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The physician-nurse relationship from a social identity perspective

Ruben Vermeir[1], Renaat Peleman[1,2] and Peter Vermeir[1,2*]

[1]*Ghent University (Belgium), faculty of medicine and healthcare sciences*

[2]*Ghent University hospital (Belgium)*

[*]Corresponding author
Peter Vermeir, Ghent University/ Ghent University Hospital, C.Heymanslaan 10 9000 Ghent (Belgium) peter.vermeir@uzgent.be

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Abstract

Introduction

Nurses and physicians are 2 key players in a well-functioning and high quality healthcare system. The relationship between these two professions is continuously evolving.
Combining the social identity theory (SIT) and the self-categorization theory, this review explores the physician-nurse relationship from a social identity perspective.

Methods

Screening of PubMed, Web of Science, Cinahl and Cochrane Library on the keywords 'Physician', 'Nurse', 'Social identity', 'Relationship', 'Medical education', 'Interprofessional collaboration', 'Teamwork'.

Results

To understand the physician-nurse relationship it is important to take note of the two very different identities of both professions. A nurse mainly provides hands-on care while physicians are tasked with diagnosing and setting up a treatment plan to cure the patient. With the evolution of the nurse practitioner we see these boundaries fading between the two professions with nurses becoming more independent. Patient care and safety relies more than ever on teams of people with a range of skills working effectively together. A well cooperating team is based upon the professional skills of each member. Physicians were considered highly competent by both nurses and other physicians. Social identity theory might be of help to make blurred distinctions clear by actively looking for dangers lurking in the stereotype threat. This could be useful to organize a better function healthcare system on an organizational level.

Conclusion

Being a nurse or a physician is a big part of the identity of the person as stated by the SIT. Nurses are becoming more and more independent. It could be useful to set up a structure with the aim of improving collaboration between physicians and nurses, and also other healthcare professions. Incorporating collaboration in the curriculum of students in de medical field could prove beneficial to both the healthcare provider and the patient.

Keywords: Physician, Nurse, Social identity, Relationship, Medical education, Interprofessional collaboration, Teamwork

Introduction

Physicians and nurses are fundamentally two distinct social identities. Both professions have different roles in the healthcare system. This can result in competing goals. In a hospital setting and in the daily practice of cure and care, physicians need to rely on nurses. Nevertheless both professions also need to work shoulder to shoulder as well. Their interaction has evolved over time from strict dependency over interdependency to independent roles for the nursing profession where they are key component of a multidisciplinary team. Mutual understanding and optimal interaction is

essential in order to achieve desired outcomes for the patient. Professionalization through improvement of skills, communication and mutual respect determines a successful relationship.

The social identity theory (SIT) offers a theoretical framework to predict intergroup behaviors on the basis of a number of perceptions, including differences of group status, legitimacy and stability of those differences, and the ability to move from one group to the other [1]. The social identity approach (SIA) is based on two main theories: SIT and the self-categorization theory. These two theories allow for a detailed analysis of the functioning of an individual as a part of a group [2].

Every person, whether conscious or not, has a strong drive to maintain a view of themselves as having integrity. Differences or discrepancies in social identities harbor the potential to harm the perception of self-integrity. Specifically, in respect to physicians and nurses, when the social group of nurses is believed to be less capable or perceived as professionally less competent, the self-concept can be affected. Reactions to such identity threats can sometimes lead to problematic outcomes (e.g., inordinate stress and/or professional disengagement in the case of disadvantaged groups, defensive attitudes and denial in the case of privileged groups).

In this review, the physician-nurse relationship is explored from a social identity approach.

Methods

A search was carried out on the databases PubMed, Web of Science, Cinahl and The Cochrane Library using the keywords: 'Physician', 'Nurse', 'Social identity', 'Relationship', 'Medical education', 'Interprofessional collaboration', 'Teamwork'. The keywords were internally validated by the co-authors. In order to qualify for this review articles needed to be 1) published between January 1, 2000 and September 30, 2020, 2) available as full text in English 3) categorizable as original research, reviews, meta-analyses or letters to the editor. Database screening was closed 2nd of October 2020. Only articles in the English language were included in order to avoid misinterpretations. Titles and abstracts were reviewed to verify inclusion criteria. If all inclusion criteria were present or if this remained unclear, the articles were fully read. All studies were screened for eligibility by two independent reviewers (PV, RV) who reviewed titles, abstracts and full text. Any disagreements were resolved by discussion and, if necessary a third reviewer (RP) was consulted. Additional literature was obtained through searching references in the manuscripts (snowball method).

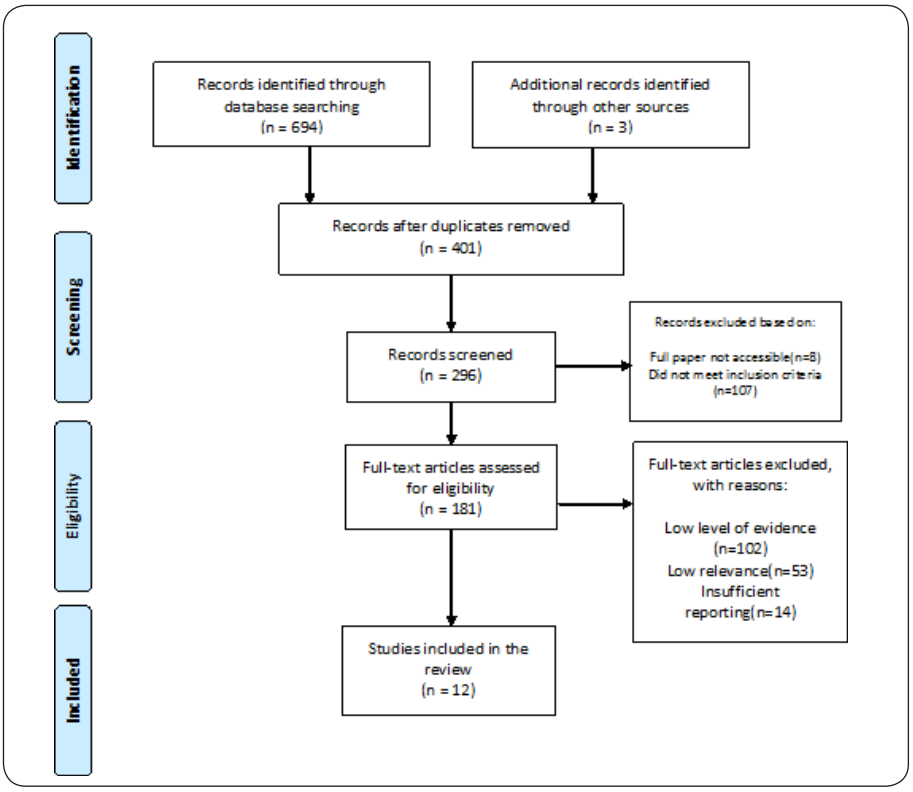

Figure 1: Review stages based on PRISMA flow diagram (3)

The results of the search process are summarized into a PRISMA flow diagram (Figure 1). Out of a total of 694 papers selected, 401 duplicates were removed. Through the snowballing method of screening the reference lists of relevant articles, 3 additional articles complying with the inclusion criteria could be identified and were added.

After screening 296 papers on title and abstract 181 papers re-

mained for full-text screening. 12 papers were included in the review.

Results

History of the "doctor-nurse" relationship

The phrasing "doctor-nurse game" was already coined by Leonard Stein in 1967. Originally the game was described as an intricate interaction, carefully developed over time, in which both players were willing participants. There was clear agreement that physicians were superior to nurses and all of their interactions were managed so that this hierarchy was not threatened. The cardinal rule of the game was that open disagreement between players was utterly forbidden [1].

In 1990, Stein et al revisited this notion, showing that one of the players, i.e. the nurse, had unilaterally decided to stop playing the game [1]. They felt that nurses had become hostile and stubborn rebels, and that this was associated with the development of autonomy in health professionals with well-defined areas of expertise. This move towards independent function fueled the wish to work as equal partners with other health care professionals, not limited to physicians. A systematic review has shown that improvements in nurse-physician collaboration are associated with improved outcomes to patients and health care managers [4].

An open and constructive debate between physicians and nurses avoids a culture of blame and favorable impacts on quality of relationships and therefore care. Fagin and Garelick (5) attribute the change in the "physician-nurse" relationship to societal changes such as the workplace context, developing multidisciplinary relationships, the status and experience of physicians and nurses, patients' expectations, training and education, institutional norms, professional norms, risk management and defensive practice.

Differences between physicians and nurses

Although nurses and physicians work side-by-side in many situations and need each other to complete certain tasks, there still remain major differences. Physicians need to take risks and deal with uncertainty, while nurses are more attuned to following protocols and providing hands-on care. However, some argue that diagnosis is almost the only skill that defines doctors [6]. This is clearly untrue, as diagnostic actions are only the beginning of an integrated management of health care, involving treatment and monitoring of evolution, communication on issues of management and prognosis with the well-informed patient. A nurse practitioner (aka NP or APRN, Advanced Practice Registered Nurse) is a registered nurse with additional education allowing patient assessment, counselling and sometimes even prescription of medication or other types of care. A nurse practitioner provides care with focus on a particular patient population or in a specific care setting, using standard operating procedures. Therefore the nurse's role is expanding into traditionally medical areas of diagnosis and treatment previously reserved for physicians. Nevertheless this remains within the framework of delegated care in a hierarchical model. In this hierarchical model physicians retain final and overall responsibility but allow degrees of autonomy through training and the acquisition of additional skills. This organization of care through delegation allows physicians to spend more time to key skills at a lower direct cost of employment. Furthermore, nurses, as well as nurse practitioners, are likely to spend more time with patients, hence allowing the exploration of issues at risk of being insufficiently addressed in physician consultations [6].

However, both roles are essential and arguably of equal importance to the medical industry. Putting stereotypes aside, these differences between physicians and nurses need to be acknowledged. First of all, physicians and nurses differ in their job descriptions. In most cases, the physician is tasked with examining and diagnosing patients. A nurse, on the other hand, will have a more hands-on role with physically treating a patient based on the physician's diagnosis. However, both jobs can be physically and emotionally demanding. It should be pointed out that the role of a nurse is not always as a subordinate to doctors. Another major difference between a doctor and nurse is their salary. While not always true, the average doctor earns a higher yearly income than the average nurse.

Nurses and doctors also differ in length of college study. While some nurses obtain specialized degrees in a graduate program, the minimum degree requirement for a registered nurse (RN) is a four-year bachelor's degree. A doctor, however, must obtain a Master's degree which takes six years on average. A specialist physician, however, could remain in university for over a decade. Both a doctor and nurse will typically earn a higher wage for obtaining advanced degrees. It seems that both are compensated for lengthy college stays.

Collaboration in medical education

The medical curriculum has changed dramatically over the years. The Flexner report sets the stage in 1910 when the medical education in North America was assessed by visiting all 155 medical schools in operation at that time in the United States and Canada. At the core of Flexner's view was the notion that formal analytic reasoning, the kind of thinking integral to the natural sciences, should hold pride of place in the intellectual training of physicians. In addition to a scientific foundation for medical education, Flexner envisioned a clinical phase of education in academically oriented hospitals. Thoughtful clinicians would pursue research stimulated by the questions that arose in the course of patient care and teach their students to do the same. To Flexner, research was not an end in its own right. It was important because it led to better patient care and teaching. Indeed, he endorsed the motto: "Think much; publish little" [7]. Thus, professionals in training must master both abundant theory and large bodies of knowledge. The final test of their efforts, however, will be not what they know but what they do and how they do it.

Presently, increasing emphasis is being placed on evidence-based practice, systems approaches, and quality improvement. Advances in these areas require the ability to integrate scientific discoveries and context-specific experimentation for the continuous improvement of the processes of medical practice.

There used to be little emphasis on the collaboration and the interaction between doctor's and other professionals. Health care has become more complex and specialized. Patient care and safety relies more than ever on teams of people with a range of skills working effectively together. Patient outcomes are contingent upon the

physicians' skills in diagnosis and treatment, as well as upon nurses' continuous observations and their skills in communicating the right information to the right professional partner.

Individual physicians and nurses frequently collaborate to care for a particular patient. While the chief medical officer and the chief nursing officer may work collaboratively, there has generally been no mechanism in place for these professions to exercise leadership together and direct the clinical work of the hospital as unique and complementary experts with a common goal [8].

Good hospital care depends on a system that secures continuity of information and inter-professional collaboration [9]. However, the relationship between physicians and nurses in hospitals has never been a symmetrical one. The two professions look at co-operation from different perspectives of patient care, different levels in the status hierarchy, and different sides of the gender gap [10].

Social identity theory (SIT), physicians and nurses

Professional identity in nursing is complicated. Historically, nurses have struggled to define their work in parallel to the other professions. It is proposed that through applying Social Identity Theory to the nursing profession, nurses can develop a fuller understanding of their own professional identity. As explained by Willetts and Clarke (11), SIT recognizes the contextual importance of organizational groups. Equally important is the context in which professional groups engage in the daily activities specific to their profession and their workplace [11].

It is in these situations that the stereotype threat may be lurking. First of all, only those who have knowledge of the stereotype, either conscious or unconscious, will feel its effect. People who have never had any exposure to the stereotype cannot experience stereotype threat (doctors versus nurses as a profession). The type of connection to the stereotyped group is also important. For example, laboratory technicians are neither doctors nor nurses and thus do not identify with either of these groups, but they do perform medical procedures. Finally, to be concerned about confirming a negative stereotype, a person must care about that domain. These people are more focused on overcoming the obstacles created by negative stereotypes and might also experience stereotype threat more profoundly [12].

The field of physician–nurse collaboration has been sociologically attractive as it condenses the classical discourse of profession, power and gender [9]. To be an attractive co-operational partner, one must also possess the professional qualifications considered necessary by the other party to reach the common goal. Physicians were considered highly competent by both nurses and other physicians. On the contrary, physicians were uncertain about the nurses' competence. To physicians, good co-operation means having their therapeutic decisions effectively implemented and being kept informed about their effect. Nurses are in the business of reforming inter-professional relationships. To them, co-operation does not only mean communicating medical observations or administering medication. It also consists of being appreciated for their independent contributions to the healing process, for example: by mapping and understanding the patients' complete situation and set of needs and thus effectively mobilizing his/her coping strength [9]. It is the recognition that it is not what people have in common, but it is their differences that make collaborative work more powerful than working separately. Working together means acknowledging that all participants bring equally valid and useful knowledge and expertise from their professional and personal experience. Working "together" rather than working "alongside" can energize people and result in new ways of facing old problems [13].

Kreindler, Dowd (2) conducted a systematic search for literature offering a group based analysis and examined it through the lens of the social identity approach (SIA). The SIA arose from the recognition that group memberships form an important part of the individual's self-concept. Focusing on the link between the individual and the group, this approach explores how seeing ourselves and others in terms of social categories affects our perceptions, attitudes, and behavior. Founded in the insight that group memberships form an important part of the self-concept, the SIA encompasses five dimensions: social identity, social structure, identity content, strength of identification, and context. Their search yielded 348 reports, 114 of which cited social identity. The authors conclude that SIA offers a coherent framework for integrating diverse literature on health care groups. Further research should take advantage of the full depth and complexity of the approach, remain sensitive to the unique features of the health care context, and devote particular attention to identity mobilization and context change as key drivers of system transformation. The paper by Kreindler concludes with a set of "guiding questions" to help health care leaders recognize the group dimension of organizational problems, identify mechanisms for change, and move forward by working with and through social identities, not against them [2].

Collaboration at organizational level

Despite many examples of collaboration on a limited scale, the literature is not so robust when it comes to descriptions of joint leadership on a regular basis at a "big picture" organizational level. One exception to this lack of big picture thinking is the concept of "whole systems shared governance." This is an approach that attempts to re-invent hospital management structures and processes to bring together all those involved in providing care in order to effectively manage the quality and efficiency of the care provided. This relatively new development had its beginnings in nursing where there was a need to empower and coordinate the work of nurses across the organization. It is now being expanded beyond the original nursing-based model. Although the whole systems hospital shared governance model includes all caregivers (not just nurses and physicians), the participation of the medical staff is particularly important. Perhaps some form of the emerging whole systems hospital shared governance model will eventually succeed in creating a much more effective and broad-based hospital operational process. However implementation of this entire model will take more time and effort. Hence, the question arises what hospitals might do to begin this journey.

At a minimum, it is time to develop a new mental model of joint medical staff/nursing staff, hospital leadership, and create structures in support of this model. What this means will surely be different from hospital to hospital because of the great variability in the current status quo. At a basic level this might mean a

joint working party of nursing leaders and medical staff leaders to begin to test drive the new collaborative approach. The group might consider meeting quarterly at first. Obvious topics for joint consideration might include product line quality, process efficiencies, strategic planning, as well as cultural and behavioral issues. Professional behavioral friction might be a particularly fertile area to begin to address jointly. Hospitals are complex organizations that utilize many categories of skilled workers. However, hospitals contain two large and unique groups of professionals—medical staff and nursing staff. The time has come to formally and structurally harness their different but complementary skills and perspectives to enhance the commonly held mission of the organization. This is not likely to happen by chance but must be designed and sustained. Physician executives are in a particularly auspicious position to help bring about this new approach—which ultimately is only about providing better patient care. Social identity theory might be of help to make blurred distinctions clear by actively looking for dangers lurking in the stereotype threat.

Conclusion

The common goal of physicians and nurses will always be to give patients the best care possible. While this goal will never change, the method of achieving this is under continuous evolution. Nurses are becoming more and more independent while still distinguishing themselves from physicians. Being a nurse or a physician is a big part of the identity of the person as stated by the SIT. Understanding this is important to have an efficient collaboration on an organizational level. It could be useful to set up a structure to not only improve collaboration between physicians and nurses, but also between the chief medical officer and the chief nursing officer as to have a more organized cooperation. Incorporating this teamwork in the curriculum of medical and nursing students could also prove beneficial. We could go even further and incorporate this into the curriculum of students of other health care professions such as physiotherapists, psychologists, speech therapists, etc. Multidisciplinary, transdisciplinary and interprofessional are the cornerstones for high qualitative care.

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