

The doctor–nurse relationship

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Abstract In this article on getting on with colleagues in the workplace we explore how the nurse–doctor relationship in psychiatry has evolved and discuss its current status in both the in-patient ward and community mental health teams. In particular, we outline the changed roles and expanding responsibilities of nurses in the UK today. We suggest ways in which doctors can improve the relationship and give areas of possible future collaboration between doctors and nurses.

This is the second of three articles by Fagin & Garelick exploring working relationships between colleagues in the mental health field. The first (Garelick & Fagin, 2004) looked at doctor–doctor relationships and the third will consider doctor–manager interactions.

This relationship has undergone major changes since the in-patient ward was the main focus of care. These are summarised in Box 1, and discussed in more detail below.

A ‘special’ relationship

‘[A nurse] must begin her work with the idea firmly implanted in her mind that she is only the instrument by whom the doctor gets his instructions carried out; she occupies no independent position in the treatment of the sick person.’

McGregor-Robertson, 1902

‘No matter how gifted she may be, she will never become a reliable nurse until she can obey without question. The first and most helpful criticism I ever received from a doctor was when he told me I was supposed to be simply an intelligent machine for the purpose of carrying out his orders.’

Sarah Dock, 1917

Hopefully, things have moved on since the above descriptions were prevalent. None the less, many issues that affect how doctors and nurses work alongside each other stem from that traditional association.

Psychiatric practice depends to a substantial degree on a good understanding between nurses and doctors. When this does not exist or is under threat, clinical care is impaired. Historically, the doctor–nurse relationship has acquired the status of a special relationship. This is particularly true in the in-patient setting and in the treatment of people with serious mental illnesses, where it becomes the dominant dyad, affecting other multidisciplinary interactions and, in particular, the nature of the association with patients.

Change begets change

Perhaps the most obvious difference is that the context of the workplace has changed. Modern psychiatry now takes place in a number of different locations in addition to the acute in-patient ward. These include community mental health centres, patients’ homes and a variety of institutional and residential units caring for individuals with psychiatric disorders. These different milieux affect the nature of the relationship, simply because they result in different styles of working arrangements and determine different roles for the participants.

A consequence of this is that the nurse–doctor pairing is no longer exclusive. Most of psychiatry operates within a multidisciplinary framework, and interactions with other professionals, such as psychiatric social workers, occupational therapists,

Box 1 Factors of change in the doctor–nurse relationship

- The workplace context
- Multidisciplinary relationships
- The status and experience of doctor and nurse
- Patients’ expectations
- Training and education
- Institutional norms
- Professional norms
- Risk management and defensive practice

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psychologists, outside agencies and service managers, have an impact on the doctor–nurse dimension, diluting its ‘specialness’.

Changes in the workplace are reflected in professional and institutional norms (e.g. medico-legal responsibilities and working shifts), and these define the nature of the interaction, setting expectations and requirements.

Nursing and medical education are undergoing major changes in direction, making the boundaries between doctors as diagnosticians and prescribers of treatment and nurses as obeyers of orders and dispensers of treatment less clear and more permeable.

The relationship between doctor and nurse is to some extent affected by what the patients think of them. Radcliffe (2000) argued that the power within it is mediated by the patient: ‘If in doubt ask the patient who is in control. The public may love its angels but it holds its medics in awe’. This reflects the traditional, popular view of doctor and nurse roles. However, patients’ expectations of what nurses and doctors do and do not do is changing very quickly. Increasing publicity of medical and nursing fallibility and use of the internet have removed some of the magical aura and gloss from these professions (Stein *et al*, 1990).

Patients and their families are also major players in the current culture of litigation, and the consequent emphasis on risk management can induce defensive practices on the part of both doctors and nurses.

In this evolving world of psychiatric practice, how well have doctors and nurses coped with these changes? Has the dilution of the ‘specialness’ of their relationship been more difficult for nurses or for doctors? How will future changes, such as those that will be determined by the European Working Directive, affect nurses’ and doctors’ roles, and thereby, their interaction? And how do new areas of collaboration between nurses and doctors become established so that improvements in patient care can take place?

The psychiatric in-patient setting

Who makes the decisions?

Traditional relationships have been slow to change in the in-patient environment. Institutional and professional norms still defer to medical decision-making, the nurses’ code of conduct and management lines of accountability. The in-patient setting highlights an essential aspect of the doctor–nurse relationship: its mutual interdependence. Neither can function independently of the other. If the psychiatrist is the responsible medical officer and a

patient is on section under the Mental Health Act, that psychiatrist is dependent on the nurses for the containment and safe care of the patient while in hospital care. Nurses rely on aspects of the doctor’s authority and medico-legal responsibility to support them and help contain the situation.

Nevertheless, doctors in psychiatry still hold essential powers and responsibilities that have an impact on this interdependence: for example, doctors are the ones who decide, either formally or informally, whether a patient is admitted and discharged. Under Section 12 of the Mental Health Act 1983, doctors have specific responsibilities that are not shared with other professional groups.

And who should make the decisions?

Daily decisions such as agreeing to a patient’s leave or the need for close observation are rarely delegated to nurses, even though in these areas doctors may have no more knowledge than their nursing colleagues. If anything, they are probably less able to make appropriate judgements because of their more distant contact with in-patients, and yet deference is paid to their ‘expertise’.

Current pilot studies delegating some of these responsibilities to nurses have shown no major difficulties, and have in fact reduced the need for expensive close nursing observations and reliance on agency staff (T. Reynolds & L. Dimery, personal communication, 2003).

The closer relationship with community mental health centres has produced some shifts in the balance of power. Community staff, whether associated with community mental health teams, assertive outreach or home treatment teams, now have more say in admission and discharge arrangements, altering what was once the exclusive province of doctors.

Although the decision to admit rests finally with doctors, it is helpful to make explicit that different staff will be able to contribute different knowledge to the decision-making process.

Senior doctors appointed to cover a catchment area are likely to be more familiar with past events in a patient’s life than most other members of the team, simply by virtue of having worked in that catchment area for longer. They therefore use experience of previous psychiatric interventions to guide their thinking when a new episode occurs. There is some suggestion that nursing turnover, especially in metropolitan districts, is increasing, making it even more likely that doctors will ‘hold the history’ of patients. Conversely, in the ‘here and now’ of an in-patient stay, nurses will be much more in touch with a patient’s current state and preoccupations. Depending on the attitudes of those involved, the

nurses' knowledge can contribute to clinical care or can become a source of contention in the battle about who knows the patient best and whose decision should prevail.

Traditionally, doctors have been seen as the repositories of clinical knowledge and have been charged with keeping abreast of recent advances and imparting this knowledge not only to their own apprentices, but also to nurses within the team. University education as opposed to hospital experience accounts for the public view that doctors 'are educated whilst nurses are trained' (Warelow, 1996). Purported knowledge, therefore, is a source of the differential power that underpins the doctor–nurse relationship. To some extent this differential has been reduced by increasing university training for nurses, as envisioned in the Department of Health's Project 2000 (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1986). However, some critics have observed a gap between theory and practice and the creation of a training deficit at graduation, as it does not meet the practical nature of service demand (Department of Health, 1997). Shared learning (with doctors and other professional groups) is beginning to happen in areas such as Mental Health Act legislation, Health of the Nation Outcome Scales (HoNOS) and ethical issues.

Plus ça change?

A quarter of a century ago, a New Zealand anthropologist studied working relationships in a psychiatric hospital in Otago, New Zealand (Parks, 1979). Many of the interactions that she described can still be seen in the UK today. She recognised that the rules operating between different staff groups in terms of lines of authority, responsibility and reciprocity were not explicit. A lot of emphasis was placed on the notion of 'teamwork', which implies a democratic structure, but in reality many teams were autocratically led and hierarchically structured. She also analysed the nurses' notion of 'supportive' and 'unsupportive' responses by doctors, and found that they thought the doctors' agreement with their opinions to be 'supportive', whereas disagreement was 'unsupportive' (rather than a factual correction or a constructive exchange of ideas). The third notion was that of 'responsibility': the nurses generally felt that it was the doctors' responsibility to ensure patient compliance with the treatments they prescribed, even if the treatments were carried out by the nurses. These often unspoken beliefs indicated that there was still an expectation of a paternalistic, hierarchical relationship between doctors and nurses, even though nurses were demanding an equal say and

influence. Most of these issues remained implicit and ambiguous, leading to conflict when the discrepancies were exposed.

The many hats of the psychiatric nurse

In a previous publication one of us (L.F.) discussed the apparent contradictory tasks of in-patient psychiatric nurses (Fagin, 2001). They are expected to be 'reality role models' for patients, organising personal self-care, confronting inappropriate behaviour and encouraging community-mindedness, while at the same time providing care, nurture and emotional support. Nurses wear many different 'hats': they uphold institutional norms, contain physical aggression, set boundaries and timetables, and offer informal personal therapy to patients in states of heightened distress. Not surprisingly, nurses become the main recipients of patients' projections. As a result they are often the targets of either erotic, loving gestures or hostile, aggressive and paranoid responses.

Nurses often comment on the distinction, in the patient's eyes, between nurses, with their multiple roles, and doctors, who have a more distant and clearly outlined function. These varying roles, both within the nurses' remit and between nurses and doctors, prompt split transference responses in patients, which can lead to splitting manoeuvres intended by the patients to accentuate disagreements between staff, particularly if these are unspoken.

Conflict between nurse and doctor

When conflict arises between nurses and doctors on communication and decision-making, the nurses' objections are often buttressed by 'You are not here as much as we are'. A familiar clinical situation is described in Vignette 1 below. The 'parental' couple of doctor and nurse are in a conflict generated (or exacerbated) by the pathology of the patient, who has a propensity to idealise paternal figures and vilify maternal ones. Such situations tend to reinforce stereotypical roles and require successful clinical management with some insight into psychodynamic interaction.

Vignette 1

Dr S comes into the acute unit on Monday morning to attend a staff meeting and is met by a scowling Nurse T, the ward manager. She tells him that it has been a dreadful weekend, mostly because of a well-known young female patient whom Dr S had admitted in a frank psychotic state.

During the staff meeting, Nurse T launches into an attack on Dr S, stating that he is not listening to nurses. She describes how the patient, who is a crack

cocaine addict, has been luring patients and visitors to import drugs into the unit: 'It's OK for you doctors. You admit the patient and then go off for the weekend, leaving us nurses to pick up the pieces.' She reminds him that in previous conversations over her care, the nurses had conveyed to him their disquiet about the patient being readmitted to the unit, because of her positive HIV status, her flirtatiousness towards male patients and her total disregard for the consequences of possible sexual activity with other patients: 'You've gone back on your word. She was up to all those tricks this weekend. She poured hot tea over one of the patients, and a nurse was hurt in the fracas whilst trying to contain her.'

In front of other nursing staff and a junior doctor, who remain quiet during Nurse T's diatribe, she says that the problem is poor communication and that the nurses' views were not taken into account. Dr S reminds Nurse T that, although he was aware of the problems, he had had no option as the patient was psychiatrically ill on admission, that he had had no other place to admit her, and that these concerns had not been raised when the patient was discussed during the review before the weekend. He asks her why this matter had not been brought to his attention then.

With benefit of hindsight, Dr S, knowing the patient well, might have anticipated that she was likely to cause havoc during her initial stay on the unit and should have taken the opportunity of the ward review to discuss with the nurses beforehand risks and detailed joint clinical strategies. Had he done this, not only would there have been an agreed course of action, but also he would have communicated that he was aware of the potential problems the patient was likely to create on the unit.

Nurse T is communicating her sense that the doctor does not 'have the nurses in mind', and this is what she means by not being heard, rather than whether there was actual verbal communication taking place. Dr S focuses on the fact that nurses did not mention their concerns when they had the chance to do so. In future staff meetings, Dr S might explore why nurses sometimes have difficulties in communicating their concerns during his ward reviews.

Family roles, patients' projections and gender issues

The doctor–nurse pairing, not surprisingly, also becomes a potent target for patient projection. Father/mother fantasies are often mentioned, particularly by patients in vulnerable and regressive states. They expect the same total, unconditional care that they expected from their real parents. The

relationship that doctors and nurses have with patients is also of an intimate nature, not only because details of the patients' lives are shared, but also because physical contact is often required during treatment and care, and the patients' illnesses might bring to the fore discussion of life and death. This is a domain that is not often shared with others in the team. In this setting the 'specialness' is regularly confirmed.

These projections are affected to some extent by gender. In contrast to general nursing, psychiatric nursing was traditionally a male domain, as working in asylums with potentially violent patients emphasised the need for physical containment. Although this is not the case today, in the UK male nurses are still relatively overrepresented in psychiatry (40%) compared with general nursing (1%; Royal College of Nursing, 2003). For obvious reasons, male nurses are still identified as those who will have a central role in control and restraint procedures when patients are agitated and at risk to themselves or others. In fact, anxiety can become palpable when there are not enough male nurses on a particular shift, especially when the unit is disturbed. These different roles and assignments have an impact on relationships between nurses as well as with doctors and patients.

Traditional sociological studies of the doctor–nurse relationship describe its patriarchal nature (Dingwall & McIntosh, 1978), understood in terms of sexual stereotypes, with gender assignments of nurturance and passivity to the female role, and decisiveness and competitiveness to the male role (Savage, 1987). Drawing parallels with family roles, doctors assumed the position of the head of the family, deciding where and how the important work had to be done, while nurses (their 'wives') looked after the physical and emotional needs of those dependent on them, whether they be patients, junior nurses or inexperienced doctors (Oakley, 1984; Willis & Parish, 1997; Gaze, 2001). Although this model still carries some validity, modern changes in nurses' roles, particularly the introduction of clinical nurse specialists, nurse consultants and modern matrons, indicate major shifts in influential positions which are now fairly well established (Department of Health, 2003a, 2003b; NHS Modernisation Board, 2003). The replacement of the ward sister with the ward manager in the 1980s has had a profound impact, some say by 'selling nursing to management rather than being led by clinical imperatives' (V. Franks, personal communication, 2004). Changes in the status of doctors have followed public airings of their fallibility, requirements to make them accountable for their actions and an increase in the general population's medical knowledge owing to widespread use of the internet.

Despite such changes, which reflect parallel shifts in all occupations, trust in the medical profession persists. Militant nurses are advocating a radical move from the status quo in terms of power relationships, and have raised awareness of their potential as agents for change in the medico-political arena.

The community team

Vignette 2 illustrates some of the complex issues that arise from team working, for example issues of responsibility, authority and control.

Vignette 2

At the weekly allocation meeting at the Mental Health Resource Centre the team leader, who is a community psychiatric nurse (CPN), announces that the team has received 17 new referrals for the week and that it will not be possible, in the time available, to discuss details of each one. He suggests that the most practical solution would be for him to allocate referrals to professionals as he thinks fit. A doctor disagrees. He says that, as responsible medical officer, he has to have a say because referrals usually come from general practitioners addressed to him, and that he therefore needs to be reassured that referrals are screened for possible psychiatric presentations. He says that GPs expect a psychiatrist to be involved in decision-making over every referral received. The CPN says that he is an experienced nurse and capable of making those decisions too. The team spends a considerable time discussing responsibility, accountability and trust between members of the multidisciplinary team.

Conflicts about who is in control and who has ultimate responsibility for decisions about patients are more likely to emerge in community teams than in in-patient settings, where traditional medical hierarchies still exist and are accepted (even though this is rapidly changing). Very often, these conflicts represent not real differences in skills or ability, but notions of professional boundaries and perceived challenges to authority. With open discussion, explanation of how decisions are arrived at and clarification of appropriate delegation, these conflicts can easily be resolved, provided each member of the team takes responsibility for their own actions. In the case illustrated in Vignette 2, the team might decide that a small group of senior clinicians, including a psychiatrist, should meet separately from the main multidisciplinary meeting to allocate newly referred patients. This would free time for other clinical discussions during the full team meeting. If this solution is adopted, GPs must be informed and anyone can raise questions about these decisions if they have any objections.

The false lure of primary care

The move into the community opened the door for psychiatric nurses to show their independent skills, particularly when they left the domain of the psychiatric team to work in primary care settings. At first, many independently minded CPNs left secondary care psychiatric services to work in primary care, because they wanted to free themselves of the shackles of the authoritarian structure, not only within the psychiatrist's domain but also within their own nursing hierarchy, which traditionally had been very controlling. Unfortunately, they soon discovered that they had switched one medically dominated field for another, in which GPs referred to them patients with complex problems and left them to their own devices, without the support of a psychiatric team. Some observers associated this development with the increase in job-related stress and burnout in psychiatric nurses (Carson *et al*, 1995; Fagin *et al*, 1995). Not surprisingly, the 1990s saw a retreat from primary care back into the fold of community mental health teams.

A flatter hierarchy

Traditionally trained psychiatrists accustomed to the formal protocol of hospitals and institutions can face stress when they move into the flattened hierarchy of multidisciplinary teams, albeit a hierarchy in which they still hold a central leadership role. Some have attempted to recreate an authoritative style of relationship in the community team, which inevitably has caused dissatisfaction and strain between professions, not least between doctors and CPNs, whose respective boundaries have had to be redefined.

Community teams tend to place greater weight on the combined efforts of all professions represented in them. In these multidisciplinary units, however, nurses often perceive that their contributions are less influential than those of others, or that they have been given much more restricted roles, for example dispensing depot injections or monitoring mental states. Even when this is not the case, however, nurses have to make adjustments in their professional relationships with doctors, which has become less unique.

Some nursing authors have cited the hierarchical nature of the nursing profession itself, which emphasises discipline, authority, punishment and adherence to rigid procedures, as the main barrier in their attempts to gain equality with other professions (Walsh & Ford, 1994; Oughtibridge, 1998). Another obstacle is the absence of a progression pathway in clinical practice for experienced senior nurses who do not wish to take

on management responsibilities (an implicit denigration of nursing care). Farrell (2001) describes how aggression and hostility *between nurses* have undermined their position in relation to other groups within the medical profession. Observations of intraprofessional conflict suggest that nurses, unable to confront existing hierarchical structures, take their frustration and vindictiveness out on their peers, colleagues and juniors. Senior nurses, reacting to their awareness of their lower status relative to other professional groups, prefer to align themselves with those groups rather than with their own professional colleagues. These authors also suggest that, despite changes in the academic aspirations of nurses and the increasing numbers that gain a university education, there is still a prevalent 'anti-academic' attitude among many, which again prevents them from seeing themselves as innovators, capable of reflective practice and embarking on research initiatives.

Changes in status and responsibilities

'No man, not even a doctor, ever gives any other definition of what a nurse should be than these – devoted and obedient! This definition would do just well for a porter. It might even do for a horse.'

Florence Nightingale

Were she alive today, even Florence Nightingale would say that the disparity in the doctor–nurse relationship is becoming less marked. Nurses have made considerable advances in their professional standing, supported by extensive university training, expansion of skills and a gradual taking over of responsibilities that used to be in the purview of medical practice, for example carrying out phlebotomies, offering independent consultations and possibly, in the future, taking over some prescribing decisions. In recent years, a range of legislative and organisational changes (some of which are listed in Box 2) have conferred on nurses significantly wider responsibilities.

The establishment of NHS Direct in the UK and the skills and competency development work supported by 'care group workforce teams' in England are greatly expanding the roles of nurses in the NHS. Furthermore, the introduction of the European Working Directive will inevitably result in a handing over of responsibilities to nurses, as doctors are unlikely to be available all of the time, even during crises. The Wanless Review, for example, has made planning assumptions whereby nurse practitioners could take over about 20% of work currently undertaken by physicians (Royal College of Nursing, 2003). Discussions are already

Box 2 Areas in which nurses' responsibilities are expanding

- Section 5(4) of the Mental Health Act 1983
- Nurses' discretion regarding Section 17 leave
- Care-coordination
- Increasing prescription responsibilities
- Screening and initial assessments
- Determining levels of observation
- Nurse therapists
- Team leadership and ward management
- Phlebotomisation

well advanced focusing on the areas in which senior and trained nurses would be able to assess patients and decide on actions in place of doctors. Nurses have already moved into administration and supervisory roles, and control their own licensing processes. Senior nurse managers often operate as team leaders, particularly in community mental health teams, and doctors come within their purview. Some have said that these extra responsibilities and status symbols have been delegated down by physicians to share the workload rather than to establish parity of influence (Tellis-Nayak & Tellis-Nayak, 1984). Nurses are still not sure to whom they are accountable: their own professional hierarchy, the doctors or management.

Despite these advances, in hospital settings nurses remain in a subordinate role. A symbolic manifestation of this is the unequal allocation of space for personal offices, differential arrangements for eating facilities and the notion that doctors' time is more 'valuable' than nurses' time. At a personal level, the relationship is viewed differently: nurses see the relationship with doctors as potentially ego-building, while doctors see it as ego-maintaining. Nurses have to prove their competence in every interaction with physicians, whereas doctors' competencies are assumed and it is their fallibility and shortcomings that have to be proved.

Regardless of this inequality, nurses and doctors are required to work together towards a common goal, and they do so by adhering to social rituals and etiquette. Barriers to collaboration are exemplified by the class and gender differences between these professional groups, the value assigned to intellectual rather than manual activities and differences in educational standards (Fagin, 1992). For some time, however, excellent services, such as those following the 'tidal model' (Barker, 2002), have highlighted the benefits of genuine collaboration between doctors and nurses as therapists and enablers, as opposed to collaboration governed by the hierarchical relationship. Such an arrangement can result in better care for the patient, improved outcomes and patient

satisfaction, reduced workloads all round, and fewer fiscal demands on health care.

The doctor–nurse game

It is quite baffling to observe how the difference in standing continues to exert an influence even though in everyday practice experienced nurses are usually the ones who induct and guide inexperienced junior doctors into the essential aspects of their disciplines. Stein (1967) described this interaction as the doctor–nurse game, and it may still be seen in play today – although times are indeed changing, as we discuss below.

To play the doctor–nurse game, nurses (in Stein's time, usually female) learn to show initiative, devotion, care and advice, while appearing to defer to the authority of the doctor (then, usually male). They use subtle techniques to guide doctors into a decision, in order not to undermine their authority and to avoid interprofessional conflict. This must be done in such a manner that suggestions appear to be the physicians' own. This apparent subservience to the doctor is inculcated early on in medical and nursing training. Doctors are very aware of the serious consequences of making mistakes: they deal with this by counter-phobic measures, assuming omniscient pretensions that cover their fear of failure. Nurses feed into this denial by not openly challenging the doctors' omnipotence.

Novice doctors learn to play the game as they progress in their careers. Nurses are taught it even before they graduate. Playing the game successfully brings rewards such as good teamwork and mutual respect; failure to do so results in penalties such as conflicts and loss of career prospects.

Historically, becoming a good nurse has been equated with the fulfilment of doctors' wishes and instructions and, by playing the game, nurses appear to do just that. There is growing evidence, however, that nurses do not always willingly play, or even wish to play. Some authors have suggested that ward managers prefer doctors to be 'incompetent zombies', so that they can run the ward in their own way (Graf, 1974). Behind the doctors' backs, nurses can express resentment and act out their feelings (Kalisch & Kalisch, 1977; Keddy *et al.*, 1986). Some become 'silent saboteurs', undermining or sabotaging, in a passive-aggressive way, decisions made by the team (Warelow, 1996). Not surprisingly, some doctors perceive this game as an elaborate charade, in which they feel manipulated by nurses. There are reports of verbal and even physical abuse by nurses, particularly if the doctor's status is low owing to inexperience, youth, gender or race; the ensuing cycle of abuse resembles that seen in families (Hughes, 1988; Marsden, 1990).

We have often witnessed how nurses have difficulties in voicing their concerns or opinions directly, particularly if the content is critical of doctors or of other senior figures within the team. Not surprisingly, unvoiced bad feelings have a tendency to be expressed in other ways, for example by silent opposition, reluctance to come to agreements over care or sudden outbursts of angry condemnation that are not in proportion to the alleged triggering event. When open discussions are eventually held, nurses often bring up incidents that have occurred many months earlier, about which they had been unhappy at the time, but lacked the confidence to voice their concerns. This can have a detrimental effect on patient care (as seen in Vignette 1).

Many nurses have rebelled against the subservient role traditionally allocated to them through institutionalisation, gender-stereotyped attitudes and military-like organisation within the nursing profession. However, this state of affairs has not remained static. Gender roles have changed, with more female doctors and male nurses in evidence. Nurses have become more specialised and confident in their knowledge, and as a result are more likely to stand on an equal footing with doctors in some areas. Nurses are wishing to move from 'dependency to autonomy and mutual interdependency' (Fagin, 1992). Furthermore, nurses increasingly are questioning narrow-minded approaches that follow the 'medical model', seeing themselves as champions of the 'holistic approach' to care, which focuses on prevention, education and management of chronic illnesses. But other nursing writers (e.g. Radcliffe, 2000) suggest that, in order to elevate the status of their profession, nurses are mimicking doctors, redefining themselves in their image by becoming nurse consultants or nurse practitioners. This, they claim, is a mistake: nurses should stick to the basics of nursing, which is about 'nourishment, problem solving, and easing the experience of suffering, medical invasion, or death' (Radcliffe, 2000).

Surveys

Although nursing journals contain an extensive literature on doctor–nurse relationships, it is interesting to note that this subject hardly figures in the medical literature. This probably reflects the traditional disparity in the relationship, particularly as far as the power differential is concerned (in status, prestige and economics) and how the 'underdog' profession perceives this (Devine, 1978; Wicker, 1989; Heenan, 1990). Heenan (1991) found that almost 50% of the nurses who participated in a UK *Nursing Times* survey were dissatisfied with their relationships with doctors, particularly in teaching hospitals, where there was an atmosphere of

competitiveness. When asked how they saw the relationship, 42% said that it was a partnership and 31% considered themselves subordinate to the doctor. Despite this, some authors suggest that the core self-view of nurses and their roles is dependent on the perceptions of 'significant others', and significant among them have been doctors (Devine, 1978). Paradoxically, more than two-thirds of nurses in Heenan's study thought that doctors failed to understand the nature of their work. Only 40% felt they were consulted about clinical matters, and almost 50% believed that doctors never read their notes. Nurses tended to feel more comfortable with junior doctors and to see consultants as 'desperately trying to keep hold of their authority'.

However, in other surveys and participant observation studies in general nursing (Porter, 1991; Mackay, 1993) nurses reported feeling less subservient to doctors and experiencing much greater participation in informal decision-making; they appeared to be more concerned about their relationships and status within their own profession. The nursing hierarchy remains quite rigid in its control of nurses and has been slow in adapting to changes.

What can doctors do to improve the doctor–nurse relationship?

Doctors can do much to improve the nature of their relationship with nursing colleagues, and here we suggest how. Most of our suggestions follow common sense, involving awareness, professional respect, tact and sensitivity. Our advice falls into three categories: engagement (Box 3); clinical management (Box 4); and help and support (Box 5). Finally, in Box 6, we list areas of future collaboration.

Conclusions

The nature of the doctor–nurse interaction is changing in substantial ways. Moving away from the traditional relationship, with its considerable differences in power and influence, nurses and doctors are now becoming equal partners in the clinical domain. Although it is important to understand the historical factors that have determined each profession's roles and responsibilities, as well as areas of conflict and disagreement, it is the mutual interdependence of nurses and doctors that will lead the way to true collaborative clinical work in psychiatry. The nature of psychiatric practice makes it even more vital to communicate and clarify the ways in which that relationship can be affected by dynamic interactions with patients in community and in-patient environments.

Box 3 Engagement

- Make sure you know the names of all the nurses on the unit, and introduce yourself to new arrivals; involve yourself in the orientation of new staff
- Seek informal opportunities to meet with nurses; spend time in informal chat in the nurses' office, hearing the issues of the day
- Familiarise yourself with evolving nursing skills and changes to their roles and responsibilities
- Ever considered spending some time with the night staff?

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Box 4 Clinical management

- Make sure that your clinical decisions are well understood by others and that you have covered all contingency plans and set review dates
- When giving instructions make sure that you address them to the senior nurse, who will delegate to other nurses if necessary
- Do not volunteer nurses to carry out a task without asking them first
- If you pick up early signs of disgruntlement, particularly with any decisions that you have made, don't let things fester, thinking that the problem will go away: be prepared to be criticised and to make changes to your clinical judgements when appropriate
- When delegating, do not presume that nurses are there to carry out menial tasks or that they are less busy than you are: it might take the same time to explain what you want done, as to do it yourself; some tasks, such as finding out information or sending invitations to care programme approach meetings, can be carried out by administrative or clerical staff

Box 5 Help and support

- Create a culture in which all team members are encouraged to contribute and air their views
- Discuss with nurses how they can take a leading role in ward reviews, organising priorities for discussion and timetabling of invitations to outside agencies and carers
- Be prepared to muck in when there is a crisis: this may involve active participation in the control of a patient who is aggressive or agitated
- Ensure that safety is high on your agenda; attend health and safety meetings with nurses
- Let nurses know well in advance when you will and will not be available
- When serious incidents occur, such as an unwarranted physical assault on a member of staff or a suicide on the ward, attend and lend support at the debriefing session, share feelings openly with staff involved and present an united front when having to address these issues with managers, patients and carers
- Acknowledge and give recognition to nurses' skills when the opportunity arises, and publicise them to outside agencies and management
- Emphasise the team approach, the need for collaboration and mutual dependency on each other's skills; refer to yourself as a member of the team
- Be prepared to support nurses when they have arrived at decisions and independent judgements in your absence, even if you have reservations about them or they have had negative consequences; review judgements fairly in open, frank discussion in circumstances where all staff can feel comfortable
- Have regular staff meetings, preferably chaired by nurses, and be prepared to take action when required; meet with the nurse manager and other senior staff to discuss policy, philosophy of care and management issues
- If possible, organise away-days with the in-patient team, with workshops and interactive sessions, attended when appropriate by an external facilitator; this will give everyone time to think about topics that you do not have time to deal with during everyday practice
- Be aware that your main role is to contain anxiety in a very stressful environment and one that exerts a considerable emotional strain on the nursing staff; it is expected that senior doctors will 'sort it out' and that they ultimately carry clinical responsibility

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Box 6 Areas of future collaboration

The following areas present opportunities for practical arrangements for joint working

- Joint training updates on, for example, control and restraint techniques in the management of violent, aggressive patients; resuscitation, management of anaphylactic shocks and epileptic seizures; child protection issues; benefits and housing; mental health law; human rights
- Joint assessments, in crisis resolution teams, community mental health teams, at the point of admission to hospital, on prison visits, in the out-patient clinic and during a domiciliary visits
- Joint opportunities for therapeutic interventions, for example in ward settings in in-patient groups, in family work or in consultations with outside agencies and services
- Work on programmes dealing with adherence to medication regimes
- Management of rapid tranquillisation
- Care programme approach plans and meetings
- Joint clinical audits examining areas of clinical practice
- Arranging for nurses to train junior doctors in their initial placements on acute wards, or in their first forays into community care
- Arranging for doctors to train junior nurses in aspects of clinical assessments, diagnosis and treatments
- Joint presentations and publications on clinical practice

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Multiple choice questions

1 The doctor–nurse relationship is affected by:

- a status
- b experience
- c working environment
- d patient diagnosis
- e gender.

2 In the doctor–nurse game, nurses will:

- a challenge the doctor's decisions
- b take control of in-patient care plans
- c suggest changes to care plans
- d start to play it only after being given their first substantive appointment
- e undermine their peer credibility.

3 Doctors can improve their working relationships with nurses by:

- a emphasising their credentials and experience
- b ensuring that nurses are kept busy and have clear lines of accountability
- c setting time aside to have informal conversations
- d arguing for better pay and conditions
- e admitting that they sometimes make mistakes.

4 In the UK, surveys have shown that:

- a over 75% of the nurses questioned are satisfied with their relationships with doctors
- b half of the nurses questioned thought that they were on an equal footing with doctors
- c most CPNs would prefer to work in a primary care setting
- d nurse stress and burnout is greater in in-patient settings
- e nurses are more concerned about peer relations than doctor–nurse relationships.

5 Nurse–doctor relationships are a fertile ground for patient projection because:

- a of patients' vulnerable, regressive state
- b of patients' unconscious need to recreate a parental transference relationship
- c of patients' fantasies that doctors and nurses are likely to become romantically entangled
- d unspoken and apparent difficulties between these two professional groups
- e traditional gender assignments.

MCQ answers

1	2	3	4	5
a T	a F	a F	a F	a T
b T	b F	b F	b F	b T
c T	c T	c T	c F	c T
d F	d F	d F	d F	d T
e T	e F	e T	e T	e T