

Speak Your Truth

*Proven Strategies
for Effective
Nurse-Physician
Communication*



Kathleen Bartholomew, RN, MN

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HCPPro

Speak Your Truth: Proven Strategies for Effective Nurse-Physician Communication is published by HCPro, Inc.

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ISBN: 978-1-60146-749-2

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Rebecca Hendren, Senior Managing Editor
Emily Sheahan, Group Publisher
Mike Mirabello, Senior Graphic Artist

Adam Carroll, Proofreader
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Jean St. Pierre, Director of Operations

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HCPro, Inc.
P.O. Box 1168
Marblehead, MA 01945
Telephone: 800/650-6787 or 781/639-1872
Fax: 781/639-2982
E-mail: customerservice@hcpro.com

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05/2010
21768



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Dedication

I would like to dedicate this book to my parents, Dan and Alice Horneman. For my father who taught me how to write and my mother who taught me how to dream.



Acknowledgments

I would like to acknowledge that this book would not have been possible without the insightful and research-based contributions of doctors Alan Rosenstein, Gerald Hickson, Jon Burroughs, and Joe Bujak, as well as Debra Gerardi's work on conflict-competent organizations. I deeply appreciate their time, effort, and partnership on our journey to create collegial teams.

Thank you also to Nancy Loftin at Parrot Eyes Photography for the cover photo.



About the Author

Kathleen Bartholomew, RN, MN

Kathleen Bartholomew, RN, MN, managed a 57-bed orthopedic and spine unit in a tertiary hospital in Seattle for five years before turning to writing and public speaking full time. The first edition of *Speak Your Truth* was accepted as her master's thesis while studying at the University of Washington, Bothell.

As a registered nurse and counselor, Bartholomew uses story to bring to light the challenges and issues facing nurses today. Her strength is her ability to link the academic world with the practical reality of the hospital. Her objective is to serve as a much-needed voice for nursing today.

Bartholomew has been a national speaker for the nursing profession for the past seven years. Recognizing that the culture of an institution is critical to patient safety, she speaks about the image and future of nursing, creating healthy work environments, communication, nurse-to-nurse hostility, and improving physician-nurse relationships.

She is the author of the HCPro books *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other* and *Stressed Out About Communication Skills*, and is the co-author of *The Image of Nursing: Perspectives on Shaping, Empowering, and Elevating the Nursing Profession*.



Foreword

This book is long overdue. If that statement seems hyperbolic, consider that even though nurses are an indispensable component of American healthcare, nursing as a profession is in crisis—due to the decreasing number of practicing nurses and the critical faculty shortage. Also, consider that in our post-IOM (Institute of Medicine) Report quest for increased patient safety, a nurse is a critical link in the processes that keep—or fail to keep—our patients safe from unnecessary harm.

So why do we need a book about physician-nurse relationships? Because for decades we have been working around and, in effect, hiding another truth: Poor relationships, poor communication, and compromised cooperation between physicians and nurses have a huge and frightening impact on our ability to keep patients safe from unnecessary harm and stay in a profession that too often demeans and devalues nurses.

This book is not an extensive complaint from the parochial perspective of an RN. Indeed, nurses not only respect physicians' central role in everything their profession accomplishes but also have a responsibility to create a renaissance in the way they and physicians work together. The closed-claim files of patient injuries are bursting at the seams with examples of disasters that resulted directly from ignoring the basics of teamwork.

Physicians who already understand in their gut and practice these methods of collegiality and teamwork will find this book an energizing validation. For those who have been trained to function in other ways, this work offers to show you, like Marley's ghost in

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Dickens' *A Christmas Carol*, the unvarnished truth of the terrible damage that poor relations and poor communication can ultimately inflict on our patients and profession.

To say that American healthcare is evolving is a gross understatement. Medical technologies change by the day, and the advent of robust evidence-based medicine roars through the landscape of traditional medical training with a combination of promise and challenge. Coupled with the sudden discovery of how risky healthcare is from the patient's point of view, these changes have spurred us to reexamine everything we do—almost. We missed one thing, and covering it is the purpose of this book.

The traditional “design” of the nurse-physician relationship is worse than archaic in today's system; it is, quite simply, dangerous to life, limb, and profession. We must do more than lay this disturbing truth on the table—we must address it, and quickly.

John J. Nance, JD

A Founding Board Member of the National Patient Safety Foundation



Introduction

The Power of Culture

My first consulting engagement was to help a general surgeon who was about to lose his medical license due to his medical negligence regarding the deaths of two of his otherwise healthy post-operative patients who were both in their 40s. On both occasions, he performed a fairly routine procedure (Roux-en-Y bypass and a partial colectomy for diverticulitis) only to have both patients die because he refused to come into the hospital in the middle of the night to address post-operative complications (a leaking anastomosis for the Roux-en-Y bypass and an unaddressed bleeder for the partial colectomy that led to hypotension and an acute myocardial infarction). Why did he refuse a nurse's request to come in when in retrospect he knew that the nurse's request was based on sound judgment? He had an undiagnosed depression that paralyzed him and made it impossible for him to function late at night. What about the nurse? What was her role in these tragic events?

As it turned out, this general surgeon was not only considered the best surgeon on the medical staff but was also considered the best physician on the medical staff. He was compassionate, respectful of the nurses, collaborative, and extraordinarily dedicated to the healing arts profession. He graduated from a prestigious medical school and residency and was an innovative and dedicated healing force in the community, constantly pushing the envelope for bringing new services and technology to a relatively small and isolated healthcare environment. He was so good that his practice was enormous and he

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cared for thousands of patients who did not even need surgery; they just wanted a superb diagnostician and caring human being to minister to them and their families at their time of need.

Everyone on the nursing staff knew that he had an undiagnosed depression. A dedicated family man, he had recently gone through a painful divorce because of his occasional outbursts of anger and abuse toward his wife. He would have rare outbursts on the medical floor and then the next day he would apologize for his disruptive behavior. The physicians and nurses covered for him out of respect, admiration, and a deep awareness of the magnitude of what he had brought to the community in balance. He was a beloved practitioner to all.

The two nights that his two post-operative patients began to fail, the nurse on duty covered for him by providing incremental measures at the bedside to address the patients' fever or hypotension because she did not want to "get the physician in trouble" or to expose what everyone knew was at the root of his pain. She knew that it was a violation of hospital policy and state law to not go up the chain of command in such an instance; yet, she admired and appreciated the physician not only because of his rare professional gifts, but because despite his undiagnosed issue, he always seemed to rise above his personal circumstances and to place the interests of his patients before his own. Unfortunately, by advocating for this wonderful physician, she abandoned her patients and partnered with the physician in inadvertently enabling them to die.

Sometime later, the physician took a leave of absence to get his depression treated and eventually returned to a successful practice, remarried, and made his peace with the devastation that his illness had caused. One day at a medical staff meeting, he asked the chief of staff why he and his colleagues had turned their back on him while he quietly

suffered from a treatable illness. The chief of staff turned to him, looked him squarely in the eye, and simply stated, “I thought we were helping you by looking the other way.”

Such is the nature of culture.

Culture is a powerful thing. It is not what we think, not what we say, not even what we intend; it is what we do at the end of each and every day. As Kathleen has poignantly and eloquently illustrated throughout the book, our culture is severely dysfunctional and broken. It is based upon a uniquely American myth that individuals are all-powerful and capable of professional perfection if they but work enough, sacrifice enough, and want it badly enough. Our culture is strewn with the broken lives of people and their families who have given everything to pursue this noble ideal, only to find they have over-reached, and in the process have damaged something deeper and even more precious: the right to be who we are and to accomplish in this life what we are really intended to do. The right to have meaningful work, rich and rewarding family lives, and passions that come from our heart and are often manifested through quirky hobbies, such as motorcycle riding, mountain climbing, or other pursuits, passions that seem to have no rational basis but provide some of the most important and meaningful experiences of our lives.

The traditional culture of the all-knowing and powerful physician with the deferential and self-abnegating nurse providing flawless medical and nursing care is a lie that must be systematically dismantled if healthcare is to remain important, relevant, and meaningful to those whom we serve. Unfortunately, it has been in existence, enabled, and supported for centuries and will not die an easy death. It must be carefully and sensitively taken down with deference and respect for what it has accomplished and with the

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urgency that recognizes the destructive impact that it has had on patients and on the medical and nursing staffs, both present and past.

We will need to rebuild a sense of meaning and mission to our shared work, awaken the growing realization that we are interdependent and rely on each other's knowledge and dedication to succeed in carrying out this important work, and realize that we cannot do it alone within the traditional self-imposed boundaries of our respective professions. Policies, procedures, tools, and best practices (e.g., SBAR) won't work until we dismantle the old culture and build something of greater value and sustainability in its place and create the policies and tools together.

Culture is not an abstraction or ideal, it is what we do alone and together when nobody else is watching or listening. It represents our true priorities and values and the decisions we make every day, both consciously or not. Physicians and nurses are both in pain today from the abuses of the past; however, we will never truly become a collaborative team until we are able to let go of our pain, release ourselves from this burden, and build something better together for ourselves, for the next generation of physicians and nurses, and for the patients whom we serve.

Jon Burroughs, MD, MBA, FACPE, CMSL

Senior Consultant

The Greeley Company

I feel lucky. I have numerous colleagues—physicians and nurses—from whom I receive a great deal of joy and satisfaction. It is empowering to know that I can call on a physician, and together we can resolve any situation. It is comforting to know that I can speak my truth, and the result will always be a clearer understanding and improved working relationships. There are many truly incredible physicians out there, and this book would do a great disservice if it did not recognize and applaud their contributions.

In fact, informal questioning reveals that less than 10% of physicians are disruptive or abusive. However, the effects are far greater. Perhaps it is simply human nature to allow a few bad apples to spoil the whole bunch. Nurses seem to recall negative relationships a lot more quickly than they can narrate the positive ones, which is why one of our challenges is to tell the good stories along with the bad. Although the focus of this book is on the damage caused by poor nurse-physician relationships, there are just as many stories that serve as tributes to the many physicians who work diligently every day to nurture partnerships, share their knowledge, and build collaborative relationships. These physicians set the standard for collegiality.

Remembering our code of ethics

E. Larson proposed in her article “The Impact of Physician-Nurse Interaction on Patient Care” that “failure of physicians and nurses to work together, to share decision making, and to communicate is not only undesirable, but is actually unethical because such behavior fails to focus on patient needs and can produce harm.”

Preface

The Hippocratic Oath states that physicians should do good and not cause harm. In addition, the American Medical Association has adopted standards of conduct for professional physician behavior that state, “A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence ...”

Likewise, the American Nursing Association code states that “the nurse is responsible for contributing to a moral environment that encourages respectful interactions with colleagues.” This book demonstrates clearly that poor physician-nurse relationships cause harm. Is it ethical, then, to tolerate in any way a lack of collaboration and collegiality?

Kathleen Bartholomew, RN, MN



Disclaimer-Acclamer

Disclaimer

To facilitate ease of reading, please note that pronouns used for physicians will be in the masculine form and those for nurses will be in the feminine form throughout the book.

Acclamer

The names have only been changed to please my publisher, not to protect the innocent because, after all, nobody is innocent.

How It All Started: The Scope of the Problem

LEARNING OBJECTIVES

After reading this chapter, the participant will be able to:

- Define the chain of command infrastructure, where it began, and when it should be activated in the hospital setting
- Explain passive-aggressive communication and give one specific example of this communication from your work setting in nursing
- Explain the key concept in Crew Resource Management and how this philosophy applies to healthcare

August 1992 ...

I was sitting at my desk fighting back tears when a concerned customer leaned over the telephone answering service counter. “What’s the matter?” he asked kindly. I didn’t need a mirror to know I looked awful. The night before, my husband had left for San Francisco. His parting words were, “You can come down later with the kids—if you want to.” I didn’t blame him. We had been arguing for more than two years, and arguing in San Francisco didn’t seem like a much better option than arguing in Seattle. Still, emotion overwhelmed me when I realized that divorce was inevitable, that I was alone with five children under the age of 11, and that I was 3,000 miles away from my nearest relative. I started to explain all of this to Bob, who was a regular customer, when suddenly he took out his business card and scratched

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the name of a lawyer on the back. Then he wrote a check for fifty dollars and pushed it into my hand, insisting that I let him cover the first appointment. The very next week, my boss told me that I didn't have a job because the treasurer had embezzled the payroll and we were out of business. It was time to see the lawyer.

* * * *

The early 1900s office building stood firmly in the heart of the city. Its dark, rich wood seemed to mimic the dreary Seattle weather, and the smell of mold in the elevator reminded me of a dank forest. I imagined myself effortlessly rising up a tree trunk as I climbed toward his office.

Inside, every chair, table, and desk was covered with books, papers, magazines, and overflowing cigar ashtrays. A thin layer of smoke hung two feet from the ceiling like a new-age mobile. My first thought was, "This was a mistake. My lawyer is Columbo." But within seconds, a portly gentleman was shaking my hand and laying out my worst fear, asking, "How are you going to take care of those five kids Bob said you have?"

"I don't know," I stammered, overwhelmed at the whole idea and wanting to vanish from reality like a genie into the safety of her judgment-proof bottle.

"Do you like nursing?"

"Well, my mother wanted me to be a nurse years ago, and I have always been interested in healthcare," I answered uneasily, taken aback by his candor. Then, hoping to score a few more points although uncertain of where the game was going, I added, "And I was a candy striper."

“I’ll make you a deal,” he said looking me squarely in the eye and reaching for his Bible. “I will do your entire divorce for \$50 if you promise me that you will become a nurse.” I barely needed time to think. I come from a long line of relatives who are proud of their thriftiness. Just last year, in fact, my sister was voted most frugal by my father when, after Christmas, she bought bags of M&Ms for 75% off the regular price and then had her children spend hours separating out the green for St. Patty’s Day and the red for Valentine’s Day.

I put my hand on the Bible. “Deal!” I said. I had bartered my divorce for my career.

* * * *

Reality for me was always an afterthought—and this situation was no different. It hadn’t occurred to me to consider the practical logistics of working, going to school, and raising five children, so when I applied to every school in Seattle and discovered there was a three-year waiting list, I was taken aback. I was 36. I didn’t have three years. The only next step I could think of was to call my aunt, who taught nursing at her local university in North Carolina. She predicted that if I moved there, I’d be able to get into school within a year. It sounded like a good deal to me because just two weeks after I lost my job, a freak windstorm brought a hundred-foot pine tree crashing down on my house. When I cleared the branches from the entryway, I found a foreclosure notice stuck to the front door. Another message from the universe: time to leave town.

Camping across the United States with five children in a beat-up ’76 Ford station wagon is a story in itself. Most nights, I’d lie half awake under the car, like a guard dog protecting my herd. When we finally arrived in Summerfield 10 days later, I was so exhausted that I slept for 17 hours.

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We lived in a small trailer in the middle of 12 beautiful acres, adjacent to another hundred. My aunts helped watch the two youngest children until they were old enough for school. In order to finish my own schooling in two years, I had to take 22 credits a semester. Our car sat in the middle of a hay field, and after dinner, I would huddle inside it with a candle and my books so I could study in silence. Apparently, this was big news for a small town because the local paper ran a story about my incandescent habits.

Then one day, the nightmare was over. When they handed me my diploma, it was like receiving a gold medal. I couldn't stop crying from joy—and relief.

In my first nursing job, I was a medical-surgical nurse in a small community hospital. Orientation to the unit covered not only the skills I needed to care for the patients but also the knowledge I needed to survive working with the physicians. I was warned about the egotistical Dr. Keeting, to whom nurses were just another piece of furniture. When nurses spoke, he would glance only for a second in their direction, as if to say, “For a moment, I thought that chair said something.” Then he would resume his charting without ever acknowledging that, indeed, the “furniture” had spoken.

It was also a well-known fact that if you called Dr. Keeting to notify him of a temperature of 103, he would hang up on you. I took care of his patients for weeks, and during this time his non-verbal communication made it clear that he expected me to be invisible. He would never make eye contact or acknowledge a mere nurse's existence—unless, of course, he had summoned her himself. As a new nurse walking into a culture that I didn't understand, I said nothing. I needed time to process this new environment, the strange interactions I saw between doctors and nurses, and my new clinical responsibilities.

How It All Started: The Scope of the Problem

Once I began to make sense of the situation, I couldn't believe the injustice that was occurring within the hospital. For the past two years, I had lived in a 500-square-foot trailer with five children, worked 30 hours a week, attended school full-time, and driven almost a hundred miles a day to work—so that I could be invisible? I don't think so.

One day Dr. Keeting decided he needed to speak to me. I had been waiting for this opportunity, like a panther in the grass, for weeks—not because I had anything planned, but because I knew that an interaction would not be meaningful unless he initiated it. At 6 ft. 4 inches tall, Dr. K. used his stature as yet another means of intimidation, so when he said, “I need to speak to you,” I responded, “Just a minute.” Then, to Dr. K.'s surprise, I pulled out the nearest chair, stood on it, looked him dead in the eye, and said, “How can I help you?” Stunned, he simply walked away. Within six months of graduating, I was promoted to charge nurse because of my ability to hold my own with the physicians.

In those first few years, I learned that the doctors' barks were worse than their bites. The next time Dr. Keeting came to the floor, I was less apprehensive. I mustered some courage and asked him if he had any children. Everyone was surprised when he stopped and took out his wallet to show us pictures of them—especially me. I had thought for certain that he would yell, “It's none of your business!” but he didn't. That simplest of human gestures seemed to shift the relationship.

With a few successes under my belt, I grew bolder and decided to see what I could do about one surgeon who intimidated the nurses with his order barking and brusque mannerisms. I found out that he was Irish, and the next time he came onto the unit, I softly began to hum “Sweet Rosie O'Grady,” an Irish limerick taught to me during glee club in a convent basement as a child. After a few weeks of this, he lightened up so much

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that he even began singing to himself as he made his rounds. To this day, the manager talks about how I could get Dr. Sweeney to sing. These interactions taught me that simply connecting on a human level is an incredible catalyst for transforming physician-nurse relationships. It was a powerful lesson.

Of course, not all of my lessons were that easily won. After working for a few years in that small community hospital, I moved to a hospital that could have passed for a small city. My years there were a continuous challenge, and I only had one thing going for me: I stood up for myself. I didn't realize it at the time, but after two failed marriages, my "dukes" were up. I had been flattened twice in the boxing ring of life, and the fighting Irish in me wasn't going down a third time. I didn't know that it was the best thing I could do; all I knew was that every time I stood up for myself, I felt better.

What's the Problem?

I was reading at the bar in a local restaurant when the lady next to me leaned over to look at the title of my book. "Oh!" she said. "Are you a nurse, too?" Knowing that every nurse has a story, I asked for hers. "In 1983," she began, not needing even a second to recall a scene that happened so many years ago, "I was working in the AIDS unit of a teaching hospital in California when the resident asked me to start an IV. I simply couldn't because I was so busy. I was so far behind and had already started so many IVs. So I said, 'Why don't you?' He replied arrogantly, 'Because the patient has AIDS.'"

Every nurse I know can narrate at least one disturbing physician-nurse scene like this, and many of these stories have left deep scars. They are extremely personal and have been extremely hurtful to our pride, integrity, and profession.

It is no surprise that the most common feeling nurses experience after an incident of verbal abuse is anger (Araujo & Sofield, 1999). There is no healthy outlet for this anger, as it is seldom expressed except through horizontal violence, which is when powerless people lash out against each other. But this form of expression creates a new problem and fails to handle the primary emotion: hurt. And because the average age of nurses is now 48, many are carrying years of hurt in all they do. Therefore, even though a new generation of physicians is emerging, demographics prevent us from changing how we respond to them.

This problem has implications far beyond personal significance. Poor physician–nurse relationships affect morale, patient safety, job satisfaction, and retention (Larson, 1999; Rosenstein, 2002; Baggs et al., 1999). Such unhealthy relationships are hurtful to us and to our profession—and they aren’t getting better. A survey published in the *Journal of Professional Nursing* showed that 90% of nurses had witnessed six to 12 unpleasant incidents between physicians and nurses within one year (Manderino, 1997). After reviewing the results of that survey, VHA West Coast—a division of VHA, Inc., a national network of community-owned hospitals and healthcare systems—surveyed 1,200 nurses, physicians, and executives (Rosenstein, 2002). Their results showed that 92.5% of respondents had witnessed disruptive behavior, which confirmed the findings of previous studies. One of the surprises of the VHA study, however, was that everyone defined the problem differently, identified different barriers, and proposed different solutions. All participants, however, agreed that poor physician–nurse relationships strongly affect morale (Rosenstein, 2002).

At the end of the VHA survey, an open-ended question asked respondents what could be done about the problem. More than 500 of the respondents suggested greater opportunities for communication and collaboration. So researchers began to study how

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communication and collaboration could enhance the physician-nurse relationship. In 1999, the SUPPORT care model was introduced. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) involved specially trained nurses who worked to improve care for more than 2,000 patients with similar ailments. The study structured a system of communication designed to change physician behavior by having nurses serve as important conduits of information (Larson, 1999). In this system, doctors had to go through the nurses to get information about their patients. The study tracked the outcomes in the following seven areas:

1. Patient-physician communication
2. Timing of do-not-resuscitate orders
3. Physician knowledge of patients' preferences regarding resuscitation
4. Number of days spent in ICU
5. Ventilation
6. Reported pain level
7. Hospital resources

But the study was a huge failure. The clinical trial resulted in no improvement in any of the outcomes. After two years of counseling and meetings designed to improve collaboration and communication, there was no improvement in physician-nurse relationships, and physicians still failed to hear what nurses said about their patients. Attempts to improve communication on its own failed.

The roles, interactions, and responses of the physician appear to have deep roots that even counseling cannot sever. And although the literature thus far has not been encouraging in terms of a solution, it has identified beyond doubt that there are serious problems that stem from poor physician–nurse relationships.

Big Problems

The stress that nurses manage is akin to being air traffic controllers—falling blood pressure in 42, crying patient in 44, irate doctor on the phone becoming impatient waiting for you (and you know it) as you struggle to help a patient to the bathroom. Nurses are extremely dedicated to their profession—even at the expense of their own time and health. We have a higher rate of “sickness presence” than any other profession—that is, coming to work even when sick to care for those sicker than ourselves. “The nurse is enculturated into an ideal that is derived from the nuns in religious orders who projected an abnegation of self in tender duty and obligation to others” (Sumner, 2003). But if we do not find our voice and do not recognize the forces that silence us, our profession will not survive.

Moral distress

I looked at the doctor's order three times, each time hoping that I had read it wrong. She had written the order quickly, totally ignoring me, and was obviously in a rush. My patient was dying. She was 90 years old and had stopped eating the week before in the nursing home. She had no family or friends. Chronic renal disease and a serious stroke had left her emaciated. As she lay motionless in the bed, she looked more like a withered plant than a human being. In my mind, she needed comfort care, but during rounds the doctor had written an order to insert an NG (nasogastric) tube and start supplementary feedings. Agh!

I went to the charge nurse, who pointed out that I needed to follow the doctor's order, but I couldn't do it. I tried to talk to the doctor, hoping to find some logic in the situation, but there wasn't a second where I could explain that there was no way I would ever treat my own mother like this. The doctor wouldn't listen. All I remember was her saying, "What's your problem again?" as if I were incompetent. It took me almost two hours to get up the nerve to call the chair of the Ethics Committee—and I did it from the lounge so the charge nurse wouldn't hear.

For your patients

When nurses believe that one course of action is right for patients and physicians, who have the power to make the decision, either disagree or ignore nurses' positions, there is always moral distress: Nurses are forced to participate in a plan of care they believe is wrong. And without the final decision-making authority, we must stand by, powerless to change the situation. In this internal battle, the patient loses because such moral distress frequently leads to unfavorable outcomes.

For your coworkers

We live in a society that values cure over care, intellect over emotions, and science over art. Even though nursing is both an art and a science, society does not value it as such. So the pace of our daily lives continues to increase, regardless of how that affects patient care, and there is less time to connect with each other. This leaves us feeling alienated from our support system of many years. Today, in fact, we can only watch coworkers flounder instead of helping them because we too are "drowning" on the floor. This helpless feeling—this powerlessness and lack of autonomy—creates a great deal of moral distress.

In addition, as we spend less time with our patients in an effort to keep our heads above water, we are deprived of the joy of caring and connecting—the very reason we chose nursing in the first place.

Burnout

As a group, nurses lack power, and those who feel this lack of power struggle to be patient advocates in a system that does not reward advocacy (Sundin-Huard, 2001). This situation leaves us feeling paralyzed.

The current nursing infrastructure is modeled after the military, which uses the “chain of command” system. In this system, nurses must seek permission before taking any action, which robs us of our autonomy. In times of patient crises, however, it often proves to be useful: If we cannot get the answers or support we need, we can move up the chain of command. Start with your peers and the charge nurse, move on to the manager and nursing supervisor, and then, if necessary, speak to the physician on call or the department chair. If your concern is not validated, then at the very least, you and your peers will learn something new about the way your hospital functions.

If you stand by and watch a plan of care executed that is different than what you would advocate for a member of your own family, there is a high possibility that you are putting the patient at risk. Nurses are often put in this situation, and researchers have realized that such moral stress causes burnout, which causes nurses to leave the profession (Rosenstein, 2002; Corley, 1995).

At the end of the shift, the doctor stormed onto the floor looking for me. “Why did you call the Ethics Committee?” she said, glaring in anger. Loud enough so the charge nurse could hear, she hollered, “Why couldn’t you just talk to me?” Right.

Work environment

Nancy knew the physician was writing discharge orders for her patient because she had glanced over his shoulder to look in the chart. She approached him tentatively and said, "Doctor, your patient has a considerable amount of blood in his urine today." The doctor looked up at her annoyed and, with disgust in his voice, said, "So?" Later, he cancelled the discharge—without ever speaking to her.

More than any other factor, the quality of relationships on a unit shapes the work environment. Studies show that improving the work environment is the best way to encourage nurses to remain in the profession. But to build significant and meaningful working relationships, we need time to do so, and to nurses and physicians, time is a luxury. Because of rising acuity, patient loads, decreasing reimbursements, and hospital cuts, health professionals must work harder and more quickly. Because healthcare is a business, there is a great deal of focus on profit and loss, but what we don't realize is that we have lost the greatest capital of all: social capital.

Social capital is the time we spend connecting with each other. Conversations about family, vacations, trials, and joys help create a feeling of belonging and community. When we share our lives, we connect through our humanity. We actively participate in creating an authentically caring environment where people are valued and appreciated. But in our fast-paced world, both physicians and nurses have started to view this time as trivial, soft, and unimportant, which negatively affects the workplace and job satisfaction.

Decreased job satisfaction

Lucía has been a nurse on the same orthopedic unit for 15 years, and her peers consider her an expert in her field. Lucía is pleased with the professional relationships she develops with patients because she knows that they feel safe and confident in her care. One day, a physician enters a room where Lucía is changing a hip dressing. In less than a minute, he berates and belittles her by questioning her competence as a nurse in front of the patient. Lucía is so embarrassed by the doctor's behavior that she walks out of the room.

In 2002, Dr. Linda Aiken of the University of Pennsylvania's Center for Health Outcomes and Policy Research released a study that made quite an impact not only on the healthcare community but on consumers as well. In her study, "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," Aiken found that higher emotional exhaustion and greater job dissatisfaction among nurses is strongly associated with higher patient-to-nurse ratios. Further, for every additional patient in a nurse's charge, there was a 23% increase in risk of burnout and a 15% increase in the risk of job dissatisfaction. Aiken stated that "40% of hospital nurses have burnout levels that exceed the norms for healthcare workers" (2002).

Another indication of poor job satisfaction is the fact that in 2001, 30% of new graduates under the age of 30 were planning to leave the profession within a year. A recent AMN Healthcare survey of 1,399 nurses found that almost half (44%) plan to make a career change over the next three years and more than one-third are dissatisfied with their jobs (AMN Healthcare, 2010). Clearly, dissatisfaction is increasing. The pace of work, level of stress, lack of meals and breaks, increased acuity of patients, and verbal abuse by physicians contribute significantly to an environment that provides little satisfaction or reward and is, at best, described as tolerable.

Retention

Rehema was in her fourth week of orientation on the unit when the charge nurse asked her to make rounds with the physicians. She proceeded to the first room, where the doctor was reviewing the chart just outside the door. She introduced herself and said the manager had asked her to round with the doctors so that she could become familiar with the physicians and learn from them. The doctor looked up for a moment, said nothing, and then continued going through the chart. Rehema waited patiently, and then followed him into the room. After several minutes of talking to the patient and ignoring her, he finally looked up and said, "Yes?" Rehema got the message. She gave up rounding with that physician and prayed that the manager would not expect her to try with another.

According to an April 2001 study by the Federation of Nurses and Health Professionals, one out of five nurses now working is considering leaving the patient-care field for reasons other than retirement (2001). But what are the reasons? In a recent online survey (2001), 35% of participants said they left nursing specifically due to verbal abuse by a physician. These statistics are symptoms of a serious problem (Aiken, 2001).

Have you ever seen a domineering parent yell at a child, only to have the child turn around, run onto the playground, and push another child off a swing? This behavior is called "submissive-aggressive syndrome" and illustrates the simplest form of horizontal violence. Nurses do it all the time. The phrase "nurses eat their young" didn't come out of a fortune cookie. It came from observations we made to each other about our own culture.

Student nurses come onto the unit and (in a nursing shortage) we complain that they are in the way and they "just don't get it." But what they don't get is lunch—or dinner. And it's not okay with the new generation to go a week without a meal break.

We offer support to each others' faces, and yet talk behind each other's backs. This "don't rock the boat" style of communicating is common in nursing. As a profession, we have a passive-aggressive pattern of communication: We stay silent at times when we should speak, and speak up when we shouldn't. We complain to one another, but when a physician says something totally inappropriate, we are silent. While the boat may be still, we are taking on water.

Patient safety

Shanna thought she was immune to comments after 30 years of nursing. But still, the doctor's anger caught her off-guard. She felt certain that this patient had an ileus and it should be worked up immediately due to the patient's nausea and hypoactive bowel tones four days postop. Yet when she asked the physician for the tests, his tone was so angry and so vile that she fled to the bathroom, tears welling in her eyes. If he struck her it couldn't have hurt more.

When KLM flight 1422 crashed in March 1977, 583 people died. The world was shocked, and the airline industry reacted swiftly to determine what had happened. After listening to the cockpit recorder, investigators realized that the culture of the cockpit prevented the first and second officers from challenging the captain—and having done so could have prevented the crash. The airline industry took a hard look at the cause of this crash and others and developed a philosophy of "Crew Resource Management." In essence, it shifted the industry's culture from one in which the captain's actions were not to be questioned to one in which every member of the team was responsible to speak up when in doubt, to confirm and question orders, and to offer insight. It also made the commander take responsibility for creating and nurturing this type of environment.

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Nine hundred twenty-three people die each week in healthcare settings across the United States as a result of medical mishaps. But because the bodies are scattered throughout the country, we don't see the terrible impact of such mistakes. If a Boeing 737 crashed every Monday, Wednesday, and Friday for an entire year, the number of deaths would be comparable to unnecessary deaths in healthcare (Leape, 1999).

In fact, the Institute of Medicine estimated in 1999 that 48,000–98,000 people die in the United States every year from medical errors. Five years later, in 2004, HealthGrades reanalyzed these numbers and concluded that not only were they accurate, but that they had been underestimated—and there have been no significant improvements in patient safety since the report's release. Preventable medical errors are now the third leading cause of death in America despite a call from the IHI and patient safety experts in 2006 to address the communication gaps which cause 84% of all sentinel events. And in a 2008 study, 77% witnessed disruptive behavior with physicians—which contributed to errors and death.

Study at a Glance: Impact of Disruptive Behavior on Patient Care

In a study of 102 hospitals with 4,530 participants (of which 2,846 were nurses) by the VHA West Coast:

- 77% reported witnessing disruptive behavior in physicians (88% RNs, 51% MDs)
- 65% reported witnessing disruptive behaviors in nurses (73% RNs, 48% MDs)
- 67% linked disruptive behavior with adverse events (medical error 71%, patient mortality 27%) (Rosenstein, O'Daniel, 2008)

Physician-nurse communication and collaboration are critical to patient safety (Baggs et al., 1999). An important study by Knaus, Wagner, Zimmerman, and Draper (1986), set in 13 ICUs, examined how staff interaction and coordination affected mortality. They were able to demonstrate that ICUs with positive nurse-physician relationships had a better risk-adjusted survival rate. They also found that communication and collaborative problem solving are key to patient safety, particularly for high-risk patients. Another study found that nurse-physician relationships are one of the seven categories of determinants of patient mortality (Tourangeau).

The Joint Commission instituted a National Patient Safety Goal in 2004–2005 that included “Improving the effectiveness of communication among caregivers.” Nothing shapes the work environment more than the quality of relationships and communication styles on the unit. Improving physician-nurse relationships improves patient safety, but facilities still continued to tolerate bad behavior that affects patient care. In 2010, The Joint Commission required healthcare facilities to “establish a code of conduct that defines and sets out a process for handling unacceptable behavior.”

Staffing levels

Significant research supports the claim that the nursing shortage and staffing levels greatly affect patient safety. A survey conducted by the Harvard School of Public Health and the William J. Kaiser Family Foundation, which was published in *The New England Journal of Medicine* (2002), found that 53% of physicians and 65% of the general public cited the shortage of nurses as a leading cause of medical errors. A study funded by the National Institute of Research found that every additional patient in an average hospital nurse’s workload increased the risk of death in surgical patients by 7%. *Health Care at the Crossroads* (The Joint Commission, 2002) looked at 1,609 deaths and injuries since 1996 and found that low nursing staff levels were a contributing factor in 24% of the cases.

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Dr. Linda Aiken concluded that “failure to retain nurses contributes to avoidable patient deaths.” Nurses report greater job dissatisfaction and emotional exhaustion when they are responsible for too many patients (2002).

Factors Affecting Today’s Nurses and Physicians

Physicians

When a fresh postoperative patient’s blood pressure plummeted, I called the operating room to tell the surgeon that his patient’s blood pressure had dropped to 78/40. I quickly organized my thoughts and relayed what I thought was the most important information. “She’s not actively bleeding, and the reported blood loss in surgery was less than 200 cc.” I was not prepared for his unmoved response: “Is that my third surgery today or my fourth?”

Do you remember as a child seeing the car of a doctor with the caduceus symbol proudly displayed on the license plate? When was the last time you saw one of those? Television shows from the '70s and '80s typically portrayed the physician as an important and respected citizen. The symbol, the caduceus, used to guarantee that a physician could park just about anywhere and not get a ticket. Although it may seem like a small thing, it was a symbol of society’s respect for the doctor. Back then, Good Samaritan laws were created to protect physicians from being sued when they stopped to help at an accident scene.

Recently, one doctor at our facility got a speeding ticket for going 80 mph as he transported a heart to another hospital. Even after he showed his identification and explained the situation, the policeman shrugged his shoulders and wrote the ticket. To the policeman, he was nobody special, and the heart in the cooler in the backseat wasn’t a good

enough reason to let him off the hook. After that incident, the doctor told me, “Times have changed.”

Another factor affecting physicians is the sharp rise in malpractice insurance. Many physicians cannot afford to be in private practice any longer, so more are working for hospitals instead. Medical associations are advocating for tort reform in a society where consumers are “sue happy.” Physicians are working longer hours for lower reimbursement rates.

Not only are physicians working longer, but they are working faster. “On average, a physician will interrupt a patient describing her symptoms within 18 seconds. In that short time, many doctors decide the likely diagnosis and best treatment” (Groopman).

In addition to these issues, “Doctors are unhappy about their loss of autonomy, falling income, and increasing workload,” says LeTourneau (2004). Because of this loss of autonomy and ability to practice privately, physician assistants and nurse practitioners, whose positions were designed to help the physician, are often seen as threats. Under such circumstances, attempts at collaboration are thwarted because the physician perceives his coworkers as competition.

Nurses

“Take a break,” said the charge nurse.

“I just can’t,” called back Julie. “They are calling for 964 for surgery NOW, and the second unit of blood is here for 68.” It was 1:30 p.m. “I’ll take a break after I get caught up,” she said. The charge nurse proceeded to take the two new surgeries, and it was 4:00 p.m. before the two reconnected.

“Missed meal, missed break” was written on both of their timecards—again.

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Like physicians, nurses have also noticed an increased workload over the past few years, and because many nurses believe strongly in duty, obligation, and getting the job done, they are stretching themselves to the max. Patient acuity is higher and length of stay is shorter, which means that the patients who are in the hospital are sicker.

Also, due to the advances in medicine, hospitals are full of patients with chronic and secondary illnesses who in earlier years would not have survived. Advances in pharmacology have yielded a multitude of medicines, but with as many as 25 pills to give one patient, the stress level rises.

The nursing shortage has also resulted in an increased use of travelers and agency staff who fulfill important roles but who need to interrupt in order to ask questions because they are unfamiliar with the unit.

Because they are so busy, nurses have less time to spend with patients (e.g., one study found that patients receive less than 20 minutes of direct care in a 12-hour shift) and less time for interacting with the physicians (Ball, Weaver, & Abbott, 2003). This precious time spent interacting with each other builds relationships and supports nurses at work, but in the fast-paced healthcare environment, there is no time. Small talk is a luxury few can afford, so nurses miss out on the personal connections that produce job satisfaction and great working relationships.

It doesn't help that nurses are the least educated members of the healthcare team. More than half of the nurses in the United States do not have a four-year college degree. This disparity in education keeps the profession in the subordinate position—as the author of *Negotiating at an Uneven Table*, Phyllis Beck Kritek, says, we are playing at an “uneven

table.” Expecting a nurse with a two-year degree to communicate effectively and collaborate with a physician or pharmacist who has a doctorate is unrealistic.

There is no other profession that nurses must collaborate with professionally that does not require at least a four-year college degree. Given the wide disparity in education between nurses and other members of the healthcare team, clinical discussions that involve research, outcomes and clinical outcomes can be challenging at best (Knox & Simpson, 2004).

Education is one of the most concrete actions that nurses can take to even the playing field. The push for evidence-based practice and standardization of care requires that nurses feel competent and knowledgeable in dialogue with physicians.

Conclusion

There is a severe nursing shortage. Nurses say the work environment is the most significant problem contributing to it, and nothing shapes the environment more than relationships. Now that poor physician-nurse relationships have been directly linked to higher patient mortality rates, administrators are paying more attention to the culture of relationships on the unit, but improving these relationships has proved to be a huge challenge.

What do we know about physician-nurse relationships? In a nutshell, research tells us that:

- Collaboration alone does not work
- Enhancing opportunities for collaboration does not work

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- Units with positive physician-nurse relationships have decreased patient mortality rates
- Perceptions about the problem, barriers, and solution differ greatly between nurses, physicians, and administrators
- Empowering nurses and developing a positive role for them doesn't work because doing so doesn't alter the power structure, so nothing changes in the end

So where do we go from here? Both nurses and physicians need to understand how poor physician-nurse relationships started, recognize the forces that prevent us from having collegial relationships, and learn key practical strategies to change these relationships. As noted communication expert Susan Scott says, "Communication isn't about the relationship, IT IS THE RELATIONSHIP! If we don't feel free to comment or ask questions, then we don't have the collegial relationship with our physician partners that is so critical to patient safety."

In the end, improving communication with physicians is about creating an equal partnership where both parties respect and trust the roles each play in patient care. In a 2004 study, only 15% of physicians and nurses perceived that they had "excellent" relationships with each other, and only 25% were "very good" (Buerhaus, 2004). Clearly there is a tremendous opportunity to improve 75% of our working relationships. And because our relationships affect patient mortality, safety, retention, morale, and job satisfaction, improving our relationships is our ethical responsibility.

How It All Started: The Scope of the Problem

Elsie is the day charge nurse for the unit. The doctor approached the main station, like a soldier with a purpose, and said, "I need to talk to you. The patient in room 64 has an autovac and the blood was not reinfused." His voice grew louder. "What's the purpose of putting in the damn drain if you don't infuse the blood? I want a QI written out about this!" And before Elsie even has a chance to speak, he storms off the floor. "I'll look into it," she says to his back. "I'll look into it and get back to you," she says to the elevator doors as they close.

REFLECTIVE EXERCISE

Imprinting

Think back to nursing school. What was your very first interaction with a physician like? How did your early experiences as a student and new nurse shape how you deal with physicians today?

Does a story come to mind? Tell someone you trust your first RN-MD story.



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