, Gill, Miller & Evans 2009, 56.)

Figure 1 shows a pictorial representation of physician-nurse collaboration with the patient.

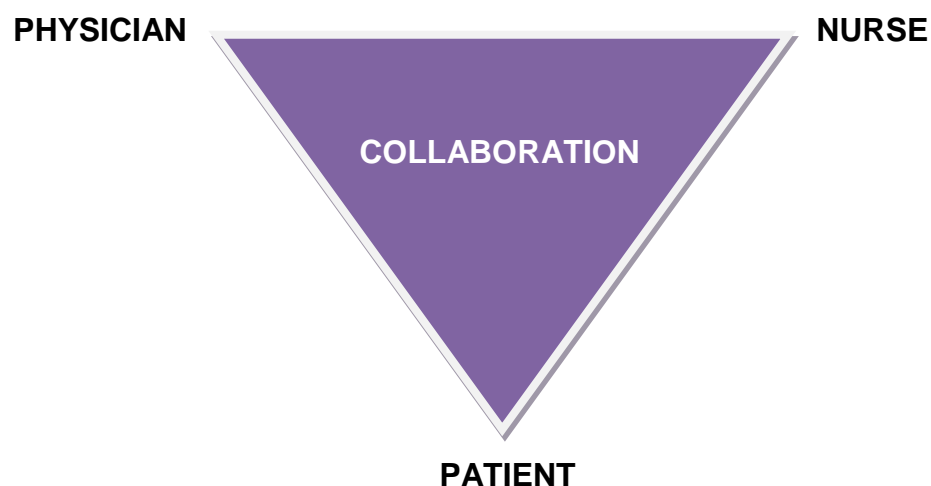PHYSICIAN   NURSE

COLLABORATION

PATIENT

FIGURE 1. Physician-nurse collaboration with the patient.

Collaboration is not an event but a process when it is accepted as a core value and translated into behaviour, collaboration becomes an organisation norm. Collaboration is best seen as a relationship, a process with ongoing interactions. (Kramer & Schmalenberg 2005, 450.)

3.1.1 Ethical foundation on physician-nurse relationship

An ethical approach to the foundations of health professionals is multidimensional. It includes professional etiquette, chores and responsibilities to patients and colleagues or politics with its focus on the society. The focus should be doctors' and nurses' responsibility towards patients and professional relationship. This focus can help in providing a foundation for setting up a new health care team. (Storch & Kenny 2007, 479.)

The working relations between physicians and nurses, as any set of relations between a pair in the place of work, are threatened to some degree by inter-professional conflicts. These conflicts can be attributed to differences such as gender, educational gap and socio-economic state, misunderstanding and incompatibility. And also the recent decision of nurses to undertake greater responsibilities. (Tabak & Koprak 2007, 321.)

Therefore, it is important to examine the landmarks that constitute both the medical profession and the nursing profession to obtain facts on the professional ideals and realities.

3.1.2 Short background on Medical and Nursing professions

Western (allopathic) medicine is rooted in the Hippocratic tradition that blended the birth of 'priestly healing' with practical science. The history of medicine is characterised by diverse conceptions of science. However, the union of the practical science and the moral commitment is a trademark of this tradition. The relationship between the brilliant and authoritative physician and the unprotected

patient requires a base of moral commitment and general promise to use the power of medicine for a patient's well-being. (Storch & Kenny 2007, 480.)

The background of nursing is closely linked to medicine, religion and healing. According to Hindu records, a nurse is expected to be trustworthy, skilful and to be of high standard. Although enjoying early identification, nursing received rather slow development compared to medicine. Florence Nightingale regarded as the mother of nursing who cared for soldiers during the Crimean war of 1854, after which she stated in Notes in Nursing ethical admonitions such as listening to patients, upholding confidentiality and putting patients' needs first. Many nurses were influenced by her care philosophy and viewed nursing as a calling of healing the body and saving the soul. (Storch & Kenny 2007, 481.)

Parse (1998) differentiated the paradigms of nursing by stating that the totality paradigm views nursing as an applied science, drawing knowledge from all other sciences while the simultaneity paradigm views nursing as a basic science with its own body of distinct knowledge. Hence, totality-paradigm-based nursing practice focuses on diagnosis and treatment in curing, controlling, and preventing disease. (Hickman 2002, 428.)

Updated versions of the Hippocratic Oath are taken by all graduating medical students even up to this day. The essential ethic of the profession is contained in all versions stated: "to act for the patient's welfare; to do 'no harm'; to keep in confidence what is learned in functioning as a physician; and to provide help for those in need". A school of thought believed the technological advancements medicine underwent, questions the moral core of the profession. However, the revival of the professional interest with its focus on the moral core is viewed as a way of redeeming medicine. (Storch & Kenny 2007, 480.)

The Florence Nightingale's Pledge (written by Lystra Gretter in the USA in 1893, but ascribed to Nightingale) was used as the pledge for thousands of probationary and graduate nurses in North America. Nursing education provides great importance to aspects of spiritual care as well as gaining mutual trust and reciprocity in interactions with a patient and his family (Storch & Kenny 2007, 481).

The Pledge also reminds us of the importance of both autonomy and collaboration with physicians:

> I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavour to aid the physician, in his work, and devote myself to the welfare of those committed to my care (Lewis 2006).

3.2 Types of physician-nurse relationship

Kramer & Schmalenberg (2003) conducted a study on securing a good physician-nurse relationship in which they analysed responses from 14 magnet hospitals and resulted in a five-category physician-nurse relationship scale. Literature regularly revealed that nurses in magnet hospitals had a "good" physician-nurse relationship. However, the question here was what do nurses refer to as a "good" relationship with the physicians? Was there any connecting factor between the quality of physician-nurse relationship and the quality of patient care delivery? Are the qualities of these relationships quantifiable? The answers to these questions might serve as an enhancer to the level of nurse job satisfaction, the quality of patient care outcomes and other outcomes closely related and affected by physician-nurse relationships.

Collaboration is often associated with "goodness" by healthcare professionals which has led many researchers into linking physician-nurse relationship or collaboration to augmented staff and patient satisfaction, enhanced retention and diminished costs of care. Even though some argue that a solid physician-nurse relationship is based on mutual respect, good communication, and a positive attitude towards patients. Previous studies from 1888 to late1990s have shown a disparate power differentiation in physician-nurse relationships in favour of the physicians. (Kramer & Schmalenberg 2003, 35.)

In a classic study, all Intensive Care Units (ICU) in 13 large hospitals nationwide were examined. ICU patients cared by physicians and nurses who worked collaboratively, revealed lower mortality rate records than those who were cared by less collaborative nurses and physicians. (Kramer & Schmalenberg 2003, 35.)

3.2.1 Collegial relationship

Collegial relationships are described as excellent relationships. The core ingredient in these relationships is "different but equal" power and knowledge. It can be clarified with an instance; "one nurse said that physicians at her facility recognise that nurses see subtle changes in patients because they are with them all the time." This in effect means that physicians' value and respect the knowledge that working with nurses will create the best care plan which can help to decide whether to discharge a patient or to insert a central line. There is also expectation from the nursing managers in these relationships that requires nurses to contribute their clinical input regarding patients. (Kramer & Schmalenberg 2003, 36.)

The collegial relationships are further characterised by equal trust, power and respect. Physicians and nurses often regard themselves as peers or colleagues in describing these relationships as illustrated in the following excerpt: "Physicians are excellent". "They value our opinion and ask for input". "The physician asked me whether or not this patient is ready to go home, and I said No, he is complicated and still needs 24 hour home care". "We have got to get that completely arranged". "We discussed what type of central line to put in before the patient goes". "It happens on a daily basis that the physician seeks us out because they know that we know". (Kramer & Schmalenberg 2009, 77.)

3.2.2 Collaborative relationships

Collaborative relationships are described as "good" or "great" relationships. It is based on mutual trust, respect and power producing the willingness of nurses and physicians to co-operate with one another. It also affords the opportunity for both

nurse and physician to provide their views on issues and adequate audience be granted. Care plan is designed by the physician together with the nurse. However, the principle guiding this type of relationships is based on "mutuality" and not "equality", the physician is still superior. (Kramer & Schmalenberg 2009, 77.)

3.2.3 Guidance relationship

In guidance relationship, the teacher can be either the physician or the nurse. These can be seen when a physician deemed to be well experienced and knowledgeable and willingly explains and teaches the nurse. However, the case of a nurse teaching can occur when a specialising physician or specialised physician who is attending to a medical case not in his or her own specialty. Therefore, they would rely upon the nurse's competence and experience in that field in teaching and guiding them. (Kramer & Schmalenberg 2009, 77.)

3.2.4 Neutral relationship

Neutral relationship can also be called a friendly-stranger relationship. It is characterised by the exchange of formal information and the conservations are neutral. Nurses' description of this relationship can be illustrated in the following excerpt: "The physician comes in, checks the patient, write orders and leaves". "If I watch for him, to tell him something about his patient, he may listen, and then he just grunts and walks off". "Sometimes I do not know the physician has been in until I see the orders on the patient's chart". "I have been with this physician for over 17 years, and he still does not know my name, although I address him by his name every morning". (Kramer & Schmalenberg 2009, 77.)

The above illustration shows how formal, neutral and distant the friendly-stranger relationship can be. It outlines the indication a friendly-stranger relationship can be detrimental to quality of care delivered since communication is limited, formal and sometimes even absent.

3.2.5 Negative relationships

Negative relationships are characterised by anger, verbal abuse, real or implied threats, or resignation. It can be illustrated in the following excerpt: "Physicians are sharp; they snap at you, is not just when they are tired but all the time". "Heads roll around if the physician complains about anything". "I watch myself very carefully". (Kramer & Schmalenberg 2009, 77.)

A poor physician-nurse relationship has a great impact on the health care system. Studies have revealed that abusive or disruptive behaviour by physicians has significantly led to nurse burnout, reduction in job satisfaction and decisions to leave the profession. Nurses have expressed difficulty dealing with the physicians who are rude, unpleasant, dismissive or intimidating. It is more prevalent among older physicians than younger which, relates to gender issues, power gaps, hierarchical traditions and an attitude that nurses are their handmaidens rather than valued professional collaborators. (Sirota 2007, 53.)

3.3 Factors affecting physician-nurse relationship

The physician-nurse relationships have been the focus of several ongoing debates. Researchers have sought answers to the evolving relationships that exist and the factors that affect the type of physician-nurse relationship. In practice, most professional relationships including physician-nurse relationships consist of several elements that determine either a positive or negative relationship (Pullon 2008, 134). Physician-nurse interaction leads to a process of perception and communication which is characterised by verbal and nonverbal behaviours. Perception is one's representation of reality and is related to past experiences, concept of self, biological inheritance and educational background. Communication, however, means the passage of information from one person to another either directly face to face or through other means. Communication forms the information component of interaction. (King 1981, 145-146.)

3.3.1 Nurse competency

Competence is defined by the Oxford English Dictionary (2010) as "the ability to do" and competent as "adequately qualified for a task, to do, effective, adequate, appropriate". Competence can be defined as a potential capability for undertaking a job and competency as the actual performance in complying with standards of care. Nurse competence is related to the nurse's ability to apply his or her knowledge while competencies are results derived from utilised skills through practice. The notion of competence is very broad. It involves a diverse set of qualities such as skills, knowledge, attitudes, motives, personal interest, perception, reception, maturity and some aspects of personal identity. (Cowan, Norman & Coopamah 2005, 356-359.)

3.3.2 Nurse autonomy

Autonomy is the freedom to make discretionary and binding decisions that are consistent within one's scope of practice and freedom to act on those decisions. Nurse autonomy is the ability of a nurse to freely make discretionary and binding decisions. The nurse has control over the required knowledge needed for decision making. The training and education of the nurse equips him or her with the requisite information and understanding to make a decision. (Lewis 2006.)

The priority of a nurse should be on functioning both as a collaborator with physicians and as an autonomous professional. The journey of an autonomous nurse is not an individual journey but a journey for both nurses and physicians and health care agencies. Ultimately, autonomy will benefit patients, medicine and the nursing discipline. Highly essential to remember is that in nursing, one's work is one's honour. (Lewis 2006.)

3.3.3 Nurse accountability and responsibility

The concept of accountability consists of two major attributes: answerability and responsibility. Accountability can be defined as being answerable for one's actions and entail giving satisfactory reasons and explanations for one's action or how one

has carried out one's responsibility. Responsibility includes everything which one is seen to have a casual relationship and not only one's intentional conduct (Fry & Johnstone 2008, 41.)

In the International Council of Nurses (ICN) code of ethics for Nurses (2006), the responsibility of the nurse is to promote health, prevent illness, restore health and alleviate suffering. A nurse is said to be accountable when he or she is able to explain how his or her responsibility has been carried out by justifying the choices and actions in accordance with accepted principles and standards of professional nursing conduct and ethics (Fry & Johnstone 2008, 41-42.)

3.3.4 Common ground of physician and nurses

Physicians and nurses both share a common ground in their historical background of caring for the sick through skill and knowledge but at present the two professions fail to understand their complementary roles. Most of Hippocrates's teachings were essentially nursing care. However, from earlier times nursing was regarded as secondary to the role of the physician (Storch & Kenny 2007, 483). The differences between physicians and nurses are that nurses concentrate on personal relationship with patients while physicians are technical and emotionally neutral (Tabak & Koprak 2007, 322).

3.3.5 Nursing knowledge

Merriam Webster Dictionary (2010) defined knowledge as the acquaintance with or understanding of a science, art or technique. In Nursing, knowledge is a key part of the preparation towards competence which involves the care of patients and assessing the personal qualities of the nurse. It includes their moral character and how well they relate with their patients and colleagues alike. (Cowan, Norman & Coopamah 2005, 356.)

3.3.6 Educational collaboration

Cook (1913) noted that Miss Nightingale said "to pit the medical school against the nursing school is to pit the hour hand against the minute hand, since both hands are necessary for telling the time" (Graham 2007, 1816). In a study, Rosenstein (2002, 31) identified that most of the respondents comprised of nurses, physicians and executives, advocated for educational collaboration between physicians and nurses. They advocated a design focused on education and training of nurses and physicians towards improving teamwork and working relationships. They included trainings on the following: sensitivity, assertiveness, conflict management, stress management, time management and courtesy such as respect, promptness and preparation. (Rosenstein 2002, 31.)

3.3.7 Physician's dominance

Dominance is defined by the Merriam Webster dictionary (2010) as dominant position especially in social hierarchy and dominant as commanding, controlling, or prevailing over others. In medical practice, dominance is closely attributed to power and authority especially in the decision making process (Ersser & Coombs 2002, 246). "Physician's Dominance has led to power imbalance in medicine and the failure of physicians to understand and respect the role, expertise and moral responsibility of nurses" (Storch & Kenny 2007, 484).

3.3.8 Trust and respect

The Merriam-Webster dictionary (2010) defines trust as assured reliance on the character, ability, strength or truth of someone or something and respect as high or special regard; the quality or state of being esteemed. The Cambridge Dictionary (2010) defines trust as to have belief or confidence in the honesty, goodness, skill or safety of a person, organization or thing. It defines respect as politeness, honour and care shown towards someone or something that is considered important.

The concept of trust and respect in Nursing is highly regarded as it includes aspects of the behaviour of one person towards another. It is based on an attitude which values other people's uniqueness and individuality and also recognises dignity. Trust and respect are important prerequisites for physician-nurse collaboration; they increase openness, communication and improved patient outcome. The development of interprofessional trust and respect begins with identification of professional roles which is based on professional competence. Figure 2 shows the link between physician and nurse in the development of interprofessional trust (Baldwin 2008, 278-279; Pullon 2008, 139-143.)
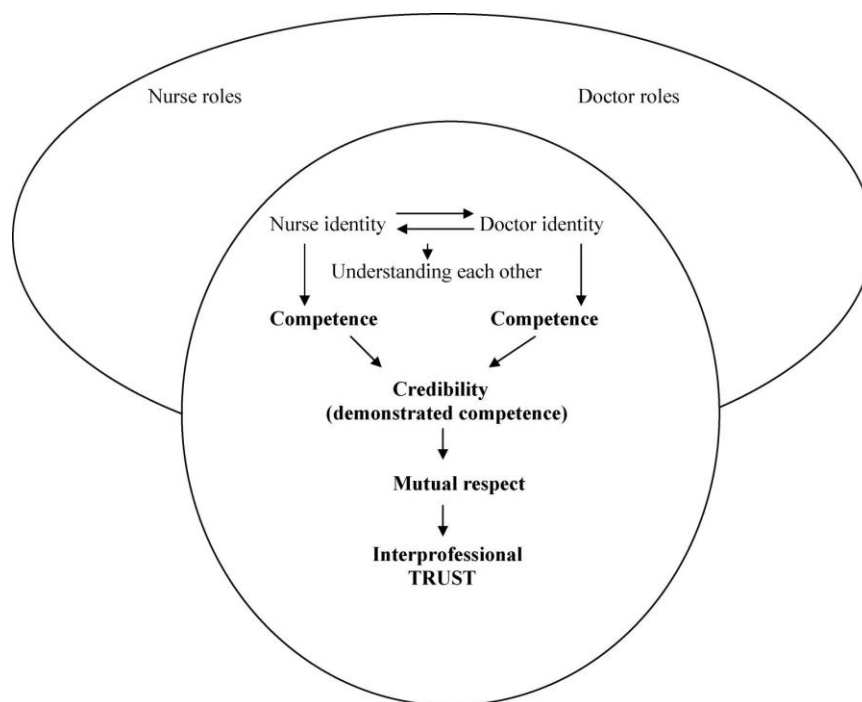

FIGURE 2. The development of interprofessional trust. (Pullon 2008, 143.)

3.4 Patient's benefit from physician-nurse collaboration

Patients can benefit from physician-nurse collaboration in any culture and also contribute to better communication and satisfaction within the professions (Rosenstein 2002). The collaboration between physicians and nurses has an impact on the patients.

3.4.1 Patient education

Patient education is an important role for the nurse which is fostered by physician-nurse collaboration. Patient education is an interactive process that involves teaching and learning. Teaching consists of a conscious, deliberate set of actions designed to help an individual gain new knowledge or skills while learning is the intentional acquisition of a new skill or knowledge. Physician-nurse collaboration enhances a guidance relationship between the nurse and the patient. (Hall 2001, 472-474.)

3.4.2 Professional collaboration

Boyle & Kochinda (2004, 61) defined collaboration as "nurses and physicians working together co-operatively to achieve shared problem solving, conflict resolution, decision making, communication and coordination". Collaboration can also be seen as a process which allows the interaction of colleagues within a flat hierarchy with individuals being able to make decisions both independently and as part of a team (O'Brien-Pallas, Hiroz, Cook & Mildon 2005, 10).

Collaborative physician-nurse relationships are responsible for improved patient outcomes, patient satisfaction, patient transfer and discharge decisions, patient care or outcomes; decreased risk-adjusted length of stay for patients and reduced medication errors. It has also been found that collaboration is an integral factor in positive patient outcomes regardless of the severity of the patient's condition. (O'Brien-Pallas et al. 2005, 11.)

4 PREVIOUS STUDIES ON PHYSICIAN-NURSE RELATIONSHIP

Coombs & Esser (2004) examined the role of Nursing in clinical decision making in three ICU in relation to the closed physician-nurse relationship that is needed in acute and complex care settings. The study was conducted in the United Kingdom with an ethnographic approach used to investigate the intensive care cultures and how physicians and nurses formulate their clinical decisions. It was in two phases, both lasting approximately one year of fieldwork, in which data collection and analysis were performed concurrently. The findings revealed a variation of roles and degree of authority in clinical decision making between the nurses and the physicians. The physicians dominated the decision making process.

Tabak & Koprak (2007) studied the relationship between how nurses resolve their conflicts with physicians, stress and job satisfaction. It was targeted at nurses of varying seniority approach to conflict resolution with physicians in relation to their stress levels. This study was carried out in Israel where 117 nurses of different status by answering four questionnaires. The result showed that five approaches emerged, in accordance to Rahim and Bonoma's conflict-resolution model (1979). They are: integrating, obliging, dominance, avoidance and compromise approaches. Integrating and dominance approaches in resolving conflict was associated with low stress levels. Obliging and avoidance approaches were associated with high stress levels. Furthermore, the seniority and status of nurses determined which tactics were used to resolve conflict.

Malloy, Hadjistavropoulos, McCarthy, Evans, Zakus, Park, Lee & Williams (2009) studied the nurses' insight into their relationship with physicians; the study was completed from a cultural and organisational viewpoint. The study was implemented with participants who were experienced nurses (n = 42) in four countries: Canada (n = 14), Ireland (n = 13), Australia (n = 6), Korea (n = 9) from 2005 to 2007. The experience of the nurses ranged from 6,5 to 37 years. They were drawn from different specialities. Data collection was through a qualitative approach using interviews. Data analysis was performed by thematic content analysis. The results showed a sense of lack of empowerment related to the

hierarchical nature of the nursing and the medical cultures. Diverging views were also perceived regarding patients' ontology; science versus care, for example. The following four themes emerged from the data analysis: philosophy of health - care versus treatment; decision process - constrained obligation; silenced voice; professional respect.

Thompson (2007) compared the attitudes of nurses and physicians to physician-nurse collaboration. The study was conducted in the medical-surgical patient care setting in the United States. The demographic characteristics of nurses and physicians as well as the measurement of their different attitudes toward physician-nurse collaboration were the aim of the study. Data collection utilised the Jefferson scale of attitude toward physician-nurse collaboration. This tool was validated with high reliability from previous studies. The results were not significant statistically even though trends were demonstrated: Nurses' attitude was more positive than those of physicians. The results of this study reiterated the need for continued efforts towards improving physician-nurse collaboration.

5 RESEARCH PROBLEM

The aim of the research was to explore the types of physician-nurse relationship that exist in the surgical and internal medicine units of Central Ostrobothnia Central Hospital, Kokkola. Moreover, the research aim was to explore the different factors that influence the types of relationship that currently exist and how patient centred care could be enhanced from improved physician-nurse relationship.

The research problem aimed to provide answers to the following questions:

1. What are the types of relationship that exist between physicians and nurses in surgical and internal medicine units?

2. What are the associated factors influencing physician-nurse relationship?

3. How can patients benefit from physician-nurse teamwork?

6 IMPLEMENTATION OF THE RESEARCH

This research was conducted using a quantitative descriptive study by survey design. The aim of a descriptive study is to explore and describe phenomena in real life situations. In practice, a descriptive design could be used to develop theory, identify problems and come to a decision (Burns & Grove 2005, 232). The descriptive study is considered as quantitative when data are collected numerically through surveys or questionnaires. Descriptive studies can help to identify relationship between variables. In this research, the exploration of physician-nurse relationship associated factors and patient outcomes were analysed. The only way to understand the beliefs and values of various people in nursing is to describe them (Houser 2008, 325-326).

The questionnaires (APPENDIX 1) were first prepared in English language and subsequently translated into Finnish language by a professional language teacher in order to limit translation errors. The translation of the questionnaires was necessary to improve nurses' participation in the study, since the official language is Finnish. The questionnaire was first approved by Thesis Supervisor and subsequently, by the Nursing Director and Managing Director of Central Ostrobothnia Central Hospital to allow the research to be conducted in the hospital. A trial was conducted (n=1) to find out whether there were obscurities in the questions and the time required to answer the questionnaire. The time taken for answering was approximately 5 minutes.

6.1 Collection of the material

In a quantitative study, the data collection phase is called the empirical phase which involves the collection of research data. It is also called the pre-analytic phase, that involves distribution of questionnaires used in the study. (Polit & Beck 2008, 67.)

The questionnaires included 20 questions, all closed and four background questions. The questionnaire was adapted from Jefferson scale of attitudes

towards physician-nurse collaboration. It was modified by the researcher to fit the purpose and research problem of the study. This was to ensure the validity of the questionnaires. The questionnaires were distributed to all wards and units included in the study through the ward nurses who served as contact person. The questionnaires were sent in sealable envelopes to ensure confidentiality and anonymity of the respondents. Moreover, a cover letter (APPENDIX 2) was attached to the questionnaire which explained the aim of the research to help the respondent understand the questions.

The time frame set for the data collection was initially three weeks. However, the deadline was extended because some nurses were on vacation at the time of the study. It was conducted during the summer holiday period. The overall time frame taken for the data collection was six weeks. Responses were collected at two-week intervals during July and August 2010. The surgical and internal medicine polyclinics were partially closed at the time of the data collection. The outpatient surgical ward was also closed during the period of data collection, hence their exclusion from the study.

The target group was 125 nurses working in the internal medicine and surgical units. The surgical unit consists of the operating room, orthopaedic ward (Ward 7) and soft tissue ward (Ward 10). The internal medicine unit consists of the cardiac ward (Ward 8) and internal diseases ward (Ward 4). Ward 4 underwent renovation at the time of the study and its nurses were deployed to Ward 12. Hence, Ward 12 was included in the study.

Priority was given to the ethical standards of the research to avoid negligence. Completed questionnaires were returned sealed through the ward nurse to the researcher. Any unsealed returned envelope was declared invalid. Therefore, data submitted through an unsealed envelope was not examined or analysed.

6.2 Analysis of the material

After receiving all the completed questionnaires, it was skimmed through by the researcher to obtain an overview of responses. The responses were subsequently categorised according to their respective wards for easy analysis.

The background information was presented in tables and the closed ended questions were presented in graphs. Emphasis was given to research problem questions, interesting results, surprising outcomes and beneficial outcomes. Each question asked specific information that would contribute to the research based on the research problems and theoretical framework. One step used by the researcher is called "coding" in the analysis of the data that involves the process of translating verbal data into numeric form. Subsequently, the data was transferred from word document to the Microsoft Excel program for analysis. (Polit & Beck 2008, 67-68.)

6.3 Ethics of the research

The permission to conduct the research in the hospital (APPENDIX 3) was given by the Director of Nursing and Managing Director of Central Ostrobothnia Central Hospital, who at that time was substituting the Medical Director on matters related to research approval. All the necessary documents related to the research approval were signed. Details regarding the number of nurses working in each ward were obtained from their respective ward nurses who all received a copy of the research approval. This was necessary to formalise the research process. A cover letter was also attached to the questionnaire explaining the purpose of the research and detailing how it should be returned. The researcher's email and telephone number were added in case of questions concerning the research. The confidentiality and anonymity of the respondents were protected. Only the researcher has accessed to the data. The development of this procedure is needed to ensure that ethical standards are strictly followed in this study, since its participants are human subjects. (Polit & Beck 2008, 67,167.)

The literature used in this research was obtained from original sources. The literature used is at most 10 years old except for classics which provided great significance to the research topic or whose author's work has not been updated. The literature was explored widely to receive the best glimpse of the subject matter. The target group used in this research was relatively large in order to obtain a reliable result.

7 FINDINGS OF THE RESEARCH

7.1 Background information of study

The study was carried out over a period of six weeks in July and August 2010. The study was carried out in the Central Ostrobothnia Central Hospital (APPENDIX 4), Kokkola, Finland. Information was collected from nurses working in the internal medicine and surgical units of the hospital. Information of the following background factors were collected in the questionnaire: gender, age, working ward and working experience in that ward. Out of the total sample (n=125), 73 nurses participated in the study. The result reached 58,4 % participation which was comprised of 95,9 % females (n=70) and 4,1 % males (n=3).

TABLE 1. Age distribution and work experience of respondents.

Age distribution		Work experience	
(n=73)	%	(n=73)	%
23 yr or less	1,4 (n=1)	1 yr or less	8,2 (n=6)
24 - 29 yr	18,9 (n=14)	2 -5 yr	20,5 (n=15)
30 - 35 yr	17,6 (n=13)	6 - 9 yr	16,4 (n=12)
36 - 41 yr	12,2 (n=9)	10 - 25 yr	42,5 (n=31)
42 - 47 yr	20,3 (n=15)	more than 25 yr	12,3 (n=9)
48 - 53 yr	17,6 (n=13)		
54 - 59 yr	10,8 (n=8)		
60 yr or over	1,4 (n=1)		
Total	100	Total	100

Table 1 shows that most of the respondents (n=15) are from age 42 to 47 years, and closely followed by 24 to 29 years (n=14), the average age stood at 40 years. The highest work experience was 10 to 25 years (n=31) followed by 2 to 5 (n=15), the average work experience stood at 15,4 years.

TABLE 2. Ward distribution of participants

Name of ward	Participants	
Surgical unit (S), Internal medicine unit (I)	%	n
Ward 12 (I)	15,1	11
Ward 10 (S)	15,1	11
Ward 7 (S)	12,3	9
Ward 8 (I)	23,3	17
Operating room (S)	34,2	25
Total	100	73

Table 2 shows the ward distribution of participants. 15,1 % (n=11) worked in Ward 12, 15,1 % (n=11) worked in Ward 10, 12,3 % (n=9) worked in Ward 7 , 23,3 % (n=17) worked in Ward 8 and the largest participation were from the operating room which represented 34,2 % (n=25).

7.2 Types of physician-nurse relationship

This research was focused on getting the types of physician-nurse relationship. The target group was asked to describe their perception of their relationship with the physicians. There were five choices, each indicating a type of relationship, adapted from Kramer & Schmalenberg's (2009, 77) research on physician-nurse relationship.
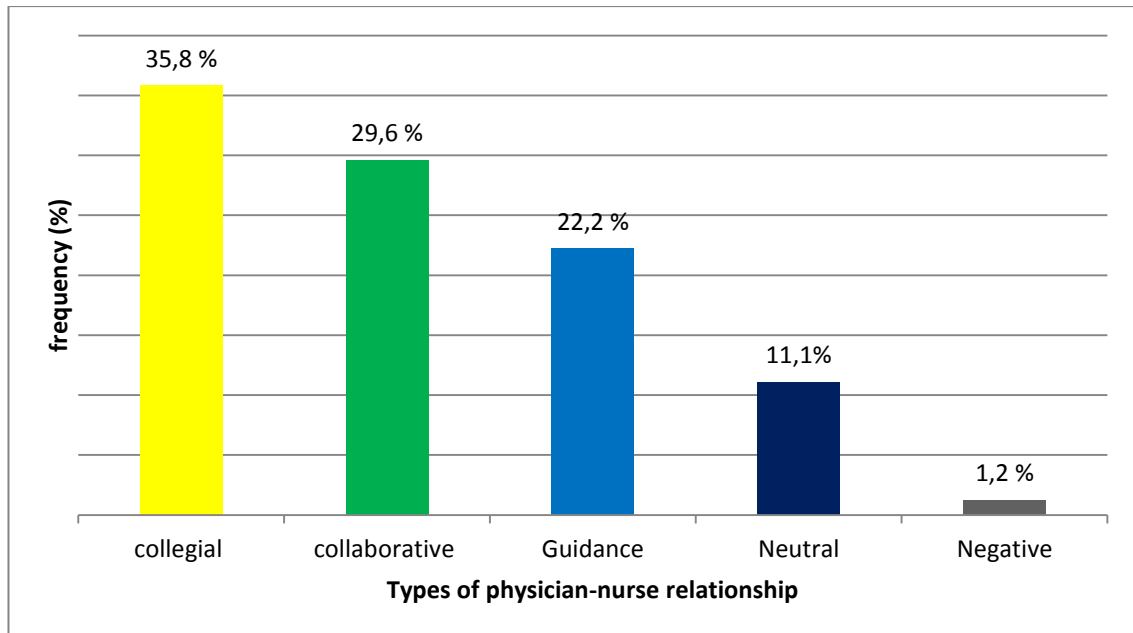
GRAPH 1. Types of physician-nurse relationship

Graph 1 reveals that 35,8% (n=29) of respondents had collegial relationship with the physicians, 29,6% (n=24) admitted collaborative relationship, guidance relationship accounted for 22,2% (n=18), the neutral relationship stood at 11,1% (n=9) and the negative relationship was the lowest with 1,2% (n=1). Interestingly, 19 participants indicated more than one relationship type with the physicians. The total response on types of physician-nurse relationship was 81 from 55 respondents.

7.3 Factors affecting physician-nurse relationship

There were several associated factors that contributed to the types of physician-nurse relationship that existed such as nurse autonomy, nurse accountability and responsibility, Nursing knowledge and experience. Closed ended questions were asked on different factors that contributed to physician-nurse relationship. Some questions had 'Yes' and 'No' alternatives. Some questions were designed according to the Likert scale with four choices: strongly agree, agree, disagree and strongly disagree. Other questions had five options that reflected nurses' perception on different factors that contributed to physician-nurse relationship. The options were always, often, sometimes, rarely and never.

Nurse autonomy analysis revealed 100% (n=73) of the participants answered 'Yes' to the question. Nurse autonomy was a pointer to the type of physician-nurse relationship that existed.

On the question on Nurse accountability the nurses' response was similar to that on nurse autonomy. 98,6% (n=72) answered 'Yes' to the question while 1,4% (n=1) answered 'No'. Nurse accountability was a strong indicator of the type of physician-nurse relationship in existence.
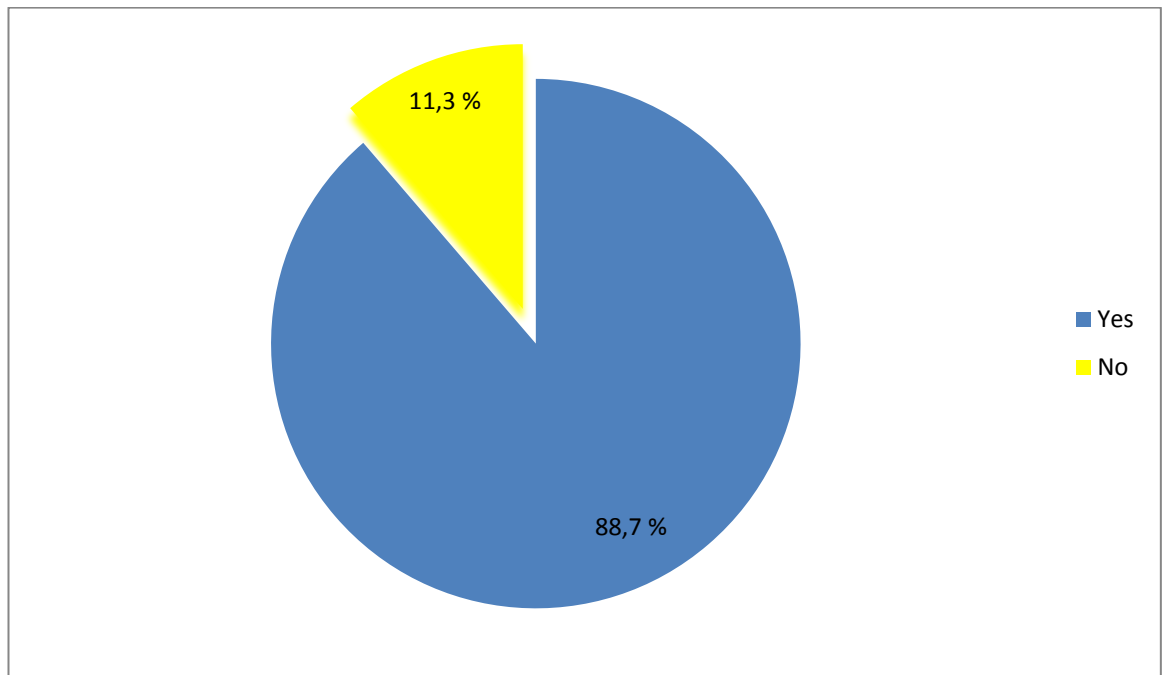
GRAPH 2. Nurse competency on patient education and psychological counselling

Graph 2 reveals 88,7% (n=63) answered 'Yes' to the question on Nurse competency on patient education and psychological counselling while 11,3% (n=8) answered 'No' to the question. The total number of participants who answered the question was 71.
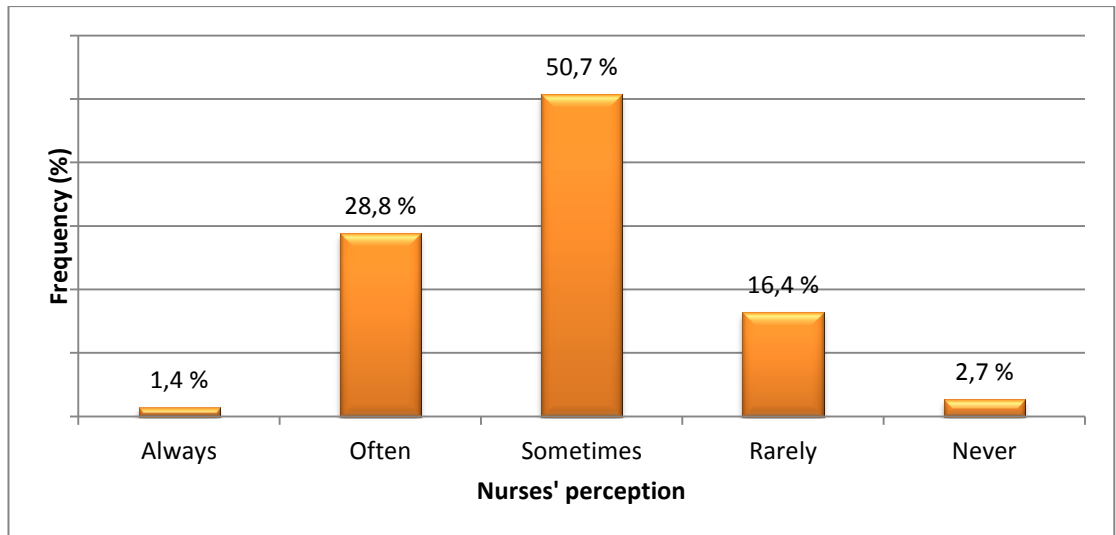
GRAPH 3. Nurse competencies on patient care approach

Graph 3 shows that the nurses' competencies on patient care approach. 1,4% (n=1) noted that they always suggested the patient care approach they perceived to be useful to the physicians. 28,8% (n=21) answered often did, 50,7% (n=37) indicated they sometimes did, 16,4% (n=12) indicated they rarely did, and 2,7% (n=2) revealed that they never did.

The nurses' perception on trust and respect in their relationship with the physicians was inquired. Graph 4 shows the response of nurses on trust and respect.
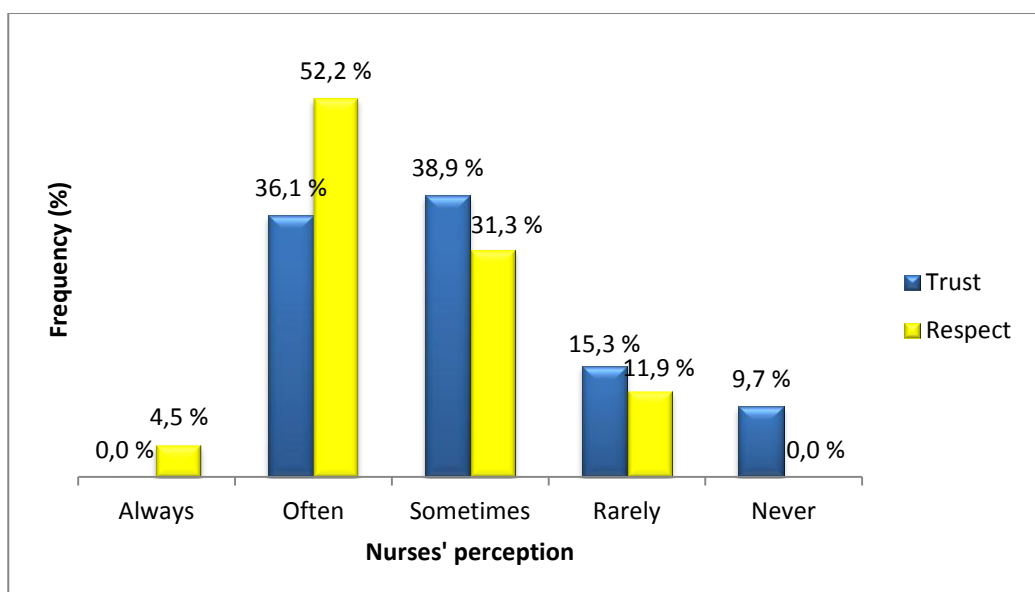

GRAPH 4. Nurses' perception on trust and respect in physician-nurse relationship.

Graph 4 shows that the perception of nurses on trust and respect in physician-nurse relationship. 52,2% (n=35) and 31,3% (n=21) of nurses perceived they were often and sometimes appreciated by physicians respectively. 38,9 (n=28) nurses indicated that they were trusted sometimes while 36,1% (n=26) revealed that they were often trusted. All the nurses were never disrespected meanwhile and none of the nurses were always trusted.
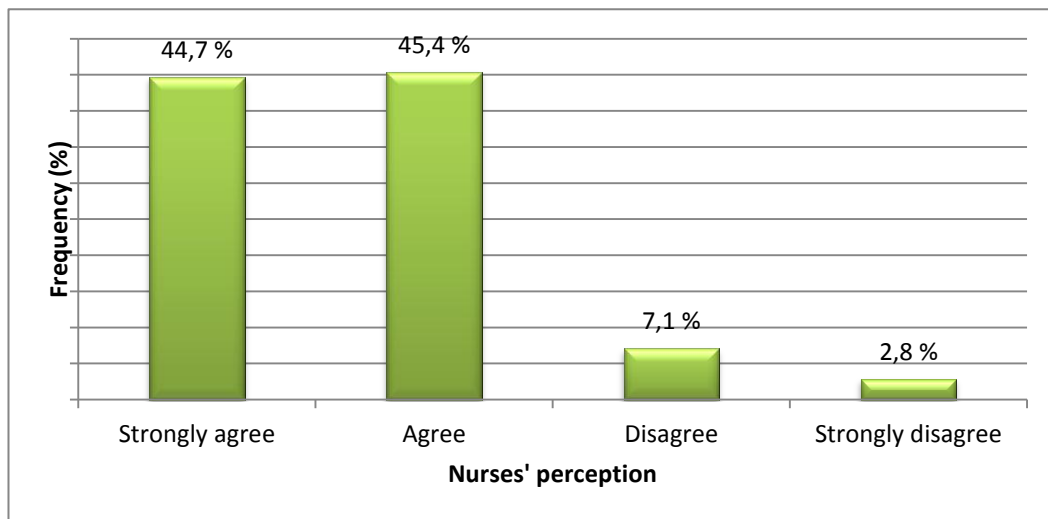
GRAPH 5. Nurses perception on educational collaboration between Nursing and Medical students.

Two questions that related to educational collaboration between Nursing and Medical students and whether inter-professional teamwork should be taught in their educational programmes was inquired. 44,7% (n=63) of nurses strongly agreed, 45,8% (n=64) agreed, however 7,1% (n=10) of nurses disagreed and 2,8% (n=4) strongly disagreed.
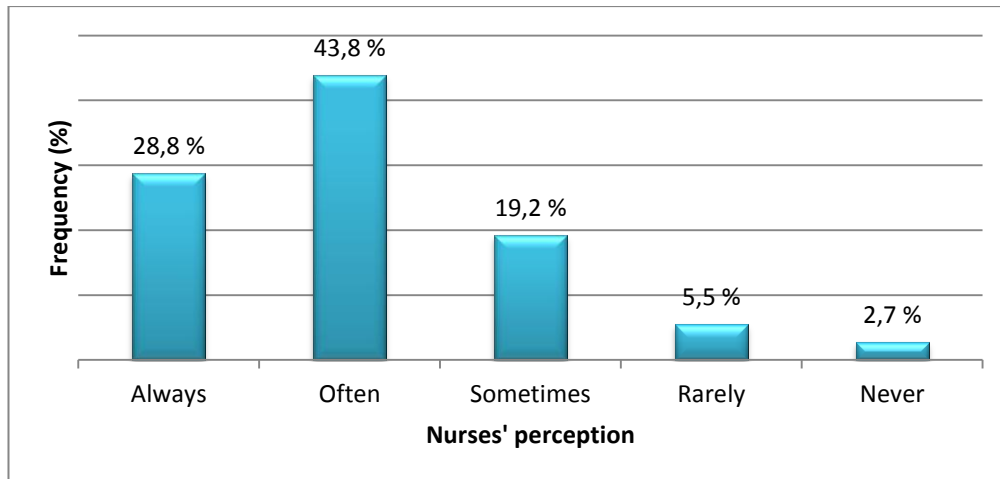
GRAPH 6. Nurses' perception on Nursing knowledge.

The perception of nurses on providing information to physicians on unique areas of Nursing was inquired. The highest percentage of nurses which accounted for 43,8% (n=32) indicated that they often provided information. 28,8% (n=21) of nurses indicated that they always did, 19,2% (n=14) indicated that they sometimes did, 5,5% (n=4) said they rarely did. The lowest percentage of nurses, 2,7% (n=2), indicated they never contributed information to physicians on unique areas of Nursing.
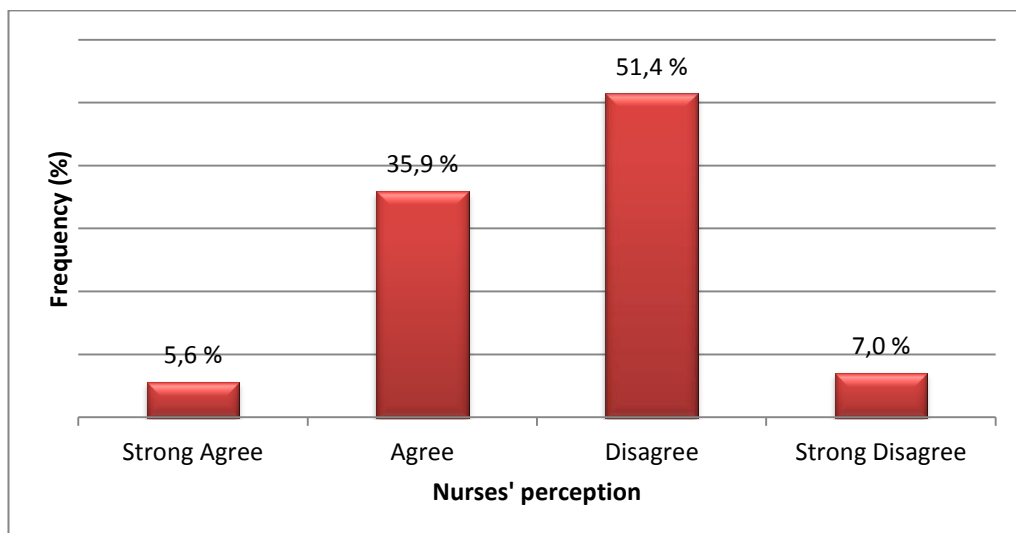
GRAPH 7. Nurses' perception on physician's dominance.

Two questions were asked regarding physician's dominance in practice. The highest percentage of nurses, 51,4% (n=73) disagreed while the lowest percentage of nurses, 5,6% (n=8) strongly agreed with physician's dominance.

Also, 35,9% (n=51) of nurses agreed with physician's dominance while 7,1% (n=10) of nurses strongly disagreed with the notion of physician dominance in practice.
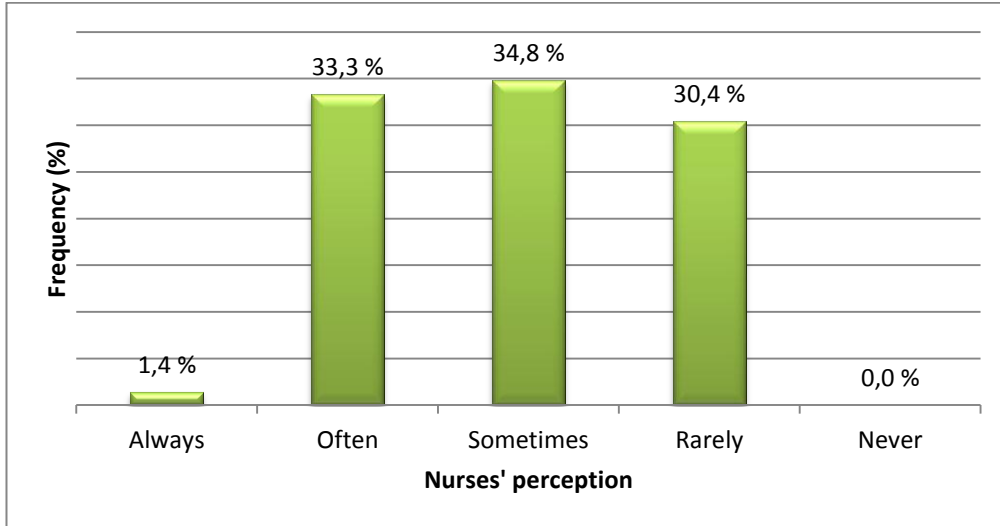
GRAPH 8. Nurses' perception on common ground with physicians.

The perception of nurses concerning overlapping areas whilst working with physicians was inquired. The perception were as follow: 1,4% (n=1) indicated that they always, 33,3% (n=23) answered often, the highest respondents, 34,8% (n=24), answered sometimes, 30,4% (n=21) indicated that they rarely did while none of nurses had never had overlapping areas whilst working with physicians.
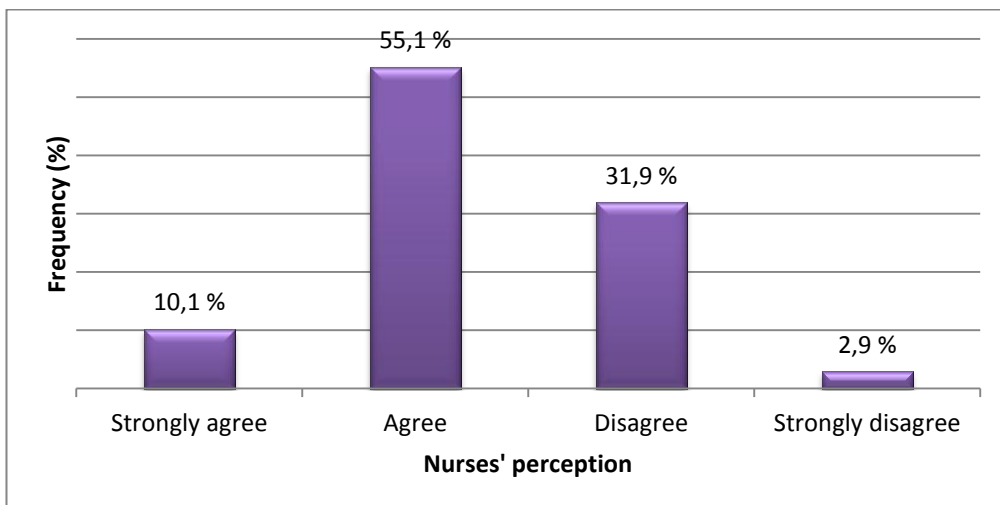
GRAPH 9. Nurses' perception on responsibility

The perception of nurses regarding responsibility on monitoring medical treatment was inquired. 10,1% (n=7) strongly agreed, 55,1% (n=38) being the highest agreed, 31,9%(n=22) disagreed while 2,9% (n=2) strongly disagreed.

7.4 Benefits of patient-centred care

The benefits a patient can derive from physician-nurse teamwork was inquired as a result of the type of physician-nurse relationship that existed and different factors that are associated with the physician-nurse relationship. Two important benefits were outlined from previous studies; physician-nurse collaboration and patient education.
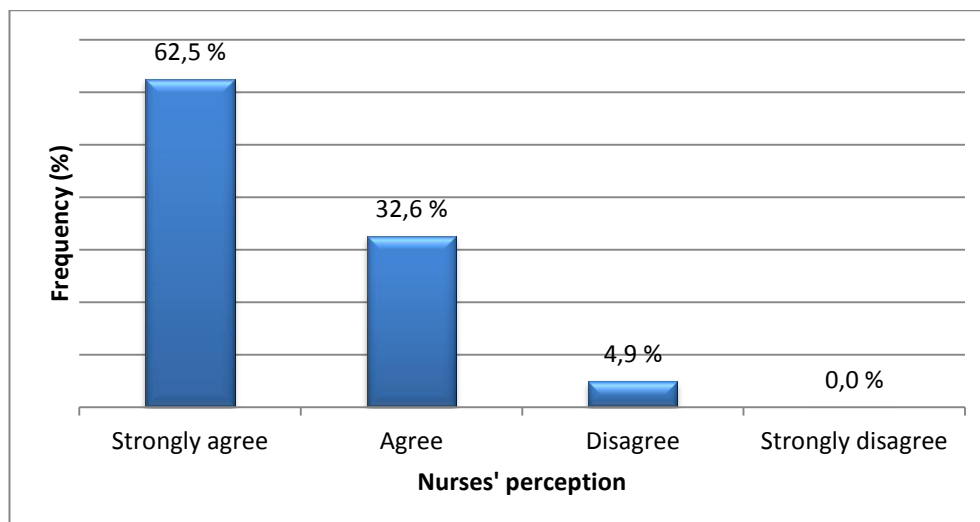
GRAPH 10. Nurses perception on professional collaboration.

Two questions were inquired of the nurses regarding their perception on physician-nurse collaboration and its impact on patient care. The result revealed that 62,5% (n=90) strongly agreed with collaboration to benefit patient care, 32,6% (n=47) agreed with the notion of physician-nurse collaboration while 4,9% (n=7) of the nurses disagreed with physician-nurse collaboration.
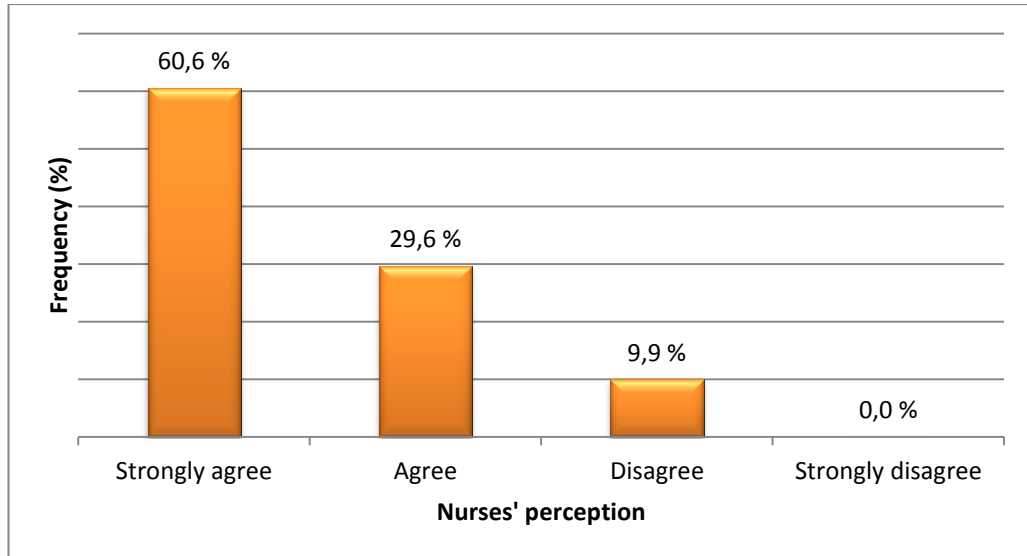
GRAPH 11. Nurses' perception on patient education.

The perception of nurses regarding patient education and its role towards improved patient care was asked. The result revealed that 60,6% (n=43) strongly agreed, 29,6% (n=21) agreed, while 9,9% (n=7) disagreed with the notion of patient education.

8 CONCLUSIONS

The goal of this thesis was to study the perception of nurses working in internal medicine and surgical units on physician-nurse relationship. The thesis discussed the important nursing theories related to nursing research to provide an overview on the topic and understand the nursing perception and key principles on which nursing is built. The types of physician-nurse relationship in clinical settings, associated factors of physician-nurse relationship and patients' benefit from physician-nurse collaboration were outlined in this thesis. A brief review of literature was given.

The methodology used in this thesis was quantitative descriptive approach by survey design. The collection of data was carried out over a period of six weeks in the Central Ostrobothnia Central Hospital in Kokkola, Finland during summer 2010.

A number of findings were identified based on the obtained results. The results suggested that the nurses' perception on physician-nurse relationship was very good. Similar to the results obtained by Kramer and Schmalenberg (2003 & 2009), five types of relationships were revealed with collegial relationship (35,8%) being the most common type while negative relationship (1,2%) was the least.

The key factors responsible for the types of relationship that emerged were nurse autonomy, nurse accountability, nursing competency, trust, respect, knowledge, responsibility, professional and educational collaboration (Baldwin 2008; Fry & Johnstone 2008; Lewis 2006; Pullon 2008). Surprisingly, the nurses were slightly divided as 58,5% disagreed with physician's dominance while 41,5% agreed with the notion regarding physician's dominance in health matters.

The results indicated that professional collaboration in terms of joint decision making played a vital role towards improved patient care. Moreover, patient education was an important tool for improved quality of care. (O'Brien-Pallas et al. 2005.)

9 DISCUSSION

Conducting this study was more challenging than originally anticipated. The chosen subject matter motivated the interest of the researcher but the process required time and commitment. The process of writing this thesis took about two years and at every phase of writing, new ideas, perspectives and modifications were introduced into the study.

The limitation of the study was the time frame of the research which affected the number of participants as it was conducted during summer and a number of nurses were on vacation. Meanwhile, obtaining the physicians' perception would have augmented the success of this research. The use of questionnaires did not provide in-depth findings from the study. Language constraints and time consumption hampered the utilisation of a qualitative approach in the study. The questionnaire could have been improved but due to time constraints it was done during the time frame available to meet the deadline.

The implication of this study is that it creates the awareness of the relevance of physician-nurse relationship in clinical settings. Furthermore, it equips nursing students and newly graduated nurses with the necessary information regarding relationships with physicians. It also raises the awareness of the importance of educational collaboration between nursing and medical schools. The incorporation of inter-professional teamwork in their educational curriculum would be highly beneficial to working relationships and subsequently, the quality of patient care.

Future studies on this subject matter are highly recommended as this work only forms an introduction to a very interesting phenomenon. Obtaining the physicians' perception would be beneficial and an empirical study of the individual elements on the subject matter could be examined. An in-depth study with a qualitative approach could be conducted on the subject matter.

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PHYSICIAN-NURSE RELATIONSHIP SCALE

INSTRUCTION: Please indicate your response by marking (X) in the appropriate box or write where necessary, from the choices given in each question.

Gender: ☐ Male ☐ Female

Age: _____ years

Your working unit: ☐ Ward 8 ☐ Ward 12 ☐ Ward 7 ☐ Ward 10 ☐ Operating room. If other(s), please state _____

Your working experience: _____ years

(1) Should nurses be involved in making policy decision affecting their working conditions?
☐ Yes ☐ No

(2) Should nurses be accountable to patients for the nursing care they provide?
☐ Yes ☐ No

(3) Do you think you have the special expertise in patient education and psychological counselling? ☐ Yes ☐ No

(4) Do you have a better working relationship with younger physicians than older ones?
☐ Yes ☐ No

(5) Do the physicians think you are capable to assess and respond to psychological aspects of patients' needs? ☐ Yes ☐ No

(6) Medical and nursing students during their education should be involved in teamwork in order to understand their respective roles

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

(7) Physician should be the dominant authority in all health matters

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

(8) Patient care is better with joint decision from both physicians and nurses.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

(9) Physicians and nurses should contribute to decisions regarding the hospital discharge of patients.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

(10)　　The primary function of the nurse is to carry out the physician's orders.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

(11)   Nurses should have the responsibility for monitoring the effects of medical treatment.

☐ Strongly agree

☐ Agree

☐ Disagree

☐ Strongly disagree

(12)   Nurses should clarify a physician's order when they think it might have the potential for detrimental effects on the patient.

☐ Strongly agree

☐ Agree

☐ Disagree

☐ Strongly disagree

(13)   Inter-professional relationships between physicians and nurses should be included in their educational programmes.

☐ Strongly agree

☐ Agree

☐ Disagree

☐ Strongly disagree

(14)   The physician seeks for my opinion and advice on a patient's condition before a decision is reached.   ☐ Always   ☐ Often   ☐ Sometimes   ☐ Rarely   ☐ Never

(15)   I suggest to the physicians, the patient care approach that I think is useful.
☐ Always   ☐ Often   ☐ Sometimes   ☐ Rarely   ☐ Never

The physician appreciates and respects the work I do as a nurse.
☐ Always   ☐ Often   ☐ Sometimes   ☐ Rarely   ☐ Never

(16)   The physician makes me feel like an important part of the patient-care team
☐ Always   ☐ Often   ☐ Sometimes   ☐ Rarely   ☐ Never

(17)   I inform the physicians about areas of practice which are unique to nursing
☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

(18)   I encounter overlapping areas of responsibility while working with the physicians
☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

(19)   Which of the statements below best describe your relationship with the physicians:

☐ We both have different roles but equal power and knowledge

☐ There is mutual trust, respect, power, and cooperation based on mutuality not equality

☐ Either I or physician teaches and it is a learning process

☐ The relationship formal and there is a near absence of feeling in the relationship

☐ The relationship is frustrating, hostile and resigned

Thank you!

LÄÄKÄRI-HOITAJA AMMATILLINEN TYÖSUHDESKAALA

OHJE: Merkitse vastauksesi oikeaan ruutuun (X) tai vastaa kysymykseen.

Sukupuoli: ☐ Mies ☐ Nainen

Ikä: _____ vuotta

Osasto, jolla työskentelet: ☐ Osasto 8 ☐ Osasto12 ☐ Osasto 7 ☐ Osasto10
☐ Leikkaussali. Muu, mikä: _____

Työkokemus: _____ vuotta

(1) Pitäisikö hoitajien osallistua päätöksentekoon, joka vaikuttaa heidän työskentelyolosuhteisiinsa? ☐ Kyllä ☐ Ei

(2) Pitäisikö hoitajien olla vastuussa potilaille tekemästään hoitotyöstä?
☐ Kyllä ☐ Ei

(3) Onko sinulla mielestäsi potilaiden opastamiseen ja psykologiseen ohjaamiseen tarvittavia taitoja? ☐ Kyllä ☐ Ei

(4) Onko sinulla parempi ammatillinen työsuhde nuorempiin lääkäreihin kuin vanhempiin lääkäreihin?

☐ Kyllä ☐ Ei

(5) Kykenetkö lääkäreiden mielestä vastaamaan potilaiden psykologisiin tarpeisiin?
☐ Kyllä ☐ Ei

(6) Lääketieteen ja hoitotieteen opiskelijoiden tulisi koulutuksen aikana osallistua ryhmätyöskentelyyn, jotta he ymmärtäisivät työn vaatimia rooleja.

- ☐ Vahvasti samaa mieltä
- ☐ Samaa mieltä
- ☐ Eri mieltä
- ☐ Vahvasti eri mieltä

(7) Lääkäreiden pitäisi päättää kaikista terveyteen liittyvistä asioista

- ☐ Vahvasti samaa mieltä
- ☐ Samaa mieltä
- ☐ Eri mieltä
- ☐ Vahvasti eri mieltä

(8) Potilaiden hoito on parempaa, kun sekä lääkärit että hoitajat osallistuvat päätöksentekoon.

- ☐ Vahvasti samaa mieltä
- ☐ Samaa mieltä
- ☐ Eri mieltä
- ☐ Vahvasti eri mieltä

(9) Lääkäreiden ja hoitajien tulisi osallistua potilaiden kotiuttamispäätöksiin.

- ☐ Vahvasti samaa mieltä
- ☐ Samaa mieltä
- ☐ Eri mieltä
- ☐ Vahvasti eri mieltä

(10) Hoitajan pääasiallinen työ on toimeenpanna lääkärin määräykset.

- ☐ Vahvasti samaa mieltä
- ☐ Samaa mieltä
- ☐ Eri mieltä

☐ Vahvasti eri mieltä

(11)　　Hoitajilla tulisi olla vastuu lääkityksen seurannasta.

☐ Vahvasti samaa mieltä
☐ Samaa mieltä
☐ Eri mieltä
☐ Vahvasti eri mieltä

(12)　　Hoitajan tulisi selventää lääkärin määräys, jos määräyksellä voi mahdollisesti olla vahingollisia vaikutuksia potilaalle.

☐ Vahvasti samaa mieltä
☐ Samaa mieltä
☐ Eri mieltä
☐ Vahvasti eri mieltä

(13)　　Lääkärin ja hoitajan ammatillinen työsuhde tulisi olla osa molempien koulutusohjelmaa.

☐ Vahvasti samaa mieltä
☐ Samaa mieltä
☐ Eri mieltä
☐ Vahvasti eri mieltä

(14)　　Lääkäri kysyy mielipidettäni ja neuvoani potilaan tilasta ennen päätöksentekoa.

☐ Aina ☐ Usein ☐ Joskus ☐ Harvoin ☐ Ei koskaan

(15)　　Ehdotan lääkärille potilaan hoitotapaa, kun se on mielestäni hyödyllistä.

☐ Aina ☐ Usein ☐ Joskus ☐ Harvoin ☐ Ei koskaan

(16)　　Lääkäri arvostaa ja kunnioittaa työtäni hoitajana.

☐ Aina ☐ Usein ☐ Joskus ☐ Harvoin ☐ Ei koskaan

(17)   Lääkäri saa minut tuntemaan tärkeäksi osaksi hoitotiimiä.

☐ Aina   ☐ Usein   ☐ Joskus   ☐ Harvoin   ☐ Ei koskaan

(18)   Informoin lääkäreitä hoitotyölle ominaisista asioista.

☐ Aina   ☐ Usein   ☐ Joskus   ☐ Harvoin   ☐ Ei koskaan

(19)   Lääkäreiden kanssa työskennellessä kohtaan päällekkäisiä vastuualueita.

☐ Aina   ☐ Usein   ☐ Joskus   ☐ Harvoin   ☐ Ei koskaan

(20)   Mitkä seuraavista väitteistä pitävät paikkansa ammatillisessa työsuhteessasi lääkäreiden kanssa:

☐ Molemmilla on erilaiset roolit, mutta yhtä suuri vastuu ja tieto

☐ Yhtäläinen luottamus, kunnioitus, toimivalta ja yhteistyö perustuu vastavuoroisuuteen, ei tasa-arvoisuuteen

☐ Joko minä tai lääkäri opettaa ja yhteistyö on oppimista

☐ Työsuhde on hyvin virallinen ja työsuhde on lähes vailla tunteita

☐ Työsuhde on turhauttava, vihamielinen ja alistunut

Kiitos!!

**CENTRAL OSTROBOTHNIA
UNIVERSITY OF APPLIED SCIENCES**

Unit of Health Care and Social Services

Isaiah Baiyekusi

Terveystie 1,

67200, Kokkola

Finland.

Cover Letter

Dear Respondent,

I am Isaiah Baiyekusi, a fourth year student of public health nursing. I am conducting a study on nurses' view of physician-nurse relationship in surgical and internal medicine units of the Central Ostrobothnia Central Hospital, Kokkola.

The objective of this research to attempt to understand the relationships that exist between physicians and nurses, the associated factors and the benefits patients derive from physician-nurse teamwork. Through your participation, I hope to eventually achieve my research objectives.

Please complete this questionnaire and send it back to me in a sealed envelope through the ward nurse.

Your participation is voluntary, if you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me at Isaiah.baiyekusi@cou.fi or +358449511196.

Yours Sincerely,

Isaiah Baiyekusi

Encl. Questionnaire

KESKI-POHJANMAAN AMMATTIKORKEAKOULU
MELLERSTA ÖSTERBOTTENS YRKESHÖGSKOLA

Sosiaali- ja terveysalan yksikkö, Kokkola

Isaiah Baiyekusi

Terveystie 1

67200 Kokkola

Finland

Tutkimus lääkärien ja hoitajien välisestä ammatillisesta työsuhteesta

Hyvä vastaanottaja,

Nimeni on Isaiah Baiyekusi, opiskelelen neljättä vuotta hoitotyön koulutusohjelmassa (terveydenhoitaja). Teen tutkimusta hoitajien näkemyksestä lääkärien ja hoitajien ammatillisesta työsuhteesta kirurgian ja sisätautien osastoilla Keski-Pohjanmaan Keskussairaalassa, Kokkolassa.

Tutkimuksen tarkoituksena on ymmärtää sitä ammatillista työsuhdetta, joka on lääkärien ja hoitajien välillä, tähän työsuhteeseen liittyviä tekijöitä ja mitä hyötyä tästä työsuhteesta ja lääkärien sekä hoitajien välisestä tiimityöstä on potilaille. Osallistumisenne on merkittävä apu tutkimuksessani.

Täyttäkää tämä kyselylomake ja palauttakaa se suljetussa kirjekuoressa osastonhoitajalle.

Osallistumisenne on vapaaehtoista. Jos teillä on kysyttävää lomakkeen täytöstä tai tutkimukseen osallistumisesta, voitte ottaa minuun yhteyttä: Isaiah.baiyekusi@cou.fi or +358449511196.

Ystävällisesti,

Isaiah Baiyekusi

liite: kyselylomake

KESKI-POHJANMAAN AMMATTIKORKEAKOULU
MELLERSTA ÖSTERBOTTENS YRKESHÖGSKOLA

TUTKIMUSLUPA-ANOMUS

Organisaatio, jolle anomus osoitetaan _Keski Pohjanmaan Erikoissairaanhoito ja Peruspalvekuntayhtymä (KPKS)._

Vastuuhenkilö organisaatiossa _OHAJO. LIISA HAUTALA-JYLHÄ_

Tutkimusluvan anoja(t) _Isaiah Baiyekusi_

Osoite _Terveystie 1, 67200 kokkola_
Puhelin _0449511196_
Sähköpostiosoite _isaiah.baiyekusi@cou.fi_

Tutkimuksen nimi _Physician-Nurse Relationship: Nurses' view in Internal medicine and Surgical units in KPKS._

Tutkimuksen tarkoitus _To Understand the relationships that exist between Physiciansand Nurses, the associated factors and benefits patients derive from Physician-Nurse Teamwork_

Tutkimuksen kohderyhmä _Registered Nurses in Internal medicine and Surgical Units of KPKS._

Aineiston keruun arvioitu ajankohta _July-August (3 weeks)._

Tutkimusmenetelmä _Quantitative descriptive study (Questionneires)_

Tutkimussuunnitelma hyväksytty _20_ / _12_ 20_09_

Tutkimuksen ohjaaja _____

Lupa myönnetään

paikka _____ aika ____ / ____ 20 __

☐ anomuksen mukaisesti   ☐ muutosehdotuksin   ☐ hylätty

Luvanmyöntäjän allekirjoitus _____

LIITTEET   ☒ Tutkimussuunnitelma
☒ Kysely/haastattelulomake
☐ Muut liitteet, mitkä _____

KESKI-POHJANMAAN ERIKOISSAIRAANHOITO- JA   **VIRANHALTIJAPÄÄTÖS**
PERUSPALVELUKUNTAYHTYMÄ

Tutkimuslupapäätös
Hallintoylihoitaja   02.07.2010   22 §

ASIA   Baiyekusi Isaiah, Keski-Pohjanmaan Ammattikorkeakoulu,
Physician-Nurse Relationship: Nurses' view in Internal Medicine and
Surgical units in Central Ostrobothnia Central Hospital, Kokkola,
2.7.2010

PÄÄTÖS   Tutkimuslupa-anomus hyväksytään.

PÄÄTÖKSEN TEKIJÄ   Pirjo-Liisa Hautala-Jylhä   Hannu Pajunpää
Hallintoylihoitaja   Toimitusjohtaja/
johtajaylilääkärin sijainen

BACKGROUND INFORMATION

Formation of Central Ostrobothnia Central Hospital

The Hospital District of Central Ostrobothnia (Keski-Pohjanmaan erikoisairaanhoito- ja peruspalvelukuntayhtymä) was founded in 1969 with 258 beds. It received a new building with an additional 50 beds in 1990. The psychiatric ward began in 1993 with 32 beds. It also established three mental health outpatient centres across the District of Central Ostrobothnia and a clinic for intellectually disabled people to cater for the needs of the disabled. The hospital district is composed of a joint municipal authority, established by 13 local authorities. The joint authority board is chosen by a 25 member council headed by a chairman. The board's responsibilities are administrative, preparatory and executive in nature. The hospital as at 31st of December 2006 oversaw 77 372 inhabitants, of which 85 per cent were Finnish speaking and 15 per cent Swedish speaking.

Management and Organisation of Central Ostrobothnia Central Hospital

The hospital has a management group which is headed by the Director. Other members of the management group include the Medical Director, Nursing Director, Director of Finance, two Consultants and an Assistant Consultant. Also in the group are the Planning Director, the representative of staff and the deputy member. The Hospital District of Central Ostrobothnia is divided into six areas; these areas are further divided into different units. They include the operative area, conservative area, psychiatric area, diagnostic services and pharmacy as well as supporting services. Each area, excepting the supporting services which are headed by the Hospital Director, is headed by an Area Director, who is a Medical Doctor and a Head Nurse. Under each area are different units and wards headed by Ward head doctors and Ward head nurses.

Statistics in 2007 revealed that hospital days were 70 185; discharges were 15 420; the average duration of hospital care was 4,6 days; the number of

outpatient visits in the somatic area was 89 169, while the number of outpatient visits in the mental health clinics was 23 709. The staff strength as at 2007 stood at 987, with nurses being the highest with 501, doctors were 120, other ward personnel were 115, other personnel were 146, while administrative, kitchen, technical and cafe personnel were 105.